

VENDOR NAME: SNAH Healthcare Software Management

BUYER: Crystal Hustead

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Non-Emergency Medical Transportation (NEMT) Proposal

Submitted by:

SNAH Healthcare Software Management

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Date: 9/24/2025

9/24/2025

West Virginia Purchasing Division
2019 Washington Street East
Charleston, WV 25305

Re: Response to Solicitation CRFP 0511 BMS2600000001
Non-Emergency Medical Transportation (NEMT) / Statewide Transport Program

On behalf of SNAH Healthcare Software Management, I am honored to submit our proposal in response to Solicitation CRFP 0511 BMS2600000001 for the Statewide Non-Emergency Medical Transportation (NEMT) program.

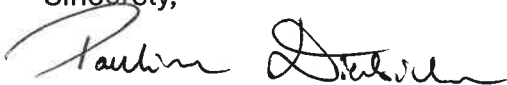
SNAH is a nationwide healthcare technology and service company with the mission to restore humanity in healthcare. Our integrated platform delivers reliable rides, eliminates fraud, and gives the Bureau for Medical Services real-time oversight of every Medicaid transportation dollar. With operations across all 50 states, a vetted national driver network, and HIPAA-compliant infrastructure, we are prepared to deliver immediate, accountable service for West Virginia.

Enclosed, please find the following documents:

1. **Technical Proposal** – including the Executive Summary, Experience, Work Plan, Fraud Prevention, Compliance, and Quality sections. Supporting attachments include the SNAH Pitch Deck, Drivers Training Book, Employee Handbook, W-9 and Certificate of Good Standing California.
2. **Attachment A – Cost Sheet** – completed in accordance with solicitation requirements.
3. **Addendum 1 Acknowledgement**
4. **Final_CRFP_0511_BMS2600000001_2_WV_CRFP_FORM**

We are committed to serving West Virginia with transparency, reliability, and innovation. Our platform was built to solve the very problems that have plagued NEMT for decades: missed rides, fraud, waste, and lack of accountability. With SNAH, those problems end.

Sincerely,



Paulina Wierzbicka
President

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1. Executive Summary

SNAH Healthcare Software Management (“SNAH”) is a nationwide healthcare technology and service provider dedicated to transforming Non-Emergency Medical Transportation (NEMT) for Medicaid populations. Our mission is to partner with states like West Virginia to deliver reliable access to care, measurable cost savings, and uncompromising accountability in the administration of Medicaid transportation benefits.

For decades, NEMT has faced the same challenges: fraud and abuse draining taxpayer dollars, members left without dependable rides, rural areas underserved, and states forced to manage fragmented systems with little transparency. SNAH was created to address these failures head-on. Our platform combines nationwide operational strength with real-time technology designed specifically to give state Medicaid agencies the oversight and control they require.

Technology-First, Compliance-Driven Solution

SNAH operates across all 50 states with a vetted national driver network integrated into a HIPAA-compliant technology infrastructure. Every ride is validated in real time using two safeguards:

1. **GPS Tracking** – Continuous trip monitoring ensures members are picked up, transported, and dropped off at the correct locations.
2. **One-Time Passcode (OTP) Verification** – At both pickup and drop-off, members confirm the ride, preventing ghost rides and billing abuse.

This dual validation system provides the proof of service that Medicaid programs require, ensuring no trip is billed without proper verification. For West Virginia, this means fraud-resistant transportation services that protect the Medicaid budget while guaranteeing members get the care they need.

In addition, SNAH delivers 24/7/365 member support through a dedicated call center. Members can also access 24/7 live chat support through the SNAH User App, ensuring immediate assistance anytime, anywhere. On the administrative side, the SNAH Insurance Portal provides state officials with 24/7 oversight, enabling real-time monitoring of utilization, spend, and performance.

Mission and Alignment with State Goals

Our mission is to Restore Humanity in Healthcare by removing barriers to access, improving outcomes, and protecting public resources. We align directly with West Virginia's priorities:

- **Improved Access:** Members statewide, including rural communities, gain dependable rides to medical appointments.
- **Program Integrity:** Fraud prevention technology ensures Medicaid dollars are only spent on legitimate trips.
- **Cost Transparency:** Live reporting allows the State to track every dollar in real time.
- **Better Health Outcomes:** Reliable NEMT reduces missed appointments, lowers ER overuse, and decreases costly hospital readmissions.

The SNAH Wallet & Insurance Portal: Real-Time Cost Control for West Virginia

Two of SNAH's most powerful innovations, the **SNAH Wallet** and the **SNAH Insurance Portal** give West Virginia Medicaid officials **unmatched financial oversight and accountability.**

- **Per-Member Spend** – Track costs at the individual level for precise budget control.
- **Utilization Patterns** – Monitor how, when, and where funds are used in real time.
- **Reallocation Tools** – Instantly return unused balances to the payer if a member becomes ineligible, passes away, or exits the program—ensuring no funds are wasted.
- **Fraud Detection** – Automated anomaly alerts stop ghost rides, duplicate billing, and overspending before they occur.
- **24/7 Oversight** – The Insurance Portal provides continuous, real-time dashboards, giving state agencies full visibility across all transactions.

This combination of **live tracking, proactive fraud prevention, and immediate reallocation** gives West Virginia **unprecedented control over Medicaid transportation spend.** No other vendor offers this level of transparency. With SNAH, every taxpayer dollar is safeguarded, and every member who needs care gets it—efficiently, equitably, and responsibly.

Statewide Coverage and Dependability

West Virginia's unique geography demands a partner who can serve both its rural and urban populations with equal reliability. SNAH's nationwide network of vetted drivers ensures full statewide coverage, backed by continuous credentialing, background checks, and compliance with all Medicaid standards.

- In rural areas, SNAH leverages local, community-based drivers to ensure no member is left behind.
- In urban centers, a larger pool of drivers guarantees consistent, on-time performance.

Every driver is trained in HIPAA, sensitivity, and member safety, ensuring professional and compassionate experience for West Virginia's Medicaid population.

Pricing that Protects the State Budget

SNAH offers predictable, transparent, and competitive pricing through a combination of PMPM and per-mile rates. Unlike legacy vendors who hide costs in fragmented systems, our model is built for clarity and sustainability:

- **Predictable PMPM Rates:** Stabilize the state budget with consistent, all-inclusive monthly costs.
- **Fair Per-Mile Pricing:** Ensure rural members have equitable access without disproportionate costs.
- **Accountability Built-In:** Every billed mile is GPS-validated and OTP-confirmed.

This dual approach guarantees that West Virginia receives both budget stability and measurable accountability.

Why SNAH is the Right Partner for West Virginia

- **Fraud-Resistant Transportation:** GPS and OTP verification for every trip eliminates ghost rides and fraudulent claims.
- **Unmatched Transparency:** Real-time dashboards and the SNAH Wallet give state officials oversight of every dollar.
- **Reliable Statewide Access:** Vetted drivers ensure dependable coverage across all counties, rural or urban.
- **Health Outcome Impact:** Dependable NEMT reduces missed appointments, ER visits, and costly hospital readmissions.
- **Budget Protection:** Competitive and predictable pricing keeps costs under control while maintaining service quality.
- **Compliance at Every Step:** HIPAA-compliant, state-ready, and built to exceed Medicaid accountability requirements.

West Virginia deserves a partner who delivers reliable transportation, uncompromising accountability, and innovative tools to protect Medicaid integrity. SNAH is that partner. With our proven technology, statewide driver network, and transparent financial controls, we offer West Virginia a solution that is not only operationally sound but also aligned with the State's mission to deliver care efficiently, equitably, and responsibly.

By choosing SNAH, West Virginia will gain a fraud-resistant, cost-predictable, member-focused NEMT program that strengthens healthcare access, protects taxpayer dollars, and delivers measurable outcomes for years to come.

Nationwide Operations

SNAH currently operates in all 50 states, maintaining a vetted network of credential drivers and caregivers. This nationwide footprint provides a scalable infrastructure that can be immediately tailored to meet the unique needs of West Virginia Medicaid beneficiaries.

- **Rural Access Expertise:** We have extensive experience delivering services in rural and frontier communities, ensuring that no member is left behind due to geography.
- **Urban Capacity:** In metropolitan areas, we leverage a larger driver pool to guarantee timely service even during peak demand periods.

- **Technology Integration:** Our HIPAA-compliant platform is live and in use today, validating every ride through **GPS tracking** and **One-Time Passcode (OTP) verification** to ensure service integrity across all regions.

Relevant Experience

SNAH brings experience across multiple Medicaid service domains:

- **NEMT Operations:** Managing large-scale transportation programs with GPS + OTP validation to prevent fraud and ensure compliance.
- **Caregiver Services:** Providing same-day or scheduled in-home support for members, reducing ER visits and improving long-term outcomes.
- **Telehealth & MobileMD:** Extending care through telemedicine and house-call physician networks, aligned with the CMS and FDA vision of the “home as a healthcare hub.”
- **Pharmacy Integration:** Same-day prescription delivery and medication adherence tools that support better chronic care management.

This cross-domain experience positions SNAH not only as a transportation broker but as a comprehensive healthcare partner capable of helping West Virginia strengthen its Medicaid program.

Past Performance

SNAH has consistently demonstrated success in delivering fraud-resistant, member-centered services that align with Medicaid’s goals of access, quality, and accountability. Highlights include:

- **On-Time Performance:** 96%+ on-time trip completion rates across comparable state programs.
- **Member Satisfaction:** Consistently rated at 90%+ satisfaction in surveys for dependability, safety, and driver professionalism.
- **Fraud Prevention:** 100% of rides validated through GPS + OTP, eliminating “ghost rides” and ensuring only authorized trips are billed.
- **Health Outcomes:** Reductions in missed appointments and avoidable ER visits where SNAH’s platform is deployed.

These results demonstrate that SNAH has the capacity, systems, and proven performance to deliver high-quality NEMT services for West Virginia Medicaid.

2. Leadership & Organizational Experience

Hans Lindor – Chief Executive Officer / Co-Founder

Hans Lindor is a seasoned entrepreneur with a proven record of scaling healthcare technology ventures. He leads SNAH's corporate strategy, growth, and investor relations, bringing together innovation and operational excellence. Hans has hands-on experience in Non-Emergency Medical Transportation (NEMT) operations and business development, giving him unique insight into the challenges states face with fraud, inefficiency, and lack of transparency. His leadership is driven by a singular vision: to build technology that empowers patients, strengthens providers, and safeguards taxpayer resources.

Elena Lopez – Chief Operating Officer / Co-Founder

Elena Lopez is an accomplished operations executive with extensive experience in healthcare administration and service delivery. She has successfully managed home care agencies, assisted living facilities, and healthcare compliance programs, earning recognition for her ability to drive efficiency while improving patient outcomes. As a certified healthcare operator, Elena oversees day-to-day operations, compliance, and partnerships at SNAH. Her expertise ensures that every solution SNAH delivers meets or exceeds federal and state regulatory standards, while maintaining a patient-centered focus.

Paulina Wierzbicka – President

Paulina Wierzbicka is a nationally recognized healthcare executive with proven expertise in Medicaid contracting, compliance, and fraud prevention. As President of SNAH, she leads strategic growth, corporate partnerships, and operational execution to deliver reliable, transparent, and cost-effective services. Under her leadership, SNAH has advanced safeguards such as GPS and OTP ride verification, real-time Medicaid spend tracking through the SNAH Wallet, and integrated caregiver and transportation solutions — all designed to eliminate fraud, protect taxpayer resources, and ensure members receive timely care.

She is also a published Forbes contributor, where she has authored articles on healthcare fraud and systemic reform, including “The Cost of Upcoding: What Industry Leaders Can Do to Combat Healthcare Fraud.” Her national thought leadership, combined with hands-on execution, positions her as a trusted partner to state agencies seeking innovation, integrity, and measurable results in healthcare delivery.

Together, this leadership team brings proven expertise in technology, operations, and compliance, giving states a trusted partner to deliver reliable, transparent, and fraud-free healthcare solutions at scale.

3. Program Integrity & Compliance

Commitment to Medicaid Integrity

SNAH Healthcare Software Management is committed to upholding the highest standards of Medicaid program integrity. We recognize that Non-Emergency Medical Transportation (NEMT) programs are vulnerable to fraud, waste, and abuse, and that states like West Virginia require a partner who can deliver transparent, auditable, and fully compliant services. Our compliance framework ensures that every trip, every driver, and every dollar can be validated in real time.

HIPAA & Data Privacy Compliance

SNAH's technology platform is fully HIPAA-compliant and designed to safeguard Protected Health Information (PHI) at every stage of the transportation process. We apply strict administrative, technical, and physical safeguards, including:

- **End-to-End Encryption:** protects all PHI at rest and in transit.
- **Access Controls:** Role-based access, least-privilege principles, and mandatory Multi-Factor Authentication (MFA) for system access.
- **Audit Logs:** Complete audit trails of user and system activity, available for state review upon request.

Security Framework Alignment

SNAH aligns with multiple recognized security and compliance frameworks:

- **HITRUST CSF & SOC 2 Type II Ready:** Industry-standard certifications for risk management and data protection.
- **NIST Cybersecurity Framework:** Continuous monitoring, incident detection, and response protocols aligned with NIST CSF.
- **Business Continuity & Disaster Recovery (BC/DR):** Redundant systems and tested recovery plans ensure uninterrupted service for West Virginia Medicaid members.

Fraud Prevention & Trip Validation

Fraudulent billing and “ghost rides” have historically undermined NEMT integrity. SNAH eliminates this risk through dual verification safeguards built into every trip:

1. **GPS Tracking:** Every ride is tracked in real time from pickup to drop-off.
2. **One-Time Passcode (OTP) Verification:** Members confirm rides at both pickup and drop-off.

This combination ensures:

- No trip can be billed without member confirmation.
- Every billed mile is validated by GPS.
- State officials have audit-ready proof of every completed ride.

Driver Compliance & Workforce Oversight

All SNAH drivers are required to meet strict compliance standards before providing services:

- **Credentialing & Background Checks:** Criminal background screening and DMV record verification.
- **Mandatory Training:** HIPAA, ADA compliance, sensitivity and cultural competency, defensive driving, and fraud awareness.
- **Ongoing Monitoring:** Re-credentialing, random audits, and continuous quality assurance to maintain compliance.
- **Incident Reporting:** Structured process for logging, investigating, and resolving complaints or safety issues.

Reporting & Audit Readiness

SNAH provides West Virginia with **transparent, real-time reporting tools** to ensure program integrity and fiscal accountability:

- **Daily & Monthly Reports:** Trip volumes, member usage, on-time performance, cost trends.
- **Fraud Detection Alerts:** Automated flags for anomalies, duplicate billing, or unusual utilization patterns.
- **Audit Support:** All data stored securely and accessible for federal or state audits.
- **Regulatory Compliance Reviews:** Regular internal compliance reviews to ensure ongoing adherence to CMS and West Virginia Medicaid requirements.

4. Operations & Service Delivery Model

SNAH delivers NEMT through a fully integrated operations model that combines advanced technology, a vetted statewide driver network, and a compliance-driven service framework. Our approach ensures that West Virginia Medicaid members receive reliable, safe, and timely transportation while the State maintains real-time visibility into performance and costs.

Scheduling & Trip Booking

Members will be able to schedule transportation through multiple access points to ensure convenience and accessibility:

- **Mobile App (SNAH User):** Members can request and confirm rides via our HIPAA-compliant smartphone app, available for free on the App Store and Google Play.
- **Website (www.snah.org):** Members can request and confirm rides via our website upon registration.
- **Web Portal (SNAH Portal):** Providers and case managers can request transportation on behalf of members.
- **24/7 Call Center (Planned):** As part of this contract, SNAH will establish a **dedicated 24/7/365 call center within 15 miles of the West Virginia Medicaid headquarters at 350 Capitol Street, Charleston, WV.** This facility will be staffed with trained agents to assist with registration and complaint resolution.

Scheduling features include:

- Same-day and advance booking options.
- Automated eligibility verification is integrated with Medicaid.
- Immediate confirmation with driver and vehicle details.

Dispatch & Ride Management

SNAH uses a real-time dispatch platform to ensure rides are efficiently assigned and monitored:

- **Automated Matching:** Trips assigned to the closest qualified driver.
- **Dynamic Routing:** Routes optimized to reduce delays and maximize efficiency.
- **Backup Assignment:** In the event of a driver no-show or cancellation, trips are automatically reassigned to the next available driver.
- **Live GPS Tracking:** State officials and members can track rides in real time.

Member Experience & Safety

SNAH prioritizes member safety, dignity, and satisfaction in every ride:

- **HIPAA & ADA-Compliant Service:** All drivers trained in confidentiality, disability assistance, and sensitivity.
- **Vehicle Standards:** Regular inspections, ADA-accessible vehicles available statewide.
- **Member Notifications:** SMS/app notifications for trip confirmation, driver arrival, and trip completion.
- **Grievance & Complaint Resolution:** Members can submit feedback through the app or portal. Complaints are logged, investigated, and resolved according to CMS and West Virginia standards.

Rural & Urban Service Delivery

West Virginia's geography requires flexible solutions for both rural and urban regions:

- **Urban Centers:** A large pool of drivers ensures high-volume trip fulfillment and reduced wait times.
- **Rural Areas:** SNAH recruits and contracts with local, community-based drivers to guarantee reliable access.
- **Guaranteed Coverage:** No member is left behind due to location; rural trips receive priority dispatch when needed.

Quality Assurance & Monitoring

SNAH's quality program ensures services meet or exceed West Virginia Medicaid requirements:

- **Key Performance Indicators (KPIs):** On-time performance, ride completion rates, member satisfaction scores.
- **Continuous Monitoring:** All rides tracked in real time; anomalies flagged for supervisor review.
- **Quarterly Reviews:** Performance reviewed with State officials; corrective action plans implemented if needed.
- **Member Feedback Loops:** Surveys and direct feedback analyzed to improve service delivery.

Reporting & State Oversight

SNAH provides transparent, real-time reporting to West Virginia Medicaid officials:

- **Daily Reports:** Trip volume, no-shows, cancellations, on-time rates.
- **Monthly Reports:** Cost trends, utilization by county, fraud prevention outcomes.
- **Custom Dashboards:** Through the SNAH Wallet, state officials gain live insight into member spend, trip validation, and anomaly detection.
- **Audit Support:** All trip records stored securely and available for immediate review.

Business Continuity & Contingency Planning

SNAH maintains tested contingency plans to ensure uninterrupted service delivery:

- **Disaster Recovery Protocols:** Redundant dispatch centers and backup servers in HIPAA-compliant cloud regions.
- **Surge Capacity:** Ability to activate additional drivers during weather events, healthcare surges, or statewide emergencies.
- **Member Safety First:** Emergency escalation procedures in place for stranded or delayed riders.

5. Technology & Innovation

SNAH was designed as a technology-first platform to solve the systemic inefficiencies of traditional NEMT providers. Unlike legacy vendors who rely on manual processes and fragmented systems, SNAH delivers a fully integrated, HIPAA-compliant technology ecosystem that provides West Virginia Medicaid with real-time visibility, fraud elimination, and cost transparency.

Core Technology Infrastructure

- **Cloud Deployment:** Built on HIPAA-compliant AWS and Google Cloud environments.
- **Data Protection:** Mandatory Multi-Factor Authentication (MFA).
- **Continuous Monitoring:** AWS GuardDuty, intrusion detection, and SIEM monitoring for proactive cybersecurity defense.
- **Audit-Ready Logging:** Every transaction, trip, and access point recorded and available for state audits.

The SNAH Platform

SNAH integrates all components of healthcare transportation and care coordination into one seamless, HIPAA-compliant system, eliminating the fragmentation that has historically plagued Medicaid services. Our interconnected modules include:

- **Member Application (SNAH User):** Mobile-friendly app for beneficiaries to book and track rides, with real-time updates and OTP validation at pickup and drop-off.
- **Provider Portal (SNAH Portal):** Secure web-based platform for case managers, facilities, and Medicaid officials to schedule, manage, and monitor transportation.
- **Driver Application (SNAH Ride):** Enables drivers to receive real-time trip assignments, GPS navigation, and OTP confirmations for service validation.
- **Caregiver Portal (SNAH Caregiver):** On-demand or scheduled in-home caregiver coordination, ensuring continuity of care beyond transportation.

- **Clinician Module (SNAH MP):** Designed for physicians and mobile healthcare providers to schedule in-home visits, telehealth appointments, and pharmacy-linked care.
- **Pharmacy Portal (SNAH Pharmacy):** Integrated tool for same-day prescription delivery, medication adherence tracking, and coordination with providers.
- **Insurance Portal (SNAH Insurance):** Real-time dashboards for payers and insurers to manage transportation benefits, monitor utilization, and oversee per-member spend through the SNAH Wallet.

Together, these modules form a single source of truth for members, providers, drivers, pharmacies, and insurers, ensuring that every stakeholder has transparent, real-time access to the data they need.

This all-in-one design ensures members, providers, and state officials operate on a single source of truth.

The SNAH Wallet – Real-Time Cost Control

One of SNAH's most innovative features is the SNAH Wallet, a proprietary tool that provides West Virginia with live financial oversight:

- **Per-Member Spend:** Monitor costs at the individual level.
- **Reallocation Tools:** Instantly return unused balances to the payer if a member becomes ineligible, passes away, or exits the program, ensuring no funds are wasted.
- **Fraud Detection:** Automated anomaly alerts prevent overspending before it occurs.
- **Budget Transparency:** Dashboards give Medicaid officials instant insight into spending, utilization, and savings.

This tool empowers the State to actively manage costs and prevent fraud in real time, not just after the fact.

Innovative Fraud Prevention

Traditional NEMT models rely on self-reported data that can be manipulated. SNAH eliminates this risk through dual trip validation:

1. **GPS Tracking:** Every mile of every ride is logged and verified.
2. **One-Time Passcode (OTP):** Members confirm pickup and drop-off with a unique code.

These safeguards ensure:

- **No ghost rides.**
- **No fraudulent billing.**
- **100% audit-ready validation of services delivered.**

Accessibility & Member-Centered Innovation

- **ADA Compliance:** Vehicles and apps designed for accessibility.
- **Multilingual Support:** English and Spanish available for apps.
- **Inclusive Design:** Apps optimized for seniors and low-tech users with simple workflows.
- **Telehealth & Caregiver Integration:** Beyond transportation, members gain access to remote care, telemedicine, prescription delivery, medication management and in-home support.

Reporting & Analytics Innovation

SNAH provides real-time reporting dashboards with drill-down capabilities for West Virginia Medicaid administrators:

- Trip volume by region, county, or provider.
- Fraud prevention metrics (GPS/OTP validation compliance).
- On-time performance and service quality indicators.
- Cost per member per month (PMPM) and per-mile trend analysis.

These analytics allow the State to make data-driven decisions, identify inefficiencies, and continuously improve program performance.

Future Innovation Roadmap

SNAH continues to expand its innovation pipeline, ensuring West Virginia gains long-term value:

- **Predictive Analytics:** Identify high-risk members for missed care or ER overuse.
- **AI-Driven Optimization:** Smarter ride-matching and demand forecasting.
- **MobileMD Fleet:** On-demand house calls for at-home Medicaid care.
- **Prescription Adherence Tools:** Integrated medication reminders and delivery tracking.

6. Emergency & Disaster Procedures

SNAH maintains a comprehensive Continuity of Operations Plan (COOP) to ensure uninterrupted service delivery during natural disasters, public health emergencies, or unexpected workforce disruptions. Our emergency framework is built around three principles: redundancy, rapid communication, and regulatory compliance.

We maintain backup pools of drivers and caregivers who can be dispatched immediately in the event of staff shortages or emergencies. GPS-enabled routing allows dynamic reallocation of trips during weather events, road closures, or local disasters, ensuring that members reach critical medical appointments without interruption. Our cloud-based technology platform ensures that scheduling, billing, and reporting systems remain online even if physical offices are closed.

Our 24/7/365 call center is trained to handle surges in call volume and provides real-time updates to members, providers, and state officials during emergencies. In addition, all caregivers using our platform are required to receive training in mandated elder abuse and neglect reporting, emergency response protocols, and health and safety compliance requirements. This ensures that members remain safe, informed, and supported under any circumstance.

Through these safeguards, SNAH guarantees that Medicaid members will receive consistent, reliable care even under the most challenging conditions, while giving the State continuous visibility into operations.

7. Staffing & Organizational Structure

SNAH Healthcare Software Management maintains a robust staffing model that combines executive oversight, program management, compliance leadership, and a trained statewide driver workforce. Our structure ensures that West Virginia Medicaid receives a program that is properly supervised, continuously monitored, and staffed with qualified professionals.

Organizational Structure

SNAH's organizational structure provides both national expertise and local accountability:

- **Executive Leadership:** Provides strategic direction, fiscal accountability, and overall program governance.
- **Program Management Team:** Dedicated managers responsible for daily operations, contract compliance, and performance monitoring in West Virginia.
- **Compliance & Quality Assurance Unit:** Oversees HIPAA compliance, fraud prevention, driver credentialing, and reporting accuracy.
- **IT & Security Team:** Maintains the HIPAA-compliant platform, cybersecurity safeguards, and integration with state systems.
- **Member Support Staff:** 24/7/365 bilingual assistance.
- **Driver Workforce:** Vetted, credentialed, and continuously trained drivers statewide to provide safe and reliable transportation.

Driver Recruitment, Credentialing & Training

SNAH enforces strict standards for all drivers:

- **Pre-Employment:** Criminal background check, DMV record review.
- **Credentialing:** Verification of driver licenses, vehicle inspections, insurance coverage.
- **Training Requirements:**
 - HIPAA & patient confidentiality
 - ADA compliance & disability assistance

- Sensitivity and cultural competency training
- Defensive driving & safety procedures
- Fraud awareness and OTP/GPS compliance protocols
- **Re-Credentialing:** Ongoing monitoring, annual background checks, and random audits.

Supervision & Quality Assurance

- **Driver Supervision:** Program managers oversee driver compliance, with supervisors assigned to specific regions.
- **Monitoring:** Real-time GPS oversight ensures accountability for every ride.
- **Performance Reviews:** Monthly driver evaluations and quarterly audits to maintain high-quality service.
- **Grievance Response:** All complaints logged, tracked, and resolved within state-defined timelines.

Member Support

SNAH's member support system ensures that beneficiaries always have live, accessible help:

- **24/7/365 Call Center (Planned):** As part of this contract, SNAH will establish a dedicated call center located within 15 miles of the West Virginia Medicaid headquarters at 350 Capitol Street, Charleston, WV.
- **24/7/365 Chat Support via the SNAH User App & Website:** Staffed with trained agents, members can receive real-time assistance anytime.
- **Bilingual Support:** Including English and Spanish, with the ability to expand based on member demographics.
- **Self-Service System:** Quick scheduling and confirmations available through the app, website, and portal.
- **Complaint Resolution Protocols:** Aligned with CMS and West Virginia Medicaid requirements to ensure timely, transparent resolution.

8. Equity & Cultural Competency

SNAH is committed to delivering equitable, culturally responsive care to every member we serve. We recognize that Medicaid populations are diverse and include rural residents, elderly adults, individuals with disabilities, and communities with varying cultural and linguistic needs. Our model ensures that no member is left behind due to language, geography, or access barriers.

Diverse, Bilingual Workforce: We recruit and retain a workforce that reflects the communities we serve, including bilingual caregivers, drivers, and support staff. This diversity strengthens trust and improves the quality of member interactions.

Language Access: SNAH provides multiple access points for scheduling and support, including our 24/7 call center, mobile app, and online portal — all equipped with multilingual capabilities. In addition, we maintain a 24/7 language line supporting over 200 languages, ensuring every member can communicate in their preferred language.

Ongoing Cultural Competency Training: All staff undergo cultural competency training at onboarding and annual refreshers. Training covers disability inclusion, trauma-informed care, aging populations, racial equity, and health equity principles. This ensures that caregivers and support staff are sensitive to each member's cultural and personal needs.

Through these measures, SNAH guarantees that services are accessible, respectful, and equitable, delivering high-quality care that meets the needs of West Virginia's diverse Medicaid population.

9. Implementation & Transition Plan

SNAH has developed a phased implementation plan that ensures West Virginia Medicaid receives a seamless transition from award to full-service delivery. Our approach minimizes disruption, accelerates readiness, and establishes a foundation for long-term program success.

Phase 1: Contract Kickoff (Day 0–30)

- **Kickoff Meeting:** Formal launch with West Virginia Medicaid officials to confirm timelines, deliverables, and communication protocols.
- **Dedicated Transition Team:** Assign a Program Director, Implementation Manager, and Compliance Officer specific to the West Virginia contract.
- **System Configuration:** Configure SNAH's platform for West Virginia-specific requirements, including Medicaid eligibility integration and reporting formats.
- **Stakeholder Communication:** Notify provider networks, community partners, and key stakeholders of the upcoming transition.

Phase 2: Infrastructure & Workforce Readiness (Day 30–60)

- **Driver Onboarding:** Recruit, credential, and train additional drivers in rural and urban counties to guarantee statewide coverage.
- **Training Deployment:** Deliver West Virginia-specific modules covering Medicaid rules, OTP/GPS validation, ADA/ HIPAA standards, and grievance handling.
- **Pilot Testing:** Conduct controlled pilot trips in select regions to validate system performance, reporting accuracy, and trip validation safeguards.

Phase 3: Full Program Launch (Day 60–90)

- **Go-Live:** Transition to full operational service across all West Virginia counties.
- **Real-Time Monitoring:** Begin statewide GPS + OTP validation, with compliance staff actively monitoring performance in real time.
- **State Oversight:** Provide Medicaid officials with live access to dashboards and financial monitoring via the SNAH Wallet.

- **Rapid Response Teams:** Deploy escalation staff to resolve any service interruptions or onboarding issues within 24 hours.

Phase 4: Stabilization & Optimization (Day 90–120)

- **Performance Review:** First 90-day performance review with state officials, including analysis of KPIs, fraud prevention outcomes, and member satisfaction.
- **Continuous Improvement:** Implement refinements based on feedback, early performance data, and state priorities.
- **Scalability Planning:** Assess capacity and prepare for volume increases or future program expansions.

Contingency Planning

To ensure uninterrupted service during the transition:

- **Redundant Systems:** Backup servers and disaster recovery protocols ensure system reliability.
- **Driver Surge Capacity:** Standby drivers activated during onboarding to prevent service gaps.
- **Communication Protocols:** Immediate escalation process with direct access to senior leadership for urgent state concerns.

10. Performance & Reporting

SNAH provides state agencies with full transparency and real-time visibility into operations, ensuring accountability at every level. Our performance and reporting framework is designed to measure outcomes, prevent fraud, and demonstrate compliance with all contractual requirements.

- **Real-Time Dashboards:** Through the SNAH Wallet and Insurance Portal, state officials have 24/7 access to dashboards that track ride validation, caregiver visits, cost utilization, and member outcomes in real time.

- **Fraud Detection & Alerts:** Automated anomaly detection identifies suspicious patterns (e.g., duplicate billing, no-show claims, or unusual utilization). Alerts are sent immediately to compliance staff and state partners, preventing overspending before it occurs.

- **Comprehensive Reporting:** SNAH provides monthly and quarterly reports detailing utilization, cost savings, grievances, member satisfaction, and performance against KPIs. All reports are fully customizable to meet state requirements.

- **Continuous Improvement:** Performance data is used to drive ongoing improvements, refine processes, and address emerging needs. Corrective action plans are implemented promptly if metrics fall below thresholds, ensuring contract compliance and accountability.

By combining real-time monitoring, proactive fraud prevention, and structured reporting, SNAH delivers the transparency, and results states require to safeguard taxpayer resources while improving member outcomes.

11. Value-Added Services (Differentiators)

While safe, reliable NEMT is the foundation, SNAH offers **additional services** that extend healthcare access and create better long-term outcomes for West Virginia Medicaid members.

- **On-Demand Caregiver Services (SNAH Caregiver):** Members can request in-home caregiver support on the same day, ensuring vulnerable populations receive assistance with mobility, daily activities, or post-discharge needs.
- **Integrated Telehealth & In-Home Care (SNAH MP):** Providers can schedule telehealth visits or in-home clinical appointments directly through the platform, reducing missed care opportunities.
- **Pharmacy Delivery (SNAH Pharmacy):** Same-day medication delivery improves adherence and reduces preventable hospital readmissions.
- **Insurer Dashboards (SNAH Insurance):** A dedicated portal for payers and managed care organizations to view spending, utilization, and outcomes in real time.

Member-Centered Enhancements

- **Multilingual Access:** Apps in multiple languages for inclusive service delivery.
- **Senior-Friendly Design:** Simplified app interface tailored for elderly and low-tech members.
- **ADA & Accessibility Standards:** Vehicles and digital platforms designed to meet the needs of members with disabilities.

Strategic Advantages for West Virginia

- **Reduced Hospital Utilization:** Linking NEMT with caregivers, telehealth, and pharmacy services reduces ER dependence.
- **Whole-Person Care:** Transportation becomes part of a larger care ecosystem, improving health outcomes.
- **Future-Proof Innovation:** West Virginia gains a partner capable of expanding beyond rides to full in-home healthcare support.

12. Conclusion

SNAH's proposal demonstrates not only the operational capability and compliance readiness required by West Virginia Medicaid, but also the innovation and accountability to deliver a fraud-resistant, member-focused, and cost-predictable program.

By selecting SNAH, West Virginia secures a partner committed to safe transportation, transparent spending, and improved health outcomes for its Medicaid members.

Appendices

- Pitch Deck
- Drivers Training Book
- Employee Handbook
- W-9
- Certificate of Good Standing (California)
- Attachment A – Cost Sheet
- Addendum 1 Acknowledgement
- CRFP Form

VENDOR NAME: SNAH Healthcare Software Management

BUYER: Crystal Hustead

SOLICITATION NO.: CRFP BMS2600000001

BID OPENING DATE: September 16, 2025

BID OPENING TIME: 1:30 PM ET

FAX NUMBER: 304-558-3970

Final_CRFP_0511_BMS2600000001_2_WV_CRFP_FORM

SOLICITATION NO.: CRFP BMS2600000001

VENDOR NAME: SNAH Healthcare Software Management

REQUEST FOR PROPOSAL

CRFP BMS2600000001

Bureau for Medical Services/Office of Drug Control Policy/Bureau for Behavioral Health- Non-Emergency Medical Transportation/Statewide Transportation Program

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1.1. Introduction:

The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the “Purchasing Division”) is issuing this solicitation as a request for proposal (“RFP”), as authorized by W. Va. Code §5A-3-10b, for the Department of Human Services (DoHS), Bureau for Medical Services (BMS) which includes both the West Virginia Medicaid Program and West Virginia Children’s Health Insurance Program (WVCHIP), the Office of Drug Control Policy (ODCP), and the Bureau for Behavioral Health (BBH) (hereinafter referred to as the “Agency”) to provide a full-risk capitation broker to directly coordinate a statewide Non-Emergency Medical Transport (NEMT) Program for BMS and optional service for a Statewide Transportation Program (STP) for ODCP and BBH.

This solicitation may be funded as a whole or in part with Federal Funds and thus this solicitation and its resulting awarded contract are subject to the requirements of Attachment 1: Federal Funds Addendum

The West Virginia Department of Health and Human Resources (WVDHHR) has developed an Equal Employment Opportunity Policy (EEOP) Utilization Report, and it is available at:

<http://www.wvdhhr.org/pdfs/H1.5%20Utilization%20Report%20and%20EEO%20policy.pdf>

The RFP is a procurement method in which vendors submit proposals in response to the request for proposal published by the Purchasing Division. It requires an award to the highest scoring vendor, rather than the lowest cost vendor, based upon a technical evaluation of the vendor’s technical proposal and a cost evaluation. This is referred to as a best value procurement. Through their proposals, vendors offer a solution to the objectives, problem, or need specified in the RFP, and define how they intend to meet (or exceed) the RFP requirements.

REQUEST FOR PROPOSAL

CRFP BMS2600000001

Bureau for Medical Services/Office of Drug Control Policy/Bureau for Behavioral Health- Non-Emergency Medical Transportation/Statewide Transportation Program

SECTION 2: INSTRUCTIONS TO VENDORS SUBMITTING BIDS

Instructions begin on the next page.

INSTRUCTIONS TO VENDORS SUBMITTING BIDS

1. **REVIEW DOCUMENTS THOROUGHLY:** The attached documents contain a solicitation for bids. Please read these instructions and all documents attached in their entirety. These instructions provide critical information about requirements that if overlooked could lead to disqualification of a Vendor's bid. All bids must be submitted in accordance with the provisions contained in these instructions and the Solicitation. Failure to do so may result in disqualification of Vendor's bid.

2. **MANDATORY TERMS:** The Solicitation may contain **mandatory** provisions identified by the use of the words "**must**," "**will**," and "**shall**." Failure to comply with a mandatory term in the Solicitation will result in bid disqualification.

3. **PRE-BID MEETING:** The item identified below shall apply to this Solicitation.

☒ A pre-bid meeting will not be held prior to bid opening

☐ A **MANDATORY PRE-BID** meeting will be held at the following place and time:

All Vendors submitting a bid must attend the **mandatory** pre-bid meeting. Failure to attend the **mandatory** pre-bid meeting shall result in disqualification of the Vendor's bid. No one individual is permitted to represent more than one vendor at the pre-bid meeting. Any individual that does attempt to represent two or more vendors will be required to select one vendor to which the individual's attendance will be attributed. The vendors not selected will be deemed to have not attended the pre-bid meeting unless another individual attended on their behalf.

An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing. It is the Vendor's responsibility to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

Vendors who arrive after the starting time but prior to the end of the pre-bid will be permitted to sign in but are charged with knowing all matters discussed at the pre-bid.

Any discussions or answers to questions at the pre-bid meeting are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

4. VENDOR QUESTION DEADLINE: Vendors may submit questions relating to this Solicitation to the Purchasing Division. Questions must be submitted in writing. All questions **must be submitted on or before the date listed below and to the address listed below to be considered.** A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are non-binding.

Submitted emails should have the solicitation number in the subject line. Question

Submission Deadline: August 20, 2025 at 10:00 AM ET

Submit Questions to: Crystal Hustead
2019 Washington Street, East Charleston, WV 25305
Fax: (304) 558-3970
Email: Crystal.G.Hustead@wv.gov

5. VERBAL COMMUNICATION: Any verbal communication between the Vendor and any State personnel is not binding, including verbal communication at the mandatory pre-bid conference. Only information issued in writing and added to the Solicitation by an official written addendum by the Purchasing Division is binding.

6. BID SUBMISSION: All bids must be submitted on or before the date and time of the bid opening listed in section 7 below. Vendors can submit bids electronically through *wvOASIS*, in paper form delivered to the Purchasing Division at the address listed below either in person or by courier, or in facsimile form by faxing to the Purchasing Division at the number listed below. Notwithstanding the foregoing, the Purchasing Division may prohibit the submission of bids electronically through *wvOASIS* at its sole discretion. Such a prohibition will be contained and communicated in the *wvOASIS* system resulting in the Vendor's inability to submit bids through *wvOASIS*. The Purchasing Division will not accept bids or modification of bids via email.

Bids submitted in paper, facsimile, or via wvOASIS must contain a signature. Failure to submit a bid in any form without a signature will result in rejection of your bid.

A bid submitted in paper or facsimile form should contain the information listed below on the face of the submission envelope or fax cover sheet. Otherwise, the bid may be rejected by the Purchasing Division.

VENDOR NAME:

BUYER: Crystal Hustead

SOLICITATION NO.: CRFP BMS2600000001

BID OPENING DATE: September 16, 2025

BID OPENING TIME: 1:30 PM ET

FAX NUMBER: 304-558-3970

Any bid received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason.

Bid Delivery Address and Fax Number:

Department of Administration, Purchasing Division 2019 Washington Street East

Charleston, WV 25305-0130

Fax: 304-558-3970

For Request for Proposal ("RFP") Responses Only: 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.

7. BID OPENING: Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when confirmation of delivery is provided by wvOASIS (in the case of electronic submission) or when the bid is time stamped by the official Purchasing Division time clock (in the case of hand delivery or via delivery by mail).

Bid Opening Date and Time: September 16, 2025 at 1:30 PM ET

Bid Opening Location:

Department of Administration, Purchasing Division

2019 Washington Street East

Charleston, WV 25305-0130

8. ADDENDUM ACKNOWLEDGEMENT: Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgement Form. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

9. BID FORMATTING: Vendor should type or electronically enter the information onto its bid to prevent errors in the evaluation. Failure to type or electronically enter the information may result in bid disqualification.

10. ALTERNATE MODEL OR BRAND: Unless the box below is checked, any model, brand, or specification listed in this Solicitation establishes the acceptable level of quality only and is not intended to reflect a preference for, or in any way favor, a particular brand or vendor. Vendors may bid alternates to a listed model or brand provided that the alternate is at least equal to the model or brand and complies with the required specifications. The equality of any alternate being bid shall be determined by the State at its sole discretion. Any Vendor bidding an alternate model or brand **shall** clearly identify the alternate items in its bid and should include manufacturer's specifications, industry literature, and/or any other relevant documentation demonstrating the equality of the alternate items. Failure to provide information for alternate items **may** be grounds for rejection of a Vendor's bid.

☐ This Solicitation is based upon a standardized commodity established under W. Va. Code § 5A-3-61. Vendors are expected to bid the standardized commodity identified. Failure to bid the standardized commodity will result in your firm's bid being rejected.

11. COMMUNICATION LIMITATIONS: In accordance with West Virginia Code of State Rules §148-1-6.6.2, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. Purchasing Division approval for such communication is implied for all agency delegated and exempt purchases.

12. REGISTRATION: Prior to Contract award, the apparent successful Vendor **must** be properly registered with the West Virginia Purchasing Division and must have paid the \$125 fee, if applicable.

13. UNIT PRICE: Unit prices **shall** prevail in cases of a discrepancy in the Vendor's bid.

14. PREFERENCE: Vendor Preference may be requested in purchases of motor vehicles or construction and maintenance equipment and machinery used in highway and other infrastructure projects. Any request for preference must be submitted in writing with the bid, must specifically identify the preference requested with reference to the applicable subsection of West Virginia Code § 5A-3-37, and must include with the bid any information necessary to evaluate and confirm the applicability of the requested preference. A request form to help facilitate the request can be found at: www.state.wv.us/admin/purchase/vrc/Venpref.pdf.

15A. RECIPROCAL PREFERENCE: The State of West Virginia applies a reciprocal preference to all solicitations for commodities and printing in accordance with W. Va. Code § 5A-3-37(b). In effect, non-resident vendors receiving a preference in their home states, will see that same preference granted to West Virginia resident vendors bidding against them in West Virginia. Any request for reciprocal preference must include with the bid any information necessary to evaluate and confirm the applicability of the preference. A request form to help facilitate the request can be found at: www.state.wv.us/admin/purchase/vrc/Venpref.pdf.

15. SMALL, WOMEN-OWNED, OR MINORITY-OWNED BUSINESSES:

For any solicitations publicly advertised for bid, in accordance with West Virginia Code §5A-3-37 and W. Va. CSR § 148-22-9, any non-resident vendor certified as a small, women-owned, or minority-owned business under W. Va. CSR § 148-22-9 shall be provided the same preference made available to any resident vendor. Any non-resident small, women-owned, or minority-owned business must identify itself as such in writing, must submit that writing to the Purchasing Division with its bid, and must be properly certified under W. Va. CSR § 148-22-9 prior to contract award to receive the preferences made available to resident vendors.

16. WAIVER OF MINOR IRREGULARITIES: The Director reserves the right to waive minor irregularities in bids or specifications in accordance with West Virginia Code of State Rules § 148-1-4.7.

17. ELECTRONIC FILE ACCESS RESTRICTIONS: Vendor must ensure that its submission in wvOASIS can be accessed and viewed by the Purchasing Division staff immediately upon bid opening. The Purchasing Division will consider any file that cannot be immediately accessed and viewed at the time of the bid opening (such as, encrypted files, password protected files, or incompatible files) to be blank or incomplete as context requires and are therefore unacceptable. A vendor will not be permitted to unencrypt files, remove password protections, or resubmit documents after bid opening to make a file viewable if those documents are required with the bid. A Vendor may be required to provide document passwords or remove access restrictions to allow the Purchasing Division to print or electronically save documents provided that those documents are viewable by the Purchasing Division prior to obtaining the password or removing the access restriction.

18. NON-RESPONSIBLE: The Purchasing Division Director reserves the right to reject the bid of any vendor as Non-Responsible in accordance with W. Va. Code of State Rules § 148-1-5.3, when the Director determines that the vendor submitting the bid does not have the capability to fully perform or lacks the integrity and reliability to assure good-faith performance.”

19. ACCEPTANCE/REJECTION: The State may accept or reject any bid in whole, or in part in accordance with W. Va. Code of State Rules § 148-1-4.6. and § 148-1-6.3.”

20. **WITH THE BID REQUIREMENTS:** In instances where these specifications require documentation or other information with the bid, and a vendor fails to provide it with the bid, the Director of the Purchasing Division reserves the right to request those items after bid opening and prior to contract award pursuant to the authority to waive minor irregularities in bids or specifications under W. Va. CSR § 148-1-4.7. This authority does not apply to instances where state law mandates receipt with the bid.

21. **EMAIL NOTIFICATION OF AWARD:** The Purchasing Division will attempt to provide bidders with e-mail notification of contract award when a solicitation that the bidder participated in has been awarded. For notification purposes, bidders must provide the Purchasing Division with a valid email address in the bid response. Bidders may also monitor wvOASIS or the Purchasing Division's website to determine when a contract has been awarded.

22. **EXCEPTIONS AND CLARIFICATIONS:** The Solicitation contains the specifications that **shall** form the basis of a contractual agreement. **Vendor shall clearly mark any exceptions, clarifications, or other proposed modifications in its bid.** Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

REQUEST FOR PROPOSAL

CRFP BMS2600000001

Bureau for Medical Services/Office of Drug Control Policy/Bureau for
Behavioral Health- Non-Emergency Medical Transportation/Statewide
Transportation Program

SECTION 3: GENERAL TERMS AND CONDITIONS

Terms and conditions begin on the next page.

GENERAL TERMS AND CONDITIONS:

1. CONTRACTUAL AGREEMENT: Issuance of an Award Document signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance by the State of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid, or on the Contract if the Contract is not the result of a bid solicitation, signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

2. DEFINITIONS: As used in this Solicitation/Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation/Contract.

2.1. "Agency" or "Agencies" means the agency, board, commission, or other entity of the State of West Virginia that is identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

2.2. "Bid" or "Proposal" means the vendors submitted response to this solicitation.

2.3. "Contract" means the binding agreement that is entered into between the State and the Vendor to provide the goods or services requested in the Solicitation.

2.4. "Director" means the Director of the West Virginia Department of Administration, Purchasing Division.

2.5. "Purchasing Division" means the West Virginia Department of Administration, Purchasing Division.

2.6. "Award Document" means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the contract holder.

2.7. "Solicitation" means the official notice of an opportunity to supply the State with goods or services that is published by the Purchasing Division.

2.8. "State" means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

2.9. "Vendor" or "Vendors" means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

3. CONTRACT TERM; RENEWAL; EXTENSION: The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

☒ **Term Contract**

Initial Contract Term: The Initial Contract Term will be for a period of one (1) year. The Initial Contract Term becomes effective on the effective start date listed on the first page of this Contract, identified as the State of West Virginia contract cover page containing the signatures of the Purchasing Division, Attorney General, and Encumbrance clerk (or another page identified as _____), and the Initial Contract Term ends on the effective end date also shown on the first page of this Contract.

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal should be delivered to the Agency and then submitted to the Purchasing Division thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Unless otherwise specified below, renewal of this Contract is limited to five (5) successive one (1) year periods or multiple renewal periods of less than one year, provided that the multiple renewal periods do not exceed the total number of months available in all renewal years combined. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's office (Attorney General approval is as to form only)

☐ **Alternate Renewal Term** – This contract may be renewed for _____ successive _____ year periods or shorter periods provided that they do not exceed the total number of months contained in all available renewals. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's office (Attorney General approval is as to form only)

Delivery Order Limitations: In the event that this contract permits delivery orders, a delivery order may only be issued during the time this Contract is in effect. Any delivery order issued within one year of the expiration of this Contract shall be effective for one year from the date the delivery order is issued. No delivery order may be extended beyond one year after this Contract has expired.

☐ **Fixed Period Contract:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and must be completed within _____ days.

☐ **Fixed Period Contract with Renewals:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and part of the Contract more fully described in the attached specifications must be completed within _____ days. Upon completion of the work covered by the preceding sentence, the vendor agrees that:

☐ the contract will continue for _____ years;

☐ the contract may be renewed for _____ successive _____ year periods or shorter periods provided that they do not exceed the total number of months contained in all available renewals. Automatic renewal of this Contract is prohibited. Renewals must be approved by the Vendor, Agency, Purchasing Division and Attorney General's Office (Attorney General approval is as to form only).

☐ **One-Time Purchase:** The term of this Contract shall run from the issuance of the Award Document until all of the goods contracted for have been delivered, but in no event will this Contract extend for more than one fiscal year.

☐ **Construction/Project Oversight:** This Contract becomes effective on the effective start date listed on the first page of this Contract, identified as the State of West Virginia contract cover page containing the signatures of the Purchasing Division, Attorney General, and Encumbrance clerk (or another page identified as _____), and continues until the project for which the vendor is providing oversight is complete.

☐ **Other:** Contract Term specified in _____

4. AUTHORITY TO PROCEED: Vendor is authorized to begin performance of this contract on the date of encumbrance listed on the front page of the Award Document unless either the box for "Fixed Period Contract" or "Fixed Period Contract with Renewals" has been checked in Section 3 above. If either "Fixed Period Contract" or "Fixed Period Contract with Renewals" has been checked, Vendor must not begin work until it receives a separate notice to proceed from the State. The notice to proceed will then be incorporated into the Contract via change order to memorialize the official date that work commenced.

5. QUANTITIES: The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

☒ **Open End Contract:** Quantities listed in this Solicitation/Award Document are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

☐ **Service:** The scope of the service to be provided will be more clearly defined in the specifications included herewith.

☐ **Combined Service and Goods:** The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

☐ **One-Time Purchase:** This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, Purchasing Division, and Attorney General's office.

☐ **Construction:** This Contract is for construction activity more fully defined in the specifications.

6. EMERGENCY PURCHASES: The Purchasing Division Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the Purchasing Division Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One-Time Purchase contract.

7. REQUIRED DOCUMENTS: All of the items checked in this section must be provided to the Purchasing Division by the Vendor as specified:

☐ **LICENSE(S) / CERTIFICATIONS / PERMITS:** In addition to anything required under the Section of the General Terms and Conditions entitled Licensing, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits upon request and in a form acceptable to the State. The request may be prior to or after contract award at the State's sole discretion.

☐☐☐☐

The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications regardless of whether or not that requirement is listed above.

8. INSURANCE: The apparent successful Vendor shall furnish proof of the insurance identified by a checkmark below prior to Contract award. The insurance coverages identified below must be maintained throughout the life of this contract. Thirty (30) days prior to the expiration of the insurance policies, Vendor shall provide the Agency with proof that the insurance mandated herein has been continued. Vendor must also provide Agency with immediate notice of any changes in its insurance policies, including but not limited to, policy cancelation, policy reduction, or change in insurers. The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether that insurance requirement is listed in this section.

Vendor must maintain:

☒ **Commercial General Liability Insurance** in at least an amount of: \$1,000,000.00 per occurrence.

☒ **Automobile Liability Insurance** in at least an amount of: \$1,000,000.00 per occurrence.

☒ **Professional/Malpractice/Errors and Omission Insurance** in at least an amount of: \$1,000,000.00 per occurrence. Notwithstanding the forgoing, Vendor's are not required to list the State as an additional insured for this type of policy.

☐ **Commercial Crime and Third Party Fidelity Insurance** in an amount of: _____ per occurrence.

☒ **Cyber Liability Insurance** in an amount of: \$1,000,000.00 per occurrence.

☐ **Builders Risk Insurance** in an amount equal to 100% of the amount of the Contract.

☐ **Pollution Insurance** in an amount of: _____ per occurrence.

☐ **Aircraft Liability** in an amount of: _____ per occurrence.

☒ **Property Damage Minimum of \$1,000,000.00 per occurrence.**

☐

☐

☐

9. WORKERS' COMPENSATION INSURANCE: Vendor shall comply with laws relating to workers compensation, shall maintain workers' compensation insurance when required, and shall furnish proof of workers' compensation insurance upon request.

10. VENUE: All legal actions for damages brought by Vendor against the State shall be brought in the West Virginia Claims Commission. Other causes of action must be brought in the West Virginia court authorized by statute to exercise jurisdiction over it.

11. LIQUIDATED DAMAGES: This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy. Vendor shall pay liquidated damages in the amount specified below or as described in the specifications:

☐ _____ for _____.

☐ Liquidated Damages Contained in the Specifications.

☒ Liquidated Damages Are Not Included in this Contract.

12. ACCEPTANCE: Vendor's signature on its bid, or on the certification and signature page, constitutes an offer to the State that cannot be unilaterally withdrawn, signifies that the product or service proposed by vendor meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise indicated, and signifies acceptance of the terms and conditions contained in the Solicitation unless otherwise indicated.

13. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification. Notwithstanding the foregoing, Vendor must extend any publicly advertised sale price to the State and invoice at the lower of the contract price or the publicly advertised sale price.

14. PAYMENT IN ARREARS: Payments for goods/services will be made in arrears only upon receipt of a proper invoice, detailing the goods/services provided or receipt of the goods/services, whichever is later. Notwithstanding the foregoing, payments for software maintenance, licenses, or subscriptions may be paid annually in advance.

15. PAYMENT METHODS: Vendor must accept payment by electronic funds transfer and P-Card. (The State of West Virginia's Purchasing Card program, administered under contract by a banking institution, processes payment for goods and services through state designated credit cards.)

16. TAXES: The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

17. ADDITIONAL FEES: Vendor is not permitted to charge additional fees or assess additional charges that were not either expressly provided for in the solicitation published by the State of West Virginia, included in the Contract, or included in the unit price or lump sum bid amount that Vendor is required by the solicitation to provide. Including such fees or charges as notes to the solicitation may result in rejection of vendor's bid. Requesting such fees or charges be paid after the contract has been awarded may result in cancellation of the contract.

18. FUNDING: This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available. If that occurs, the State may notify the Vendor that an alternative source of funding has been obtained and thereby avoid the automatic termination. Non-appropriation or non-funding shall not be considered an event of default.

19. CANCELLATION: The Purchasing Division Director reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The Purchasing Division Director may also cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules § 148-1-5.2.b.

20. TIME: Time is of the essence regarding all matters of time and performance in this Contract.

21. APPLICABLE LAW: This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code, or West Virginia Code of State Rules is void and of no effect.

22. COMPLIANCE WITH LAWS: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendor acknowledges that it has reviewed, understands, and will comply with all applicable laws, regulations, and ordinances.

SUBCONTRACTOR COMPLIANCE: Vendor shall notify all subcontractors providing commodities or services related to this Contract that as subcontractors, they too are required to comply with all applicable laws, regulations, and ordinances. Notification under this provision must occur prior to the performance of any work under the contract by the subcontractor.

23. ARBITRATION: Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

24. MODIFICATIONS: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any change to existing contracts that adds work or changes contract cost, and were not included in the original contract, must be approved by the Purchasing Division and the Attorney General's Office (as to form) prior to the implementation of the change or commencement of work affected by the change.

25. WAIVER: The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

26. SUBSEQUENT FORMS: The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or Purchasing Division such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

27. ASSIGNMENT: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments.

28. WARRANTY: The Vendor expressly warrants that the goods and/or services covered by this Contract will: (a) conform to the specifications, drawings, samples, or other description furnished or specified by the Agency; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship.

29. STATE EMPLOYEES: State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

30. PRIVACY, SECURITY, AND CONFIDENTIALITY: The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in www.state.wv.us/admin/purchase/privacy.

31. YOUR SUBMISSION IS A PUBLIC DOCUMENT: Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq. and the Freedom of Information Act West Virginia Code §§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All submissions are subject to public disclosure without notice.

32. LICENSING: In accordance with West Virginia Code of State Rules § 148-1-6.1.e, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Obligations related to political subdivisions may include, but are not limited to, business licensing, business and occupation taxes, inspection compliance, permitting, etc. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

SUBCONTRACTOR COMPLIANCE: Vendor shall notify all subcontractors providing commodities or services related to this Contract that as subcontractors, they too are required to be licensed, in good standing, and up-to-date on all state and local obligations as described in this section. Obligations related to political subdivisions may include, but are not limited to, business licensing, business and occupation taxes, inspection compliance, permitting, etc. Notification under this provision must occur prior to the performance of any work under the contract by the subcontractor.

33. ANTITRUST: In submitting a bid to, signing a contract with, or accepting a Award Document from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

34. VENDOR NON-CONFLICT: Neither Vendor nor its representatives are permitted to have any interest, nor shall they acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency.

35. VENDOR RELATIONSHIP: The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, licensing fees, etc. and the filing of all necessary documents, forms, and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

36. INDEMNIFICATION: The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

37. NO DEBT CERTIFICATION: In accordance with West Virginia Code §§ 5A-3-10a and 5-22-1(i), the State is prohibited from awarding a contract to any bidder that owes a debt to the State or a political subdivision of the State. By submitting a bid, or entering into a contract with the State, Vendor is affirming that (1) for construction contracts, the Vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, neither the Vendor nor any related party owe a debt as defined above, and neither the Vendor nor any related party are in employer default as defined in the statute cited above unless the debt or employer default is permitted under the statute.

38. CONFLICT OF INTEREST: Vendor, its officers or members or employees, shall not presently have or acquire an interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.

39. REPORTS: Vendor shall provide the Agency and/or the Purchasing Division with the following reports identified by a checked box below:

☒ Such reports as the Agency and/or the Purchasing Division may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

☐ Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the Purchasing Division via email at purchasing.division@wv.gov.

40. BACKGROUND CHECK: In accordance with W. Va. Code § 15-2D-3, the State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check. Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

41. PREFERENCE FOR USE OF DOMESTIC STEEL PRODUCTS: Except when authorized by the Director of the Purchasing Division pursuant to W. Va. Code § 5A-3-56, no contractor may use or supply steel products for a State Contract Project other than those steel products made in the United States. A contractor who uses steel products in violation of this section may be subject to civil penalties pursuant to W. Va. Code § 5A-3-56. As used in this section:

- a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.
- b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open hearth, basic oxygen, electric furnace, Bessemer or other steel making process.
- c. The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:
 1. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars (\$2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or
 2. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

42. PREFERENCE FOR USE OF DOMESTIC ALUMINUM, GLASS, AND STEEL: In Accordance with W. Va. Code § 5-19-1 et seq., and W. Va. CSR § 148-10-1 et seq., for every contract or subcontract, subject to the limitations contained herein, for the construction, reconstruction, alteration, repair, improvement or maintenance of public works or for the purchase of any item of machinery or equipment to be used at sites of public works, only domestic aluminum, glass or steel products shall be supplied unless the spending officer determines, in writing, after the receipt of offers or bids, (1) that the cost of domestic aluminum, glass or steel products is unreasonable or inconsistent with the public interest of the State of West Virginia, (2) that domestic aluminum, glass or steel products are not produced in sufficient quantities to meet the contract requirements, or (3) the available domestic aluminum, glass, or steel do not meet the contract specifications. This provision only applies to public works contracts awarded in an amount more than fifty thousand dollars (\$50,000) or public works contracts that require more than ten thousand pounds of steel products.

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products. This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

All bids and offers including domestic aluminum, glass or steel products that exceed bid or offer prices including foreign aluminum, glass or steel products after application of the preferences provided in this provision may be reduced to a price equal to or lower than the lowest bid or offer price for foreign aluminum, glass or steel products plus the applicable preference. If the reduced bid or offer prices are made in writing and supersede the prior bid or offer prices, all bids or offers, including the reduced bid or offer prices, will be reevaluated in accordance with this rule.

43. INTERESTED PARTY SUPPLEMENTAL DISCLOSURE: W. Va. Code § 6D-1-2 requires that for contracts with an actual or estimated value of at least \$1 million, the Vendor must submit to the Agency a disclosure of interested parties prior to beginning work under this Contract. Additionally, the Vendor must submit a supplemental disclosure of interested parties reflecting any new or differing interested parties to the contract, which were not included in the original pre-work interested party disclosure, within 30 days following the completion or termination of the contract. A copy of that form is included with this solicitation or can be obtained from the WV Ethics Commission. This requirement does not apply to publicly traded companies listed on a national or international stock exchange. A more detailed definition of interested parties can be obtained from the form referenced above.

44. PROHIBITION AGAINST USED OR REFURBISHED: Unless expressly permitted in the solicitation published by the State, Vendor must provide new, unused commodities, and is prohibited from supplying used or refurbished commodities, in fulfilling its responsibilities under this Contract.

45. VOID CONTRACT CLAUSES: This Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law.

46. ISRAEL BOYCOTT: Bidder understands and agrees that, pursuant to W. Va. Code § 5A-3-63, it is prohibited from engaging in a boycott of Israel during the term of this contract.

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

(Printed Name and Title) PAULINA WIERZBICKA, PRESIDENT

(Address) 9440 Santa Monica Blvd, Beverly Hills, CA 90210

(Phone Number) / (Fax Number) 1-800-666-6293 ext. 810

(email address) paulina.wierzbicka@snah.org

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.

SNAH Healthcare Software Management

(Company)

Paulina Wierzbicka

(Signature of Authorized Representative)

PAULINA WIERZBICKA, PRESIDENT, 9/24/2025

(Printed Name and Title of Authorized Representative) (Date)

1-800-666-6293 ext. 810

(Phone Number) (Fax Number)

paulina.wierzbicka@snah.org

(Email Address)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS2600000001

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

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

Addendum Numbers Received:

(Check the box next to each addendum received)

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

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that 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.

SNAH Healthcare Software Management

Company


Authorized Signature

9/24/2025

Date

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

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SECTION 4: PROJECT SPECIFICATIONS

Background and Current Operating Environment: The West Virginia Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The West Virginia CHIP provides medical assistance to help working families who do not have health insurance for their children and qualifying pregnant women. The federal and state governments jointly fund Agency programs. At the federal level, the Centers for Medicare and Medicaid Services (CMS) administers the program. While each state has considerable flexibility in designing and operating its programs, it must comply with applicable federal requirements.

BMS, within the DoHS, is the single state agency responsible for statewide administration of the Title XIX Medicaid Program and the Title XXI CHIP Program. The nature, extent, and scope of these programs coverage, including reimbursement rates and methodologies, are federally approved by the Centers for Medicare and Medicaid Services (CMS). The Agency also interacts with other interdepartmental divisions as well as with medical service practitioners, providers and provider organizations.

Pursuant to 42 CFR § 440.170, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec440-170.pdf>, the transportation benefit includes transportation expenses and related travel expenses determined necessary by the agency to secure medical examinations and treatment for a beneficiary. Examples of modes of transportation that the state authorizes include, but are not limited to, ambulances and/ or specialized motor vehicles (e.g., wheelchair-accessible vans) and common carriers (e.g., taxis, personal vehicles, and public transportation).

The Deficit Reduction Act of 2005 gave states the option to “[establish] a non-emergency medical transportation brokerage program in order to more cost-effectively provide” transportation for Medicaid beneficiaries. The statute requires that brokers: be selected through competitive bidding; have oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous; be subject to regular auditing and oversight by the states; and comply with all prohibitions on referrals and conflicts of interest established by the Secretary of DoHS.

OPTIONAL SERVICE- OFFICE OF DRUG CONTROL PREVENTION/BUREAU FOR BEHAVIORAL HEALTH

In 2017, West Virginia developed an Opioid Response Plan to address key topics related to substance use disorder from prevention to treatment and recovery. Due to the recommendations in this plan, the West Virginia Legislators created the West Virginia Drug Control Policy Act (Act), W. Va. Code 16-5T-1 *et seq.* This Act established the Office of Drug Control Policy within the West Virginia Department of Human Services to improve drug overdose surveillance and help

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strengthen the state's response. The Act created a central repository that will store drug overdose information, making drug overdoses a notifiable condition and placing limits on opioid prescribing. The repository is aimed at building upon West Virginia's efforts to access and make available complete and timely data for action, providing support to state and community professionals, portraying the scope of the epidemic and helping target prevention and response efforts.

The ODCP Director directly reports to the Office of the Governor, and works in cooperation with the State Health Officer, the Bureau for Public Health, and the Bureau for Behavioral Health, and is charged with leading development of West Virginia's drug control policy. This includes all programs and services related to prevention, treatment, recovery, and reduction of substance use disorder, in coordination with Department Bureaus and other state agencies.

Established by the West Virginia Legislature to address the state's substance use disorder crisis, Jobs & Hope WV aims to address the Substance Use Disorder Crisis through a statewide collaboration of agencies to provide linked services to participants. Jobs and Hope WV is for individuals in recovery who are education and career ready; however, programs through Jobs and Hope WV are available to all West Virginians who have a barrier to career employment.

The working mission of the BBH is to ensure that West Virginians with mental health and/or substance use disorders and intellectual/developmental disabilities experience services that are comprehensive, readily accessible, and tailored to meet individual, family, and community needs. BBH, in accordance with the Public Health Service Act, is the federally designated single state agency responsible for planning, carrying out and evaluating activities to prevent and treat substance abuse and related activities.

4.1. Project Goals and Mandatory Requirements: Enhanced by a full-risk capitation brokerage model, the West Virginia NEMT program exemplifies a comprehensive grasp of engagement's scope and the services it entails, underpinned by a transparent timeline outlining the strategy for achieving project milestones. The vendor is encouraged to articulate their approach and methodology for service provision or problem-solving, aligning with the specified goals and objectives. Furthermore, the vendor should delineate the strengths and weaknesses of their proposed approach in comparison to alternative strategies.

4.1.1. Goals and Objectives – The project goals and objectives are listed below.

4.1.1.1 The vendor should address Appendix 1, Operational Specifications, including all deliverables and proposal components described therein.

4.1.1.2 The vendor should address Appendix 2, Implementation Specifications, including all deliverables and proposals components described. The vendor's approach should exhibit an up-to-date knowledge and understanding of the NEMT Brokerage Program and

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NEMT Services in general, including the requirements of BMS Chapter 524, which can be found at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf> of the West Virginia State Medicaid Manual for Provider requirements, Chapter 27 of the West Virginia Bureau for Family Assistance (BFA) Income Maintenance Manual (IMM) for member eligibility, which can be found at:

<https://dhhr.wv.gov/bfa/policyplans/Documents/Binder4.pdf> and 42 CFR § 440.170, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec440-170.pdf>.

4.1.1.3 The vendor should list all subcontractors that the vendor intends to use for any administrative functions of the NEMT Brokerage Program, other than NEMT Providers, Additionally, for each subcontractor, the Vendor should:

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

4.1.1.3.2 Detail the exact nature of the subcontractor's responsibility for the NEMT Brokerage Program, and the projected dates the subcontractor will begin and end work.

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

4.1.1.3.4 Identify the policies and procedures for handling subcontractors when they fail to meet company, State and/or Federal regulations.

4.1.1.3.5 Provide three (3) references for the subcontractor.

4.1.1.3.6 Provide a draft of the proposed subcontract.

4.1.1.4 The vendor should describe their approach and methodology for developing and managing an up to date database for a statewide NEMT brokerage system for a population similar to that of WV Medicaid, including the ability to submit data via batch mode, perform statistical analysis (including transportation utilization analysis), and provide detailed reports as listed in Appendix 3 (Reporting Requirements) and the flexibility to produce additional ad hoc reports based on the data collected.

4.1.1.5 The vendor should describe their approach and methodology for report development and production and should also provide examples of reports produced for projects of the type, size and scope of that described in this RFP.

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4.1.1.6 The vendor should describe their plan, to include timeframes, to supply all deliverables as described in Appendix 3 (Reporting Requirements) and perform according to the approved Service Level Agreements listed in Appendix 4 (Service Level Agreements).

4.1.1.7 The vendor should describe their approach to supply all written material, including (but not limited to) reports, letters, training materials, Agency recipients' education materials, provider manuals and operations manuals to the Agency for approval thirty (30) calendar days in advance of distribution.

4.1.1.8 The vendor should describe their plan to adjust and/or provide increased training of NEMT Providers without additional cost to the Agency, if the vendor or the Agency determines that requirements, quality or other standards (Appendix 1) are not being met.

4.1.1.9 The vendor should describe their plan to follow proprietary formalized change control procedures for all changes to project scope, including (but not limited to): changes arising during the Implementation and Operations phases of the project and changes necessitated as a result of new and amended federal and state regulations and requirements.

4.1.1.10 The vendor should describe their communication plan that addresses communication with all interested parties, including the Agency, which could include face to face, video conference, internet conference or teleconference meetings to discuss and resolve administrative and operational issues.

4.1.1.11 The vendor should articulate their grievance process in alignment with the Agency's policies and procedures as detailed in the BMS policy Chapter 800, which can be found at: <https://dhhr.wv.gov/bms/Pages/Manuals.aspx> of the West Virginia State Medicaid Manual for Provider requirements process for Medicaid recipients. Additionally, providers should be afforded a transparent review process.

4.1.1.12 The vendor should describe their plan for contracting with qualified NEMT Providers, including examples of reasons they would terminate a provider service agreement and timeframes.

4.1.1.13 The vendor should describe their plan for screening staff and providers to include but not limited to fingerprint-based background checks.

4.1.1.14 The vendor should only describe their plan/process to address Medicaid recipients that are non-compliant pertaining to safety issues, hostile behaviors/environment, and/or exhibit aggressive behaviors.

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4.1.1.15 The vendor should describe their plan to work collaboratively with the Agency's programs, the Agency's Utilization Management vendor or the State's Managed Care Organization (MCOs) to ensure that the most appropriate Level of Service is utilized for the member's transportation needs.

4.1.1.16 The vendor should describe their plan to work collaboratively with the Agency's Utilization Management Vendor or State MCOs or Office of Drug Control Policy/Bureau for Behavioral Health to assure that member services have met any prior authorization requirements prior to vendor scheduling and/or paying for member transportation.

4.1.1.17 The vendor should describe their plan/process to notify providers of expiring credentials, the renewal process and consequences of not recertifying by due date.

4.1.1.18 The vendor should describe their plan/process for handling requests that are out of the members area, such as out-of-network/out-of-state services, how the service distance will be measured and their plan/process for verification of the prior authorization of the Out-of-Network service by the Agency's Utilization Management Vendor, Fiscal Agent, and/or MCO.

4.1.1.19 The vendor should provide a detailed description of their plan and processes for identifying and preventing potential fraud, waste, abuse, or misuse of NEMT payments. This should include, but not be limited to, procedures for verifying pick-up locations, confirming medical provider legitimacy, and managing repayments. Additionally, the vendor should outline their trip verification protocols, and the procedures used for reimbursing members and/or providers.

4.1.1.20 The vendor should describe their plan to establish an advisory committee composed of NEMT interested parties as approved by the Agency, to include, but not be limited to, members, healthcare providers, NEMT providers and at large community members for the purpose of maintaining relationships and identifying program improvements and shortcomings.

4.1.1.21 The vendor should describe their plan to provide Gas Milage Reimbursement (GMR) or transportation to other persons designated by the Agency, which may or may not be current members, to designated covered events. These other persons include but are not limited to the members of the Beneficiary Advisory Council (BAC) to quarterly meetings, which are currently held in Charleston, WV. These persons will consist of a dedicated group, which will be provided to the vendor thirty (30) days in advance of any covered event.

4.1.1.22 The vendor should describe their plan to provide a monthly report of the previous month's transportation trips that include but are not limited to: Agency recipient

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identification document (ID), date of service, servicing medical provider, and other data elements as determined by the Agency.

4.1.1.23 The vendor should describe their plan to develop a monitoring report that tracks monthly changes—both increases and decreases—in transportation trips for individuals receiving services for Medication Assisted Treatment (MAT), including methadone and buprenorphine. At a minimum this report should include data that illustrates trends in NEMT utilization for MAT.

4.1.1.24 The vendor should describe how they will inform the Agency when providers are not compliant with verification that the member is being transported to a medically necessary service.

OFFICE OF DRUG CONTROL POLICY – OPTIONAL SERVICE

Contract services must meet or exceed the mandatory requirements listed below. The Office of Drug Control Policy will have authority for final approval of any and all implementation plans or other required materials specific to the Jobs and Hope program. All plan requests are to be submitted as part of the bid response.

4.1.1.25 The vendor should develop and submit a plan on their engagement process with the Jobs and Hope program transition agents, who will be responsible for booking non-medical travel with the NEMT broker.

Note: Members dually enrolled in both Medicaid and the Jobs and Hope program will utilize the vendor's services. Medicaid NEMT travel will be arranged directly with the member. Any travel under the Jobs and Hope program must be arranged through the Jobs and Hope transition agent.

4.1.1.26 The vendor should develop and submit a strategic plan for how the vendor will design, develop, and implement a ride sharing solution.

4.1.1.27 The vendor implements all contract requirements by the “go live” date of the contract.

4.1.1.28 The vendor should provide documentation of their experience within the last five (5) years' operating a statewide Transportation Services program(s).

4.1.1.29 The vendor should provide a plan as to how they will provide statewide transportation services in all fifty-five (55) counties of West Virginia.

4.1.1.30 The vendor should provide a plan as to how they will provide on-demand ride response services with responses occurring within a maximum of one 24-hour period.

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4.1.1.31 The vendor should provide a detailed plan outlining its strategy to arrive on time per the scheduled booking.

4.1.1.32 The vendor should describe how they will use multi-passenger trips when possible.

4.1.1.33 The vendor should provide a plan as to how they will maintain an eighty (80) percent on-time rate for all rides authorized using the ride booking platform.

4.1.1.34 The vendor should provide an approach and methodology to personnel management that include contingency plans to ensure adequate coverage of program needs and requirements.

4.1.1.35 The vendor should provide a plan as to how they will develop and implement a platform for users with the following services:

4.1.1.35.1 Ride scheduling and dispatch platform for participants by an Authorized User.

4.1.1.35.2 Coordinated transportation network services.

4.1.1.35.3 Network intelligence applications (analytics and reporting tools).

4.1.1.35.4 In person training and on-boarding of Authorized Users.

4.1.1.36 The vendor should provide a plan as to how they will conduct training and education about the application to Authorized Users as designated by the ODCP.

4.1.1.37 The vendor should outline their approach to meeting the monthly reporting requirements set forth by ODCP. These reports should facilitate effective monitoring of service level agreements to ensure compliance.

4.1.1.38 The vendor should describe their plan to partner with ODCP/BBH on the option to roll after-hours calls over to a 24/7 behavioral health line.

4.1.1.39 The vendor should describe their plan to partner with ODCP/BBH on options for people to receive transportation to a behavioral health level of care not eligible for NEMT; for example, those leaving one level of SUD treatment service (e.g., residential treatment, crisis service, hospital, etc.) to be transported to another level of care, such as recovery residences; or to the safest and most secure location for interim services while the person waits for another level of residential service or receives outpatient treatment services.

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4.1.1.40 The vendor should describe their plan to partner with ODCP/BBH on optional initiatives to recruit drivers/driving services or other methods to increase acceptance call rates in counties with a history of unsuccessful trips.

4.1.1.41 The vendor should describe their plan to partner with ODCP, as part of their Education for Providers, to educate behavioral health providers on the process for “urgent” protocols in which the receiving facility verifies the individual’s visit as both urgent and requiring services within a certain number of hours.

4.1.1.42 The vendor should describe the option for its procedures for follow-up with individuals within the same business day of urgent trips, re-routed trips, or refused/declined trips, via notification of a method approved by the individual such as a call from an approved call line, peer worker, receiving facility’s outreach worker, or family member or friend.

4.1.1.43 As part of the secure, web-based inquiry system for NEMT providers to access NEMT Services trip authorization information, the Vendor should describe its online/electronic process for urgent, same-day request submissions to be merged with the Agency data file; and to assign a “ODCP/BBH Transport Charity Care” number prior to when the Medicaid ID number is assigned or otherwise who do not have NEMT eligibility on the date of service.

4.1.2. 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. The vendor should describe how it will comply with the mandatory requirements and include any area 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 with, and areas where the mandatory requirements are exceeded, will be included in technical scores where appropriate. The mandatory project requirements are listed below.

4.1.2.1 The vendor must observe and comply with federal and State of West Virginia laws, local laws, ordinances, orders, and regulations existing at the time of, or enacted after, the execution of a resulting contract which in any manner affects the completion of the work. The Vendor must also comply with Chapter 524 of the West Virginia State Medicaid Manual, Chapter 27 of the West Virginia Bureau for Children and Families Income Maintenance Manual, 42 CFR § 440.170, and follow the Agency’s exclusions.

4.1.2.2 The vendor must agree to provide increased staffing levels if requirements, timeliness, quality or other standards are not met, based solely on the discretion of and without additional cost to the Agency. In making this determination, the Agency will evaluate whether the vendor is meeting deliverable dates, producing quality materials, maintaining high quality and production rates and meeting contract standards without significant re-work or revision. Beginning thirty (30) calendar days prior to the operations

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start date and commencing through the end of the contract, the vendor will not reduce staffing without Agency approval.

4.1.2.3 The vendor must agree to establish and operate the NEMT Call Center within a fifteen (15) mile radius of the West Virginia State Medicaid agency located at 350 Capitol Street, Charleston, WV to facilitate the Agency's ability to conduct on-site monitoring and oversight activities. The Call Center must be staffed with personnel who reside within the State of West Virginia. At a minimum, the following key personnel must be physically housed at this Call Center location:

- Project Manager
- Provider Manager
- Provider Relations Manager
- Call Center Manager
- Exceptions Manager
- Mass Transit Coordinator
- Report Manager
- Two (2) Fraud, Waste, Abuse, and Misuse Claims Reviewers
- Two (2) Complaint Coordinators
- Two (2) Appointment Verification Staff
- Two (2) Field Service Specialists
- Two (2) Claims Processors

All inbound and outbound calls related to the Reservation, Ride Assist, Exceptions, and Provider Support Lines must be handled within the State of West Virginia, except during approved after-hours operations. The after-hours call handling location must be approved in advance by the Agency.

Under no circumstances shall the vendor route any calls outside the continental United States of America or its territories. Additionally, the vendor shall not delegate screening, authorization, or scheduling responsibilities to transportation providers or subcontractors without the Agency's prior written approval. While the vendor may delegate dispatch functions to NEMT providers, the vendor shall remain fully responsible for the proper execution and performance of all dispatch-related activities.

4.1.2.4 The vendor must agree to provide NEMT services described in the RFP from the operational start date until service delivery is turned over to a successor vendor at the end of the contract, including any optional renewal periods. Program changes include, but are not limited to, processes, protocols, flowcharts or any other program administration guideline changes/modifications must receive approval from the Agency prior to changes/modifications being implemented by the vendor. All program changes affecting member benefits must be communicated to members, through an Agency approved written

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communication, no less than thirty (30) calendar days prior to implementation of program change.

4.1.2.5 The vendor will be responsible for reimbursing NEMT Providers. The vendor will not be required to reimburse unauthorized NEMT Services to out-of-network providers. The Vendor will not use NEMT Providers with which the Vendor has not executed a contract. The Vendor must maintain an appropriate reserve equivalent to ten percent (10%) of the annual contract cost bid for NEMT services during the contract period. The vendor will enroll as an Agency provider and receive payment for services through the State's Medicaid claim system, Medicaid Management Information System (MMIS).

4.1.2.6 At the conclusion of each state fiscal year (June 30), the vendor will report pre-tax net income, of the West Virginia NEMT Program (Medicaid services only), to the Agency. Any amount over 7.5% profit will be returned to the state within thirty (30) days of the completion of the audit, which must be completed within ninety (90) days of the end of the state fiscal year. This serves as cost containment, ensuring the successful continuity of the program. For purposes of computing rebate, the vendor may carryover, from the prior reporting period only any expenses (losses) in excess of 100% of premium revenue received, not to exceed 5% of total loss amount (e.g. revenue received is \$100; expenses are \$100; vendor may carryover %.50 for rebating calculation in following year). The vendor must provide documentation that the carryover amount is in compliance with contractual standards via reporting completed by an independent auditor.

4.1.2.7 The vendor must complete all start-up activities within three (3) months prior to go live of contract award date.

4.1.2.8 The vendor will have monthly administrative meetings with the Agency staff to provide program updates to include, but not limited to: program cost, utilization trends, issues, program accomplishments/deficits and other data as requested by the Agency.

4.1.2.9 The vendor must provide all data, including data the vendor may consider proprietary, as requested for any State and/or Federal audit.

4.1.2.10 The vendor must agree to price individual tiers on the pricing page with no more than 20% variance between the individual tiers.

4.1.2.11 The vendor must agree to be bound by all Service Level Agreements (SLA) included in Appendix 4.

4.2. 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

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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 were 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. The vendor should propose a staffing plan that can address the unique needs of members while guaranteeing services 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.

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

4.2.1.1. Organizational chart(s) showing the number and geographic location of all staff that will perform duties under the contract, including the vendor and subcontractor staff. Key staff members, off-site (i.e., location other than the vendor's call center facility), vendor staff, and subcontractor staff should be clearly identified as such on each organizational structure, including all parent entities. This chart should show the relationship of the vendor's proposed project organization to its overall organizational structure. The vendor should provide a revised organizational chart, within thirty (30) calendar days, at any time during the contract period that a change is made in the organizational structure.

4.2.1.2. Description of the roles, responsibilities and skills associated with each position on the organization chart.

4.2.1.3. Job description and requirements for call center staff demonstrating a high school diploma or equivalent certification and all management staff demonstrating a bachelor's degree and at least two (2) years of qualifying experience for this project.

4.2.1.4. For any proposed work to be performed off-site, including work of subcontractor(s), the bidder should describe the assurance of quality and timeliness of the work done off-site or through subcontractors.

4.2.1.5. Approach to staff retention and ensuring continuity of staff to include employee continued education/training programs, employee performance incentives and other employee benefits/programs that provide for staff enhancement in education and/or performance. The vendor is to assume all costs associated with referenced programs.

4.2.1.6. Approach and methodology to personnel management to include contingency plans to ensure adequate coverage of program needs and requirements. The vendor is to assume all costs associated with referenced programs.

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4.2.1.7. The vendor should describe their experience within the last five (5) years' operating a full brokerage NEMT services program(s) for a population similar to that of West Virginia Medicaid, including the following:

4.2.1.7.1 State Medicaid and/or other governmental NEMT programs.

4.2.1.7.2 Providing NEMT or other transportation services.

4.2.1.7.3 Brokering NEMT or other transportation services.

4.2.1.7.4 Recruiting NEMT Providers.

4.2.1.7.5 Operating an Automatic Call Distribution (ACD) system.

4.2.1.7.6 Staffing a NEMT or other transportation service customer service center.

4.2.1.7.7 Developing and managing a transportation database, including reporting and transportation utilization analysis activities.

4.2.2. 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 area 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.

4.2.2.1. Key staff positions: Project Manager, Assistant Manager, Provider Relations Manager, Outreach and Communications Manager and Call Center management staff, identified with named individuals and resumes demonstrating a bachelor's degree, licenses, skills and at least two (2) years' experience that qualifies them for their role in this project. The bachelor's degree may be substituted with four (4) years of full-time or equivalent part-time paid NEMT experience in addition to the two (2) years already specified. Resumes should be limited to three (3) single-sided pages per individual.

4.2.2.2. 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 or implementation staff). Resumes should include licenses, skills and relevant experience as they pertain to this project. Resumes should be limited to three (3) single-sided page per individual.

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4.2.2.3. The vendor should provide detailed evidence of their related experience and capabilities in providing NEMT services in a full brokerage program. At least three (3) Vendor references from work performed for government entities within the last five (5) years should be provided. A reference from an MCO is acceptable when accompanied by a letter from that state's Medicaid agency explaining the relationship and size of the population served.

4.3. Oral Presentations (Agency Option): The Agency has the option of requiring oral presentations of all Vendors participating in the RFP process. If this option is exercised, points will be allocated in Section 6.2 below at the time the RFP is issued, or via addendum prior to technical bid opening. During oral presentations, Vendors may not alter or add to their submitted proposal but only clarify information. A description of the materials and information to be presented is provided below:

Materials and Information Requested at Oral Presentation:

4.3.1. There will be no Oral Presentation required for this solicitation.

SECTION 5: VENDOR PROPOSAL

5.1. Economy of Preparation: Proposals should be prepared simply and economically providing a concise description of the items requested in Section 4. Emphasis should be placed on completeness and clarity of the content.

5.2. Incurring Cost: Neither the State nor any of its employees or officers shall be held liable for any expenses incurred by any Vendor responding to this RFP, including but not limited to preparation, delivery, or travel.

5.3. Proposal Format: Vendors should provide responses in the format listed below:

5.3.1. Two-Part Submission: Vendors must submit proposals in two distinct parts: technical and cost. Technical proposals must not contain any cost information relating to the project. Cost proposal must contain all cost information and must be sealed in a separate envelope from the technical proposal to facilitate a secondary cost proposal opening.

5.3.2. Title Page: State the RFP subject, number, Vendor's name, business address, telephone number, fax number, name of contact person, e-mail address, and Vendor signature and date.

5.3.3. Table of Contents: Clearly identify the material by section and page number.

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5.3.4. Response Reference: Vendor's response should clearly reference how the information provided applies to the RFP request. For example, listing the RFP number and restating the RFP request as a header in the proposal would be considered a clear reference.

Proposal Submission: All proposals (both technical and cost) must be submitted to the Purchasing Division **prior** to the date and time listed in Section 2, Instructions to Vendors Submitting Bids as the bid opening date and time.

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SECTION 6: EVALUATION AND AWARD

- 6.1. Evaluation Process:** Proposals will be evaluated in two parts by a committee of three (3) or more individuals. The first evaluation will be of the technical proposal and the second is an evaluation of the cost proposal. The Vendor who demonstrates that it meets all the mandatory specifications required, attains the minimum acceptable score and attains the highest overall point score of all Vendors shall be awarded the contract.
- 6.2. Evaluation Criteria:** Proposals will be evaluated based on criteria set forth in the solicitation and information contained in the proposals submitted in response to the solicitation. The technical evaluation will be based upon the point allocations designated below for a total of 700 of the 1000 points. Cost represents 300 of the 1000 total points.

Evaluation Point Allocation:

Project Goals and Proposed Approach (§ 4.2)

- Approach & Methodology to Goals/Objectives (§ 4.2.1) (500) Points Possible
- Approach & Methodology to Compliance with Mandatory Project Requirements (§ 4.2.2) (100) Points Possible

Qualifications and experience (§ 4.3)

- Qualifications and Experience Generally (§ 4.3.1) (75) Points Possible
- Exceeding Mandatory Qualification/Experience Requirements (§ 4.3.2) (25) Points Possible

(Oral interview, if applicable) (§ 4.4) (0) Points Possible

Total Technical Score: 700 Points Possible

Total Cost Score: 300 Points Possible

Total Proposal Score: 1,000 Points Possible

- 6.3. Technical Bid Opening:** At the technical bid opening, the Purchasing Division will open and announce the technical proposals received prior to the bid opening deadline. Once opened, the technical proposals will be provided to the Agency evaluation committee for technical evaluation.

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6.4. Technical Evaluation: The Agency evaluation committee will review the technical proposals, assign points where appropriate, and make a final written recommendation to the Purchasing Division.

6.5. Proposal Disqualification:

6.5.1. Minimum Acceptable Score (“MAS”): Vendors must score a minimum of 70% (490 points) of the total technical points possible in order to move past the technical evaluation and have their cost proposal evaluated. All vendor proposals not attaining the MAS will be disqualified.

6.5.2. Failure to Meet Mandatory Requirement: Vendors must meet or exceed all mandatory requirements in order to move past the technical evaluation and have their cost proposals evaluated. Proposals failing to meet one or more mandatory requirements of the RFP will be disqualified.

6.6. Cost Bid Opening: The Purchasing Division will schedule a date and time to publicly open and announce cost proposals after technical evaluation has been completed and the Purchasing Division has approved the technical recommendation of the evaluation committee. All cost bids received will be opened. Cost bids for disqualified proposals will be opened for record keeping purposes only and will not be evaluated or considered. Once opened, the cost proposals will be provided to the Agency evaluation committee for cost evaluation.

The Purchasing Division reserves the right to disqualify a proposal based upon deficiencies in the technical proposal even after the cost evaluation.

6.7. Cost Evaluation: The Agency evaluation committee will review the cost proposals, assign points in accordance with the cost evaluation formula contained herein and make a final recommendation to the Purchasing Division.

Cost Evaluation Formula: Each cost proposal will have points assigned using the following formula for all Vendors not disqualified during the technical evaluation. The lowest cost of all proposals is divided by the cost of the proposal being evaluated to generate a cost score percentage. That percentage is then multiplied by the points attributable to the cost proposal to determine the number of points allocated to the cost proposal being evaluated.

Step 1: $\text{Lowest Cost of All Proposals} / \text{Cost of Proposal Being Evaluated} = \text{Cost Score Percentage}$

Step 2: $\text{Cost Score Percentage} \times \text{Points Allocated to Cost Proposal} = \text{Total Cost Score}$

Example:

Proposal 1 Cost is \$1,000,000

Proposal 2 Cost is \$1,100,000

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Points Allocated to Cost Proposal is 300

Proposal 1: Step 1 – $\$1,000,000 / \$1,000,000 = \text{Cost Score Percentage of } 1 (100\%)$
Step 2 – $1 \times 300 = \text{Total Cost Score of } 300$

Proposal 2: Step 1 – $\$1,000,000 / \$1,100,000 = \text{Cost Score Percentage of } 0.909091 (90.9091\%)$
Step 2 – $0.909091 \times 300 = \text{Total Cost Score of } 272.727273$

- 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.

SNAH Healthcare Software Management

(Company)

PAULINA WIERZBICKA, PRESIDENT

(Representative Name, Title)

1-800-666-6293 ext. 810

(Contact Phone/Fax Number)

9/24/2025

(Date)

Paulina Wierzbicka
9/24/2025

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Attachment A: Cost Sheet

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Attachment A: Cost Sheet

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Department of Human Services

Bureau for Medical Services/Office of Drug Control Policy/Bureau for Behavioral Health
Non-Emergency Medical Transportation (NEMT)/Statewide Transportation Program
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Appendix 1: Operational Specifications

The following operational specifications have been developed by the West Virginia Bureau for Medical Services here and after referred to as "the Agency" to describe expectations for the provision of Non-Emergency Medical Transportation (NEMT) and Statewide Transportation Program (STP) Services by the vendor. 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.

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Bureau for Medical Services/Office of Drug Control Policy/Bureau for Behavioral Health
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I. NEMT Service Request Processing

The vendor should provide screening, assignment, dispatch, payment and monitoring of NEMT requests to ensure consistent application of:

- BMS Chapter 524, which can be found at: <http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx> of the West Virginia State Medicaid Manual for Provider requirements.
- Chapter 27 of the West Virginia Bureau for Family Assistance (BFA) Income Maintenance Manual (IMM) for member eligibility, which can be found at: <https://dhhr.wv.gov/bfa/policyplans/Documents/Binder4.pdf>
- 42 CFR § 440.170, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec440-170.pdf>
- Assurance of Transportation A Medicaid Transportation Coverage Guide, which can be found at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf>

The Vendor is responsible for maintaining compliance with,

- West Virginia Code, Chapter 46A, Art. 2A, which can be found at: <http://www.legis.state.wv.us/WVCODE/ChapterEntire.cfm?chap=46a&art=2A>
- West Virginia Code, Chapter 61, Art. 3C, Computer Crime and Abuse Act, which can be found at: <http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=61&art=3C#03C>
- Policies Issued by West Virginia Office of Technology, Chief Technology Officer, which can be found at: <http://www.technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx>
- The West Virginia Executive Branch Privacy Policy: Security Safeguards, which can be found at: <http://www.privacy.wv.gov/SiteCollectionDocuments/Privacy%20Policies/6%20Security%20Safeguards%20Policy%20WVEB-P106.pdf>

The vendor should fully and specifically describe in their Proposal how it intends to screen, authorize, schedule, and assign trips to NEMT providers and communicate the information to the NEMT providers. The vendor should also describe its procedure for assigning standing orders, urgent trips and re-routed and/or refused trips.

A. Screening

Based on authorization of previous NEMT Services, the vendor should consider Agency members' permanent and temporary special needs, appropriate modes of transportation, any special instructions regarding the nearest appropriate provider, and any additional information necessary to ensure that appropriate transportation is authorized and provided. This information should be easily accessible by all vendor staff. NEMT request screening should adhere to the following specifications:

1. Requests for NEMT services may be made by Agency members, their families, guardians or representatives, and by medical or NEMT providers.

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2. The vendor should screen all NEMT requests to determine each of the following items:
 - a. The Agency members eligibility for NEMT services at the time of service.
 - b. The Agency members medical need which requires NEMT services.
 - c. The Agency members lack of access to appropriate and/or available transportation. The vendor should require the member to verbally certify this.
 - d. The Agency members' service, for which the NEMT service is requested, meets one or more of the following criteria:
 1. Services must be provided by an in-network provider who is either enrolled with West Virginia (WV) Medicaid or one of the state's Managed Care Organizations (MCOs) located within the state or within thirty (30) miles of its border.
 2. The Agency member received prior authorization from the Utilization Management Contractor (UMC) or from an authorized Agency representative to receive medical services from an out-of-network/out-of-state provider, defined as a provider not enrolled in WV Medicaid located out of state beyond the thirty (30) mile border. The medical service for which the NEMT service is requested is a medical service covered by WV Medicaid and if it requires prior authorization that it has been granted by the appropriate entity:
 3. If an Agency member is dually eligible for Medicaid and another type of coverage, Medicaid is always billed last. If a medical service is covered in full by another coverage type, such as Medicare, that trip is ineligible for NEMT service(s), however, if a trip is paid in part by WV Medicaid, then that trip is eligible for NEMT service(s).
 - e. The most economical mode of transportation appropriate to meet the medical needs of the member, based on the member's mobility status and personal capabilities on the date of service. The reasons for approval of mode of transportation that is not the most economical should be documented in detail.
 - f. The nearest appropriate provider to the member. If the medical provider is an excessive distance from the member's residence (as described in **Section Error! Reference source not found.** (Part **Error! Reference source not found.**) of this Appendix); and
 - g. Necessity of attendant or assistance request. The vendor may require a medical certification statement from the member's medical provider in order to approve door-to-door service or hand-to-hand service.
3. The vendor will not be responsible for arranging the transportation of the remains of a member who expires while receiving medical treatment. If a member expires

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while in transit, the vendor's NEMT provider should contact the nearest law enforcement agency for instructions. The vendor should notify The Agency of the occurrence within one (1) business day.

B. Advance Reservations

The vendor should educate WV Agency members on how to request NEMT services, including how to request services that will be made at least five (5) business days before the service is needed. The vendor will develop processes to handle urgent requests including but not limited to the last minute, evening or those falling upon weekends and/or holidays. The vendor should additionally develop processes to adjust for scheduling changes, NEMT providers not arriving for scheduled pick-ups, as well as challenges posed by inclement weather conditions.

C. Notification of Arrangements

The vendor should notify the member or their representative of the transportation arrangements during the initial phone call when requesting NEMT services. If unable to do so during the initial call, the vendor should inform the member or their representative promptly by a subsequent phone call, facsimile, or letter. If notifying by letter, it should be sent in time for the member to receive it at least two (2) calendar days before the scheduled NEMT service date.

D. Scheduling and Dispatching Trips

The vendor should schedule and assign authorized trips to an appropriate NEMT provider. The following standards are to be maintained:

1. The vendor should ensure that the average waiting time for a pick-up does not exceed fifteen (15) minutes. The vendor may propose a method to ensure that Agency Members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return trip if the covered medical service follows a reliable schedule. The pre-arranged times may not be changed by the NEMT provider or driver without prior permission from the vendor.

2. The vendor should indicate the process for rescheduling NEMT providers which is to be followed in situations where the NEMT provider is or may be late for a previously scheduled pick-up due to traffic, road closure, vehicle failure, inclement weather or any other unforeseen circumstance(s).

3. The vendor and NEMT provider may group Agency members and trips to promote efficiency and cost effectiveness. The vendor may contact providers in this process.

4. Agency members receiving behavioral health services covered by Agency programs for the scheduled trip should have transportation services scheduled

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with a licensed behavioral health center or licensed behavioral health provider as available/appropriate.

5. Agency members scheduling NEMT services should not be permitted to choose transportation by a particular NEMT provider. However, the vendor should strive to build and maintain relationships between NEMT providers and Agency Members. Additionally, the vendor should try to accommodate a member's request for specific NEMT provider enrolled with the vendor.

6. The vendor should notify the NEMT provider of the assignment at least two (2) business days prior to the trip and should assign the trip to another NEMT provider if necessary.

7. The vendor should contact an appropriate NEMT provider so that pick-up occurs within one (1) hour after notification of a hospital discharge.

8. Specific scheduling and dispatching standards unique to specific trip types are defined as follows:

- a. Single Trip Requests: The vendor should require that requests for NEMT services for a single appointment be made via a toll-free telephone number (844-549-8353). Other methods of single trip requests may be allowed with the Agency approval.
- b. Standing Order Trip Requests: The vendor should establish procedures to be approved by the Agency to handle trip requests so that Agency Members are not required to continually make arrangement for repetitive appointments. The vendor should also include a recertification process with the medical provider at least every ninety (90) 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 can be transported home via private auto, basic vehicle, wheelchair vehicle, or commercial air, the vendor should make the appropriate arrangements for the one-way transport for the member and one (1) attendant.
- d. Commercial Air Travel: In limited situations, the medical care required for a member cannot be provided within the State of West Virginia. Agency programs have enrolled specialty hospitals located elsewhere in the United States of America for which medical services have been prior authorized by WV Medicaid's UMC. The vendor should receive, schedule, and arrange air transports as

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requested by the UMC. The vendor should determine if the medical services have been prior authorized and that the medical certification of the need for commercial air travel is obtained from the medical provider. The vendor should be responsible for making the appropriate arrangements, purchasing the tickets and distributing them to the member and one (1) attendant. The vendor should use the most cost-efficient arrangements possible with reasonable allowances for choosing a flight that would reduce the number of transfers and/or reduce travel time and/or choosing an appropriate departure/arrival time based on the medical needs of the member. All tickets purchased for commercial air travel are to be coach/economy seating.

9. In certain situations, meals and lodging may be provided for a member and one (1) attendant for extended treatment out-of-state which requires at least one (1) overnight stay. All requests for out-of-state meals and lodging are to be evaluated and pre-approved by the vendor. The vendor may propose a method to use discounted lodging and meal services that might be offered through the medical provider or charitable organizations, such as Ronald McDonald House.

10. The vendor should evaluate and arrange 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. Appropriate air transport may be a commercial flight with or without a medical escort or private charter flight (non-air ambulance).

a. The vendor may purpose a method to prior authorize all fixed wing air transportation flights. The vendor should make provision for retroactive reviews of authorization requests for air transports that occur after business hours, on weekends and holidays. Appropriate air transportation includes commercial air and private charter flights.

11. The vendor may transport family member(s) and/or caregivers if space and conditions allow. However, there should not be a reimbursement for the transport of persons other than the beneficiary.

II. NEMT Providers

A. Network of NEMT Providers

The vendor should establish a network of NEMT providers and negotiate reimbursement with interested, willing and qualified transportation entities; including but not limited to licensed behavioral health centers that meet the transportation provider requirements. The vendor is encouraged to develop innovative and creative strategies to reduce per-trip

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costs such as providing reimbursement for gasoline and making greater use of fixed-route public transportation. The vendor should develop and maintain strong working relationships with NEMT providers, medical professionals, and relevant professional associations necessary for fulfilling the contract requirements.

The vendor should submit with its Proposal Letters of Commitment from proposed NEMT providers with whom the vendor intends to negotiate a contract for NEMT Services. Each letter of Commitment should include the number of vehicles by type that the proposed NEMT provider operates and the geographic areas in which the proposed NEMT provider is to operate. The vendor will notify the Agency within thirty (30) calendar days of service level changes to the approved providers' fleets and/or operational areas.

The vendor should include in its Proposal the proposed number of vehicles by type operated by all proposed NEMT providers as of the anticipated operations start date of the NEMT Broker Program. The vendor should include in its proposal contingency plans to be approved by the Agency for the unexpected. Examples include, but are not limited to: peak transportation demands, weather and other related natural disasters. Additionally, the vendor will detail back up plans for instance when a NEMT provider's vehicle is excessively late or is otherwise unavailable for service. The vendor should identify NEMT providers for bariatric transportation by geographic areas of coverage.

The vendor should recruit existing NEMT providers, the vendor should ensure that drivers may continue to provide NEMT Services under the current state-administered program until coverage under the NEMT Brokerage Program starts. The vendor should include in its Proposal a plan ensuring that there is **NO** delegation of service(s).

B. NEMT Provider Contracts

The vendor should identify, recruit and negotiate contracts with NEMT providers, including all modes of transportation listed in Section III of Appendix 1, sufficient to meet the needs of the Agency Members. The vendor should offer a contract to any willing provider and all willing licensed behavioral health centers that meet the transportation provider requirements. The vendor should secure sufficient NEMT providers' resources (numbers and types of vehicles, drivers) under contracts so that the failure of any NEMT provider to perform should not impede the ability of the vendor to provide NEMT Services in accordance with the requirements of the contract.

The vendor should submit with its proposal a model contract that the vendor intends to use with NEMT providers. The model contract for each mode of transportation should be reviewed and approved by the Agency prior to use.

The model contract should address the following items:

1. Payment administration and timely payment.
2. Modes of transportation.

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3. Geographic coverage area(s).
4. Attendant services.
5. Telephone and vehicle communication services.
6. Information systems.
7. Scheduling.
8. Dispatching.
9. Pick-up and delivery standards.
10. Urgent trip requirements.
11. Driver qualifications.
12. Expectations for door-to-door, hand-to-hand, curb-to-curb.
13. Driver conduct.
14. The driver manifest delivery.
15. Vehicle requirements.
16. Back-up service.
17. Quality assurance.
18. Non-compliance with standards.
19. Training for drivers.
20. Confidentiality of information.
21. Specific provision that, in the instance of default by vendor, the agreement should be passed to The Agency or its agent for continued provision of NEMT Services. All terms, conditions, and rates established by the agreement should remain in effect until or unless otherwise terminated by The Agency at its sole discretion.
22. Language Indemnification to protect the State of West Virginia and the Agency.
23. Evidence of insurance for the vehicle and the driver.
24. Submission of documentation as required by the Agency.
25. Appeal and dispute resolution.
26. Assurance of no overlap of services with other programs.

C. NEMT Provider Reimbursement

The vendor should provide timely payment, defined as thirty (30) calendar days, to each contracted NEMT provider for the services rendered. The vendor reimbursement to NEMT providers will demonstrate adequacy to ensure access for Medicaid members and provider participation. The vendor may reimburse NEMT providers through any payment arrangement agreeable to both parties, including a sub-capitation arrangement. All payment arrangements are to include an incentive or safeguard to ensure utilization data for every encounter is submitted to the vendor. The vendor's proposal should describe the following:

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1. Payment methodology.
2. Billing system.
3. Billing policies
4. NEMT providers instructions and procedures.
5. Penalties for late submission of reimbursement request.

The vendor's billing options should include options for electronic submission of invoices by NEMT providers. The vendor should pay all "clean claims" from NEMT providers within thirty (30) calendar days following receipt of the claim. A "clean claim" is defined as a claim that can be processed without obtaining additional information from the NEMT provider, medical provider, member or any other third party.

An exception to this timeframe would be any claim(s) submitted by or on behalf of a NEMT provider or provider who is under investigation for fraud, waste, misuse, or abuse or a claim that is under review for medical necessity.

Complaints are subject to the vendor's provider grievance resolution system.

D. Geographic Coverage Area

The vendor should record the geographic area from which each NEMT provider may accept assignments. This should include county-level detail throughout the state and medical communities in the adjacent states of Virginia, Ohio, Kentucky, Maryland and Pennsylvania.

The vendor should submit the NEMT provider Networking and Geographic Coverage Report for The Agency's review and approval, including details on the final subcontracted network, at no less than thirty (30) calendar days before the start date of operations. The vendor is not authorized to commence operations until an approved version of this report has been obtained from the Agency.

III. Modes of Transportation

The following modes of transportation are to be used in the NEMT Brokerage Program:

A. Fixed Route

Fixed route transportation is defined as transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from route or schedule and picks up passengers at designated stops.

The vendor is encouraged to maximize the utilization of fixed route transportation whenever more economical and appropriate. The vendor should be familiar with schedules of fixed route transportation in communities where fixed route transportation is available and in areas where it becomes available during the term of the contract. The vendor may distribute or arrange for the distribution of fixed route passes to Agency

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Members for whom fixed route transportation is the most appropriate mode of transportation. The furthest distance a member should be required to commute to or from a fixed route transportation stop is one-half (½) mile.

If the vendor determines that fixed route transportation is an appropriate mode of transportation for a member, but the member requests a different mode of transportation, the vendor may require the member to supply documentation from his or her physician. The vendor should consider the following when determining whether to allow an exception:

1. The member's ability to travel independently, including the age of the member and any permanent or temporary debilitating physical or mental condition that precludes use of fixed route transportation.
2. The availability of the fixed route transportation in the member's area or community including the accessibility of the location to which the member is traveling and whether the member should travel more than one-half (½) mile to and from the fixed route transportation stop.
3. Inclement weather conditions (including extreme heat or cold) or other pertinent factors that make use of fixed route transportation unfeasible.
4. The compatibility of the fixed route transportation schedule with the member's appointment times for the covered medical service. The schedule for the fixed route transportation should allow the member to arrive at the drop off location no more than ninety (90) minutes prior to the scheduled appointment time and should allow the member forty-five (45) minutes after the estimated time the appointment may end to arrive at the pick-up location.
5. Any special needs of the member which requires the coordination of services with other providers.

B. Private Auto

Private auto transportation is defined as a member's personal vehicle or the personal vehicle of a family member or friend, to which the member routinely has access to drive or be transported to routine non-medical locations such as a grocery store, schools, and churches.

C. Basic Vehicle

Basic vehicle transportation is defined as a motorized vehicle used for the transportation of passengers whose medical condition does not require the use of a wheelchair, hydraulic lift, stretcher, medical monitoring, medical aid, and medical care or treatment during transport. This does not include private auto (as defined in item B above).

D. Enhanced Vehicle

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Enhanced vehicle transportation is defined as a motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs or other mobility devices. Enhanced vehicles can only be used to transport passengers that do not require medical monitoring, medical aid, medical care, or medical treatment during transport. This does not include private auto or basic vehicle (as defined above).

E. Other Transportation

Other transportation may include, but is not limited to, any commercial carrier (e.g., Amtrak), buses (e.g., Greyhound), taxis and/or airplanes.

IV. Miscellaneous Operation Rules

A. Excessive Distance

The vendor should question whether a covered medical service could be provided closer to the member's residence. Examples of possible excessive distance requests include, but are not limited to, a request for NEMT services to a provider that is not in the area where the member resides, or a request for NEMT services to a provider that is not in the same county, bordering county or metropolitan area in a bordering state for Agency members living in rural areas. The vendor may deny the request if the covered medical services are available closer to the member's residence, and they do not provide medical certification that the closer provider cannot provide the care.

Generally, in determining if the transport is within reasonable proximity of a member, the vendor should permit transports to contiguous counties, and/or any bordering counties or parishes in adjoining states (Ohio, Virginia, Pennsylvania, Maryland, and Kentucky) which are considered to be in-network/in-state providers, defined as enrolled providers located in-state and/or within 30 miles of the WV border. The vendor should ensure that any transportation requests for non- in-network/in-state medical providers that are not in-network/in-state receive prior authorization by the UMC. The vendor will have the ability to identify these providers through the use of file exchange and granted system accessibility as specified in Appendix 2, Section IV: Data Systems Requirements of this RFP.

If an Agency member has recently moved to a new area, the vendor should allow long distance transportation for up to ninety (90) calendar days if necessary to maintain continuity of care until the transition of the member's care to a closer appropriate provider can be completed. The vendor should monitor the frequency of authorization of NEMT Services involving excessive distance per member. The vendor should monitor the frequency of and provide detailed reports of authorization of NEMT Services involving excessive distance per member.

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The vendor will also report to the Agency when a member is requesting a pick-up from out of state, except upon discharge from a medical provider or facility. Some areas may be in West Virginia and have a "911 address" in another state. However, if a member is residing out of state, the State will need to investigate to determine if the member should continue to receive the program through West Virginia or the state of current residence.

B. On-Time Arrival

The driver should make his presence known to the Agency Members and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present for pick up, the driver should notify the NEMT provider's dispatcher before departing from the pick-up location. Providers are not to change the assigned pick-up time without permission from the vendor. If the NEMT provider cannot arrive on time to the pick-up location, the NEMT provider or vendor should contact the member or the member's representative and the provider. No more than five percent (5%) of the scheduled trips should be late or missed per day. The Agency may waive the five percent late/missed requirement in situations for non-critical medical services where a delay or failure to appear for a pick-up may arise from unforeseen circumstances in a geographic area such as flooding, excessive snow, other widespread weather conditions, or security threats impeding travel which may or may not result in a state of emergency issued by the Governor.

C. Travel Time on Board

For trips involving multiple passengers, the NEMT provider should schedule transportation so that no member remains in the vehicle more than forty-five (45) minutes beyond the average direct travel time for their individual trip. (This requirement does not apply to commercial air or fixed-wing transport.)

D. Adverse Conditions Plan

The vendor should have a written plan for transporting Agency Members who need critical covered services during adverse weather conditions, instances of security threats, states of emergency or other instances where normal road, air, or rail travel is impeded or dangerous. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, hurricane, tropical storms, flooding, tornado, and heavy snowfall. "Security threats" include, but is not limited to, massive chemical spills, terrorist attacks, police stand-offs or rioting. The vendor should submit a final completed plan to the Agency for approval no later than two (2) weeks prior to the operation's start date, upon any revisions to the plan, and thereafter upon the Agency request. The vendor should not begin operations without an approved Adverse Conditions Plan from the Agency.

E. Vendor as a NEMT Provider

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The NEMT broker is prohibited from also serving as a NEMT provider under the West Virginia NEMT Service Program.

F. Post-Transportation Authorization Requests

The vendor's proposal should include a description of the vendor's approach to post-transportation authorization of NEMT services. The vendor should not implement a policy to allow or disallow post-transportation authorization of NEMT services without the Agency review and approval. The vendor should submit a final completed policy to the Agency for approval no later than thirty (30) calendar days prior to the operation's start date. The vendor should not begin operations without an approved post-transportation authorization of NEMT Services Policy from the Agency.

Post-transportation authorization should be allowed in instances when travel was conducted in a private automobile or prior authorization was not obtainable, such as services requested when the vendor's call center was closed. The vendor's post-transportation authorization policy should ensure that all applicable requirements of pre-transportation authorization are considered for the post-transportation authorization and should establish a timeliness requirement for the submission of post-transportation authorization requests.

G. Accidents and Incidents

The vendor should document accidents and incidents that occur in conjunction with a scheduled trip when a member is present in the vehicle. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip causing the driver to stop the vehicle, such as when a passenger becomes unruly or ill. Details should be reported in the Accident and Incident Report (as described in Appendix 3, Reporting Requirements).

V. NEMT Service Denials

The vendor's Proposal should include a description of the vendor's approach to NEMT Service denials (as defined below).

A. Denial Policies and Procedures

Vendors should comply with the following NEMT Service denial policies and procedures:

1. If a request for a NEMT service is received that meets one of the denial reasons listed in section V, subsection B, the vendor should deny the request and record the reason(s) for the denial in its information system on the same business day.

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2. The vendor should generate and mail denial letters to members and providers no later than the next business day following the date the denial decision was made. The vendor should bear all costs of generating and sending denial notices. The denial letter should notify the members of the right to appeal the denial. The vendor should develop the denial letter and criteria for sending the denial letter. The Denial letter should specify the denial reason, as listed in section V: B "Denial Reasons". The vendor should submit the final completed denial letter and criteria to the Agency for approval no later than thirty (30) calendar days prior to the operation's start date. The vendor should not begin operations without Agency-approved versions of these deliverables.
3. In the event a member does not have sufficient information to arrange the transport and has to hang up and call back at a later time, the initial phone call with incomplete information should not be considered a trip denial for reporting purposes.

B. Denial Reasons

NEMT service requests may be denied for one or more of the following reasons:

1. The member is not eligible for NEMT services on the date of service.
2. The member does not have a medical need that requires NEMT services.
3. The medical service for which NEMT service is requested is not a covered medical service.
4. The medical service for which NEMT service is requested requires prior authorization and prior authorization has not been obtained.
5. The service was done out-of-network without prior authorization and did not meet policy criteria for an emergency or foster child placed out-of-state.
6. The member has access to affordable transportation, (i.e. member's vehicle or another mode of transportation that does not cause financial hardship for the member.
7. The medical service for which NEMT Service is requested is covered under another program.
8. The request was for post-transportation authorization and was not received timely or did not meet established criteria.
9. The medical appointment is not scheduled or was not kept.
10. The vendor cannot verify that there was a medical appointment.
11. The vendor is unable to verify the member's physical address.
12. The trip was not requested within an appropriate timeframe and the request cannot be accommodated because of this.

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13. Additional documentation was requested and was not received within an appropriate timeframe.
14. The member refuses the appropriate mode of transportation.
15. The member refuses the NEMT provider assigned to the trip and another NEMT provider is not available.
16. The member's medical need(s) requires an ambulance level of transportation. In these situations, the vendor should refer the member to appropriate resources, such as local ambulance providers in their area.

VI Timeliness

A. Routine NEMT Services

The vendor should authorize and schedule routine NEMT Services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request. This allows for the member and vendor to receive timely notice to deal with and make alternative transportation arrangements. The Vendor should authorize and schedule routine NEMT Services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request.

B. Non-Routine NEMT Service

If the vendor requires additional information in order to authorize a request, the vendor should place the request on hold and should request the additional information within twenty-four (24) hours after receipt of the request. The vendor should specify the date by which additional information should be submitted. Timely requests by the vendor for additional information should state the authorization period. If additional information is not received by the date specified by the vendor, the vendor should deny the request except NEMT Services to an appointment for chemotherapy, dialysis, and high-risk pregnancy. In those instances, the vendor should authorize single trips and pursue receipt of necessary information to authorize a standing order.

VII

Validation Checks

The vendor's payment procedures should ensure that NEMT provider claims for reimbursement match authorized trips and that the trips actually occurred. The vendor should have a written plan for validating that transportation services paid for under the contract are properly authorized and rendered. The vendor should perform validation checks on a minimum of ten percent (10%) of NEMT services requests each month, both prior to the authorization of the request and after the services are rendered, as specified below. The Agency at its sole discretion may require validation checks of trips to specific services.

The vendor should submit a final completed Validation Plan to The Agency for review and approval no later than thirty (30) calendar days prior to the operational start date. The vendor should not begin operations without an approved Validation Plan from the Agency.

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A. Pre-Transportation Validation Checks

The vendor should conduct pre-transportation validation checks prior to authorizing the request for a minimum of six percent (6%) of NEMT services. The vendor should contact the provider and verify that the member has an appointment for a covered medical service. The vendor is not required to verify the medical necessity of an appointment. If the vendor verifies with the provider that no appointment exists, or that the service is not a covered medical service, the vendor should record in its computer system the reason for the failed validation check, and the vendor should deny the request. If a pre-transportation validation check cannot be completed because the call to the provider resulted in a busy signal or no answer, the vendor should flag the request for a post-transportation validation check, and the attempt at validation should not be counted toward the six percent (6%) pre-transportation validation check rate.

B. Post-Transportation Validation Checks

The vendor should conduct post-transportation validation checks on a minimum of four percent (4%) of the NEMT Service. The vendor should verify that the member had an appointment for covered medical service. The vendor should verify that the member received a covered medical service. The vendor is not required to verify the necessity of transportation or of the medical service, but only that the service occurred. If the vendor verifies with the provider that there was no appointment, that the service was not kept, or that the service was not a covered medical service, the vendor should record in its computer system the reason for the failed validation check. If a post-transportation validation check cannot be completed because the call to the provider resulted in a busy signal or no answer after three (3) attempts, the vendor should enter into its system information that should alert call center staff that any future requests to this specific provider are to be validated before it can be authorized.

C. Fixed Route

The vendor should perform pre-transportation and post-transportation validation checks for a percentage of fixed route transportation. The policy and procedures for validation of fixed route transportation, including the inclusion in the overall ten percent (10%) validation check Service Level Agreement, included in Appendix 4, should be developed by the vendor with input from the Agency.

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VIII. Suspected Fraud, Abuse, Waste, and Misuse

The vendor should refer suspected fraud, waste, abuse, or misuse by Agency Members, NEMT providers, medical providers or contractor staff to the Agency's Office of Program Integrity (OPI) and the Agency's Contract Manager within three (3) calendar days after discovery of suspected fraud, waste, abuse, or misuse. The vendor should expect the contact for all investigations to be provided by the Agency prior to operations start date. The referral should detail the NEMT provider's name and provider number, the member's name and Medicaid ID number, if applicable, the provider's name and provider number and a narrative of all information the vendor has regarding suspected fraud, waste, abuse, or misuse, including whether the vendor was able to verify that the member was transported to or from a source of medical care. Vendor's staff and management are to be available and are to fully cooperate with any Office of Inspector General (OIG) or law enforcement investigations or review at no additional cost to the Agency. Vendors should require adherence to these requirements in any contract it enters with subcontractors, NEMT providers or providers.

The vendor may establish, or have an established, in-house Fraud Unit which will be expected to work with the Agency, OPI, and/or the OIG. If the vendor has an in-house Fraud Unit, it may request claim dates from the Agency in order to review paid NEMT trips with paid Medicaid services, member address history, member current address on record, recipient Medicaid enrollment history and other information deemed necessary for an investigation.

IX. Vehicle Requirements

A. Americans with Disabilities Act (ADA) Compliance

Vehicles are to comply with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation, which can be found at: <https://www.ada.gov/>. The vendor should supply all NEMT providers with a copy of the ADA vehicle requirements or post them on the vendor's provider information website and inspect the vehicles for compliance. Vehicles used for transporting Agency Members with disabilities are to be in compliance with applicable ADA vehicle requirements to be approved for use under this program. The Agency may require vendors to supply additional notice of ADA vehicle requirements to NEMT providers.

B. Other Compliance

Vehicles should also comply with all requirements listed below:

1. The number of people in the vehicle, including the driver, should not exceed the vehicle manufacturer's approved seating capacity.

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2. All vehicles should have adequately functioning heating and air conditioning systems and should always maintain a temperature that is comfortable for the member.
3. All vehicles should have functioning seat belts and restraints as required by federal, state, county or local statute ordinance. All such vehicles should have an easily visible interior sign that states: "ALL PASSENGERS ARE REQUIRED TO USE SEAT BELTS". Seat belts are to be stored off the floor when not in use except in wheelchair accessible vehicles having permanent anchoring belts attached to the floor of the vehicle.
4. Each NEMT provider should have at least two (2) seat belt extensions available.
5. For use in emergency situations, each vehicle should be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.
6. All vehicles should have an accurate, operating speedometer and odometer.
7. All vehicles should have two (2) exterior rear-view mirrors, one (1) on each side of the vehicle.
8. All vehicles should be equipped with an interior mirror for monitoring the passenger compartment.
9. The exterior of all vehicles should be clean and free of broken mirrors or windows, excessive grime, major dents or paint damage that detract from the overall appearance of the vehicle.
10. The interior of all vehicles should be clean and free of torn upholstery, floor, or ceiling covering; damaged or broken seats; protruding sharp edges; dirt; oil, grease or litter; and hazardous debris or unsecured items.
11. All vehicles should be operated within the manufacturers safe operating standards.
12. All vehicles should have NEMT provider's business name and telephone number displayed on at least both sides of the exterior of the vehicle. The business name and phone number are to appear in lettering that is at least three (3) inches in height and of a color that contrasts with its surrounding background.
13. To comply with confidentiality requirements, which can be found at: <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>, no words may be displayed on the vehicle that implies that Agency recipients are being transported. The name of the NEMT provider's business may not imply that Agency recipients are being transported.
14. The vehicle license number and the vendor's toll-free and local phone numbers should be prominently displayed on the interior of each vehicle. This information and the complaint procedures should be clearly visible and available in written format in each vehicle for distribution to Agency recipients upon request.

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15. Smoking/Vaping/E-Cigarette should always be prohibited in vehicles. All vehicles should have an easily visible interior sign that states: "NO SMOKING/VAPING/E-CIGARETTE".
16. All vehicles should carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.
17. All vehicles should be equipped with a first aid kit stocked with, at minimum, antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash.
18. Each vehicle should contain a current map (a GPS unit may be considered a map) of the applicable geographic area with sufficient detail to locate member and provider addresses.
19. Each vehicle should be equipped with a multipurpose dry chemical fire extinguisher for use on Class A, B, and C fires. Except for sedans, the fire extinguisher should be mounted securely within reach of the driver and visible to passengers for use in emergencies when the driver is incapacitated. In sedans, the extinguisher may be mounted securely in a rear compartment if there is no space for mounting it in the interior of the vehicle.
20. Insurance coverage for all vehicles during the Contract period should follow state law, and any county or local ordinance. The vendor should be listed as "an additional interested party" to ensure notification is made to the vendor in the event of a lapse in insurance coverage.
21. Each vehicle should be equipped with a "spill kit" that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
22. Each vehicle will be equipped with a spare tire, tire jack, lug wrench and any additional items required to change a tire on the vehicle.
23. The vendor should document the lifting capacity of each vehicle in its network to route trips to NEMT providers that have appropriate lift capacity for Agency Recipients.
24. The vendor should require that every vehicle in a NEMT provider's fleet has a real-time link, phone or two-way radios. Pagers are not acceptable as a substitute.
25. The vendor should have in its network NEMT providers that have the capability to perform bariatric transports of patients up to eight hundred (800) pounds.
26. Each vehicle which requires the Agency Members to step up to enter the vehicle should include a step, or a safe stool to aid in passenger boarding. The step stool should be used to minimize ground-to-first-step height, should have four (4) legs with anti-skid tips, and be sturdy metal with non-skid treads. Under no circumstances should a milk crate, plastic stool, or similar substitute be considered a viable alternative for a step stool. Milk

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crates, plastic stools, or similar substitutes should not be permitted on any vehicle. Step stools should be secured away from aisles and doorways while the vehicle is in motion to avoid obstructing the paths of passengers in the event of an emergency evacuation.

27. Each wheelchair vehicle should comply with the following:

- a. **Wheelchair Lifts.** Each wheelchair vehicle with a mechanical lift should have an engine-wheelchair lift interlock system, which requires the transmission to be placed in park and emergency brake engaged to prevent vehicle movement when the lift is deployed. All wheelchair lifts should meet current ADA guidelines, which can be found at: <https://www.ada.gov/law-and-regs/design-standards/>.
- b. **Wheelchair Securement Devices.** Each wheelchair vehicle should have, for each wheelchair position, a wheelchair securement device (or "tie-down") which meets current ADA guidelines.

C. Vehicle Inspection

The vendor should inspect all NEMT providers' vehicles prior to the operational start date and at least every six (6) months thereafter. The state of West Virginia vehicle inspection sticker does not serve as a substitute or alternative to Vendors vehicle inspection and credentialing. The vendor should ensure that NEMT providers maintain all vehicles to meet or exceed local, state, and federal requirements, and manufacturer's safety, mechanical, operating, and maintenance standards. In addition, the vendor should test all communication equipment during regularly scheduled vehicle inspection.

Upon completion of a successful inspection, an inspection sticker approved by the Agency should be applied to the vehicle. The vendor should place the inspection sticker on the outside of the passenger side rear window in the lower right corner. The sticker should state the license plate number and vehicle identification number of the vehicle. Records of all inspections should be reported pursuant to Appendix 3, Reporting Requirements, (Report #R20) of this RFP.

Authorized employees of the Agency or the vendor should immediately remove from service any vehicle or driver found to be out of compliance with these requirements. The vehicle or driver may be returned to service only after the vendor verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, should be documented and become a part of the vehicles and the driver's permanent records.

The vendor should submit the final plan for vehicle inspection, forms, inspection sticker and a list of trained inspectors to the Agency at least thirty (30) calendar days prior to the operations start date. The plan should include the names of all employees or sub-vendors who are authorized to inspect the vehicles for the vendor, and the vendor's inspection

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requirements, including those mandated by local, state and federal law. The vendor should not begin operations without an approved NEMT Vehicle Inspection Plan to be approved by the Agency.

X. NEMT Providers' Drivers Policies and Procedures

A. Driver Requirements

The vendor should ensure that NEMT providers' drivers follow the below requirements:

1. All drivers should abide by any applicable state or local laws.
2. All drivers, during their employment, should be at least eighteen (18) years of age and have a current valid driver's license to operate the transportation vehicle to which they are assigned.
3. Drivers who receive citations and are convicted of two (2) moving violations within one (1) year or accidents related to transportation provided under the NEMT Brokerage Program should be immediately removed from service.
4. Drivers should not have had their driver's license suspended or revoked for moving traffic violations in the previous five (5) years.
5. The vendor agrees to require that NEMT providers' drivers comply with the 42 CFR § 455.434 Criminal background checks, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec455-450.pdf>. The vendor should conduct criminal background checks on all drivers, and the vendor's proposal should include the specific criteria the vendor may use to determine if a driver can provide services under the NEMT brokerage program.
6. All drivers should be courteous, patient, and helpful to all passengers and be neat and clean in appearance.
7. No driver may to use alcohol, narcotics, illegal drugs, over-the-counter medications or prescription medications that impair their ability to perform.
8. All drivers should wear and have a visible nametag that is easily readable and identifies the employee and the employer.
9. No drivers should smoke, vape, and /or use E-Cigarette while in the vehicle, while assisting a member, or in the presence of any member. Agency Recipients should not be allowed to smoke, vape, and /or use E-Cigarette in the vehicle.
10. Drivers should not wear any type of headphones at any time while on duty, except for hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider or to call 911 in an emergency. Drivers should not talk on mobile phones and/or text when the vehicle is in motion.

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11. Drivers should provide an appropriate level of assistance to a member when requested or when necessitated by the member's mobility status or personal condition. This includes, but is not limited to, curb-to-curb, door-to-door, and hand-to-hand assistance, as required. Before departing the drop-off point, the driver should confirm that the member is safely inside the destination.
12. The driver should assist the member in the process of being seated; confirm that all seat belts are fastened properly and that all passengers are safely and properly secured. The driver should be responsible for properly securing any mobility devices utilized by the member.
13. Upon arrival at the destination, the driver should park the vehicle so that the members do not have to cross streets to reach the entrance of the destination.
14. Under no circumstances should a member be left unattended in the vehicle at any time except in trips exceeding sixty (60) miles one way where the member and/or driver may need to utilize facilities at a rest stop, gas station, or other establishment.
15. If a member or other passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver should park the vehicle in a safe location out of traffic, notify the dispatcher, and request assistance.
16. Drivers with more than one (1) confirmed incident of failure to properly secure a member's wheelchair should be removed from providing services until such time as the NEMT provider submits documentation to the vendor to support the idea that the driver has been properly trained in the use of the securement devices.

B. Provider Daily Trip Logs

The Vendor should ensure that all NEMT Providers' drivers (both commercial and personal) maintain daily trip logs containing the information specified below. These records should be retained by NEMT providers and made available to interested parties if selected for audit. This requirement excludes fixed route transportation as described in Section III of this Appendix. Trip logs should be validated according to the Vendor's Validation plan outlined in Appendix 1, Section VII: "Validation Checks". The date of service must be included in each log entry. The logs should contain, but are not limited to:

1. Driver's name.
2. Driver's signature.
3. Member's name.
4. Member's or attendant's signature.
5. Vehicle Identification Number (VIN) or other identifying number on file with the vendor.
6. NEMT provider's name.
7. Trip ID Number.
8. Mode of transportation authorized.
9. Actual drop off time in military time.

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10. Miles driven per trip odometer; and
11. Notes, if applicable. The log should contain notes that include, but are not limited to cancellations, incomplete requests, "no-shows", accidents and incidents.

C. Trip Manifests

1. At least forty-eight (48) hours prior to the trip, the vendor should provide a trip manifest to the NEMT provider.
2. To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), which can be found at: <https://www.hhs.gov/hipaa/>. The vendor should send trip manifests to the NEMT provider by facsimile or other secure electronic submission transmission to be approved by the Agency.
3. The trip manifests supplied to NEMT providers should include all necessary information for the driver to complete the trip, including, but not limited to, the following:
 - a. Request Tracking Number.
 - b. Member's name.
 - c. Member's phone number.
 - d. Address and time of the pick-up and the address and time of the appointment for covered medical service (including the name and phone number of facility);
 - e. Mode of transportation.
 - f. Directions to the members' home, if appropriate.
 - g. Return trip time(s), if appropriate.
 - h. Any special needs of the member or instructions to the driver.
4. If the vendor sends a trip manifest to a NEMT provider less than forty-eight (48) hours before the pick-up time, the vendor should also contact the NEMT provider by telephone or electronically to confirm that the trip has been accepted by the NEMT provider.
5. The vendor should include provisions regarding these requirements in any subcontracts with NEMT providers.
6. The vendor should include provisions regarding these requirements in any subcontracts with NEMT providers.

D. Real-Time Communication

The vendor should require that every vehicle in a NEMT provider's fleet has a real-time link, phone or two-way radio. Pagers are not acceptable as a substitute. In its Proposal, the vendor should detail the communications equipment that may be used to fulfill the requirements of the vendor including how communication among Agency Members, vendor, NEMT providers, and drivers should be managed to ensure that there are no

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delays in services or in emergency relief. The vendor should list by name the management staff that may be responsible for real-time communication efficiency.

The vendor should ensure that all real-time activities, including those listed below, are managed in a professional manner.

1. Emergencies: In the event of an emergency (such as accidents, incidents, and vehicle breakdowns), the driver should notify the NEMT vendor immediately to report the emergency and arrange for alternative transportation for the member(s) on board (if necessary).

2. Cancellation of a trip by a Member: Vendor should communicate information regarding cancellations to the NEMT provider to avoid unnecessary trips.

3. No-Shows: In the event of a no-show, the driver should immediately notify the NEMT provider and the NEMT provider should immediately notify the vendor so that the authorization may be cancelled.

E. Monitoring Plan

The vendor should develop and implement a plan to be approved by the Agency for monitoring NEMT providers' compliance. The vendor should ensure that NEMT providers comply with the terms of their contracts and all NEMT provider-related requirements of the vendor, including driver requirements, vehicle requirements, complaint resolution requirements and the delivery of courteous, safe, timely and efficient transportation services. The vendor should submit a final completed plan to the Agency for approval no later than thirty (30) calendar days prior to the operational start date. The vendor should not begin operations without an Agency-approved NEMT provider Monitoring Plan.

Monitoring activities should include, but are not limited to, the following:

1. On-street observations.
2. Accident and incident reporting.
3. Statistical reporting of trips.
4. Analysis of complaints.
5. Driver licensure, driving record, experience and training.
6. Member safety.
7. Member assistance.
8. Completion of driver trip logs.
9. Driver communication with dispatcher.
10. Routine scheduled vehicle inspection and maintenance

The vendor's NEMT provider monitoring plan should include written procedures for ensuring that an appropriate corrective action is taken when NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services

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that should have been furnished, or when a NEMT provider is out of compliance. The vendor should report monthly to The Agency on monitoring activities, monitoring findings, corrective actions taken, and improvements made by the NEMT provider.

F. Member Satisfaction Surveys

The vendor's proposal should describe the vendor's approach to, and experience with customer satisfaction surveys, various methods of measuring customer satisfaction and its plan, if any, for surveying specific populations such as Agency Members with disabilities, family members of Agency Members, facilities, and medical providers.

Every six (6) months, the vendor should conduct a member satisfaction survey regarding the NEMT Brokerage Program. The purpose of the survey should verify the availability, appropriateness and timeliness of the trips provided and the way the vendor's staff and the NEMT provider's staff interacted with Agency Members. The initial six (6) month period should be the first six (6) months during which the vendor delivers NEMT Services. The format, sampling strategies and questions of the survey should be reviewed and approved by the Agency prior to use, and the Agency may specify questions that are to appear in the survey.

The survey topics should include, but not be limited to, the following:

1. Confirmation of a scheduled trip.
2. Driver and vendor staff courtesy.
3. Driver and attendant assistance, when required.
4. Overall driver behavior.
5. Driver safety and operation of the vehicle.
6. Condition, comfort and convenience of the vehicle.
7. Punctuality of service.

The survey responses received, and the vendor's analysis of those responses are to be submitted to the Agency no later than sixty (60) calendar days after the surveys are taken.

XI. Call Center

A. Facility

The vendor should assume all costs related to securing and maintaining the NEMT call center facility for the duration of the contract, including but not limited to hardware and software acquisition necessary to maintain contract requirements throughout the life of the contract, maintenance, lease hold improvements, utilities, office equipment, supplies, janitorial services, security, storage, transportation and insurance. The vendor's proposal should include a description of the vendor's approach to securing and establishing the call center facility.

B. Telephone Access

The vendor call center should adhere to the following telephone access specifications:

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1. The call center should include, but not be limited to, at least one (1) statewide toll-free telephone number for receipt of requests for NEMT Services and one (1) statewide toll-free telephone number for all Agency Members to call if their ride is more than fifteen (15) minutes late.
2. The call center toll-free telephone numbers are to be answered by live operators Monday through Friday, 7:00 a.m. to 6:00 p.m. Eastern Standard Time. The Agency recognizes daylight savings time and the hours of operations for the vendor's call center will make any adjustments for Eastern Standard Time and Eastern Daylight Time. Operation days include all state holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Official State holidays the call center should be in operation include:
 - Marthin Luther King, Jr. Day (Third Monday in January)
 - President's Day (Third Monday in February)
 - West Virginia Day (June 20)
 - Columbus Day (Second Monday in October)
 - Veterans Day (November 11)
 - Lincoln's Day (Fourth Friday in November)
 - Half a day on Christmas Eve (December 24)
 - Half a day on New Year's Eve (December 31)
 - Primary or General Election days
 - Other officially declared holidays
3. Calls received during days and/or hours that the call center is not open should receive a voice message, in English, stating the hours of operation and advising the caller to dial "911", or the appropriate emergency number, in the case of an emergency.
4. The vendor may route calls placed during non-operational hours, as required by the Agency, to any call center operated by the vendor staff in any location in the continental United States of America.
 - a. The vendor should never route calls outside of the continental United States of America.
5. The vendor should accommodate for callers who are deaf, hard of hearing, blind, and/or speech disabled in compliance with ADA recommendations, which can be found at: <https://www.ada.gov/law-and-regs/design-standards>.
6. The vendor will make translation services available for callers that speak a language other than English or that may not fully have English comprehension.

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7. The vendor should release and transfer the toll-free telephone number(s) to the Agency or a successor vendor upon termination of contract.

C. Language Requirements

Oral contact between the vendor and a member should be in a language the member understands. The vendor should employ English-speaking call center staff. If the member's language is one other than English, the vendor should offer and, if accepted by the member, supply and bear the cost of interpretive services. If a member requests interpretive services to be done by a family member or acquaintance, the vendor should not allow such services by anyone under the age of 18.

As part of its ongoing commitment to safety and the well-being of all individuals involved in transportation, the vendor shall provide Agency-approved training to its staff on the geography, regional dynamics, and cultural nuances of West Virginia. Preparedness helps ensure the selection of safe routes and helps avoid potential conflicts or misunderstandings that could arise from lack of local awareness. The training shall also include region-specific terminology—such as the term “holler,” commonly used by West Virginia residents to describe certain geographic features.

D. Customer Care

The vendor should ensure that its call center staff treats each caller with dignity and respects the caller's right to privacy and confidentiality. The vendor should process all incoming telephone inquiries regarding NEMT Services in a timely, responsive and courteous manner. Telephone staff are to greet callers and should identify the vendor and themselves by name when answering.

The vendor should monitor at least two (2) “live” calls for each call center staff member monthly by listening to the conversation as it occurs. Calls should be recorded and reviewed with the staff member. The vendor should use this monitoring to identify problems, issues, for quality control and/or training purposes. The vendor should document and retain the results of this monitoring and subsequent training and report results to the Agency as defined in Appendix 3 (Reporting Requirements).

The vendor's proposal should provide a plan for customer service monitoring, including the following: the process to be used to monitor phone conversations of the customer service representatives (CSRs); to evaluate the quality and appropriateness of the services provided to callers; and the evaluation scoring process used to score CSR's performance.

E. Automatic Call Distribution System

The vendor should operate an automatic call distribution (ACD) system. Callers should be advised that calls are monitored and recorded for quality assurance purposes. Administrative lines need not be recorded. The ACD and reporting system should be able to record and aggregate the following information and should be able to produce the

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reports listed below daily, weekly, or monthly, as well as on an ad hoc basis. Examples include, but are not limited to:

1. The number of incoming calls.
2. The number of calls answered.
3. The average time for a call is to be answered by a live operator.
4. The number of abandoned calls during the wait in queue for interaction with call center staff.
5. The average abandonment time.
6. The highest call abandonment call time (to the nearest 15-minute increment).
7. The average talk time.
8. The identity of the call center staff member taking the call and authorizing the request.
9. The daily percentage of abandoned calls and calls answered by a live operator.
10. The number of available operators by time of day and day of the week, in hourly increments.
11. The number of complaint calls.
12. Reason for complaint.
13. Identification of supervisor who addressed the complaint.

F. Data Analysis

The vendor should analyze data collected from its phone system monthly as necessary to perform quality assurance and quality improvement; fulfill the reporting and monitoring requirements of the vendor; and ensure adequate staffing. Upon Agency request, the vendor should document compliance in these areas.

G. Multiple Queues

The vendor should route incoming calls to multiple areas of operation, including non-English speaking member queue and provider queues. The vendor should obtain Agency approval prior to implementing any queue not specified in the contract.

H. Sufficient Resources

The vendor should maintain sufficient equipment and call center staff to ensure that, monthly:

1. The ACD system is programmed to answer all calls within three (3) rings.
2. The average queue time after the initial automatic voice response is five (5) minutes or less.
3. The average abandonment rate is no more than five percent (5%).
4. All ACD criteria stated in Appendix 1, Section XI (E) are captured or met.

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5. Sufficient qualified staff are available on-site to communicate with callers who speak English, and an interpreter telephone service is available for callers who speak other languages.
6. The vendor should record all incoming calls for quality control, program integrity and training purposes. The vendor should provide prior notification to the caller that the conversations are being recorded. Vendor should maintain the recordings for no less than twelve (12) months, at the direction of the Agency. The Vendor should provide copies to the Agency upon request.
7. In the event of a power failure or outage, the vendor should possess a battery backup system capable of sustaining the telephone system for a minimum of eight (8) hours at full operational capacity, ensuring uninterrupted data collection as specified in the contract. Alternatively, the vendor may redirect calls to a redundant call center as a backup measure. The vendor is required to inform the Agency when their phone system is operating on battery power, routed to a redundant call center, or non-operational. Additionally, the vendor should have a manual backup procedure in place to facilitate request handling in the event of computer system downtime.
8. The ACD system logs should be maintained daily, tallied and sent to the Agency monthly by the 15th day of the month following the report month, in a reporting format approved by The Agency. The vendor should also maintain daily logs on the call center to comply with the reporting requirements contained in Appendix 3 (Reporting Requirements) of the RFP.
9. In the event where the call center is closed or inaccessible, the vendor will detail in the RFP response the procedure for re-routing calls, taking requests, and/or other actions to be taken to accommodate Agency Members.

The vendor's Proposal should include a detailed description of the proposed ACD system and its capabilities and capacities. The vendor should describe how the ACD should meet the specifications and include a sequence of questions and criteria that the call center representatives are to use to determine the member's eligibility, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip. All scripts are to be approved by the Agency prior to use by the vendor.

XII. Training and Education

A. NEMT Provider Manual

The vendor should develop and maintain a NEMT provider manual. The vendor's NEMT provider manual should contain all policies and procedures for the NEMT brokerage program. The vendor should work closely with the Agency on the development of the NEMT provider manual and should obtain Agency approval prior to release of the manual.

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The manual should be reviewed, updated, and distributed to all NEMT providers annually and whenever changes in operation are made. Updates and changes are to be approved by the Agency before distribution. The Agency should notify the vendor in writing if a modification is required, and the vendor should incorporate any modifications within ten (10) business days after such notification.

The vendor should submit a draft outline of the NEMT provider manual with the vendor's proposal. The vendor should submit a final completed manual to The Agency for approval no later than thirty (30) calendar days prior to the operations start date. The vendor should not begin operations without an approved NEMT provider manual. The manual should include, at minimum, the following:

1. NEMT provider enrollment and participation requirements.
2. NEMT provider file maintenance and record keeping requirements.
3. Standard reimbursement requirements.
4. Covered and Non-Covered Services.
5. Vehicle requirements.
6. Limitations and considerations of NEMT services to covered medical services.

The vendor should distribute the NEMT provider manual to all NEMT providers within the vendor's network and to all vendor staff. The manual should be accessible electronically via a link on the vendor's website and provided by email upon request. Furthermore, the vendor should integrate the NEMT provider manual into all training programs for NEMT providers, in addition to vendor and Agency employees.

B. NEMT Provider and Provider Training and Education

The vendor's Proposal should include an overview of the vendor's plan to educate NEMT providers and medical providers: including, but not limited to, information on training sessions, training materials, ongoing meetings with NEMT providers and medical providers and continuing education. Separate training programs should be submitted for NEMT providers and medical providers, for the purposes of educating and training NEMT providers regarding the NEMT brokerage program and training providers regarding request for transportation, standing orders and documentation of need from medical providers.

The vendor should submit to the Agency its final plan for educating NEMT providers and medical providers at least thirty (30) calendar days prior to the operational start date. The vendor should not begin operations without an approved version of the NEMT provider manual, provider training manual and education plan.

No later than fifteen (15) business days prior to the operational start date, the vendor should conduct NEMT provider and provider training sessions in at least five (5) locations throughout the state. The Agency should pre-approve these training locations, and all costs of the training sessions should be borne by the vendor. The vendor should not begin

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operations without completion of these training sessions. The vendor may perform additional NEMT provider or medical provider training, as deemed necessary and approved by the Agency.

C. Member Outreach and Education Plan

The vendor's proposal should include an overview of the vendor's plan to develop and implement NEMT member outreach and education regarding the NEMT brokerage program. The member Outreach and Education Plan included with the vendor's proposal should include but not be limited to, the following:

1. The vendor's plan to educate current and future Agency Members and other NEMT program interested parties (e.g., facilities, local human service agencies, licensed behavioral health centers, NEMT providers, and medical providers) in the state on NEMT services, procedures and the transition of service administration from one vendor to another during plan turn-over as described in Appendix 1, Section XV (A) of this Appendix.
2. Written and verbal instructions to educate Agency members and other NEMT program interested parties. All materials related to member outreach and education, including instructions, should:
 - a. Emphasize the availability of NEMT services, eligibility for these services, standing orders, medical documentation of need, and how to request and use NEMT services.
 - b. Be easily understood and written at an approximately 5th grade reading level.
 - c. Be available in English and in Spanish.
 - d. Be available in alternative format for the intellectually disabled as well as for those with vision and hearing impairments.
3. Strategies for working with Medicaid Recipients who fail to comply with established policies and procedures (as described in Section XII.D below).
4. Strategies for working with facilities such as hospitals, nursing homes, and dialysis centers to achieve NEMT efficiencies.

The vendor should submit a final completed Member Outreach and Education Plan to the Agency for approval no later than thirty (30) calendar days prior to the operational start date. The vendor should not begin operations without an Agency-approved Member Outreach and Education Plan.

At least thirty (30) calendar days prior to the operational start date, the vendor should send written materials (via first class mail and at vendors expense) to inform and educate Agency Members and other interested parties about the NEMT Brokerage Program. The vendor should work with the Agency to obtain a listing of Agency Members, other interested parties and addresses. The vendor should not begin operations without the mailing of these materials.

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D. Non-Compliant Member Education

The vendor's Member Outreach and Education Plan should include, but not be limited to, a description of continuing education for Agency Members who do not comply with established policies and procedures of the NEMT Brokerage Program, including, but not limited to, additional education to Agency Members who habitually request transportation less than three (3) business days in advance of the appointment date. The vendor may impose transportation options and limits on Agency Members with excessive incidents of non-compliance.

In the case of Agency Members who are chronically late or absent for scheduled trips, the vendor may require the member to call when the member is ready for pick-up. Neither the vendor nor the NEMT provider may charge Agency Members for no-shows.

The vendor's Member Outreach and Education Plan should include an education policy and transportation options for Agency Members whose behavior enroute threatens the safety of the member, driver, or other passengers.

XIII. Operations Procedures Manual

The vendor should develop an Operations Procedures Manual to be approved by the Agency detailing all procedures to be used in scheduling and delivery of NEMT Services. The vendor should submit a draft outline of this manual with the vendor's proposal. The vendor should submit a final, completed Operations Procedures Manual to the Agency for review and approval no later than thirty (30) calendar days prior to the operations start date. The vendor should not begin operations without an Agency approved Operations Procedures Manual. The vendor should provide a copy of the Operations Procedures Manual to all the vendor staff and should incorporate it into all training programs for new employees.

The manual should be reviewed, updated and distributed to vendor staff annually and whenever changes in operating procedures are made. The Agency may require modification of the Operations Procedures Manual at any time and notify the vendor in writing of the required modification. The vendor should modify the Operations Procedures Manual within ten (10) business days of notification.

XIV. Complaint Policies and Procedures

The vendor's Proposal should include a description of the vendor's approach to member and NEMT provider complaint policies and procedures, including separate complaint resolution processes for Agency Members and NEMT providers (as described in Sections XIV.A and XIV.B below). The policies and procedures should provide for prompt resolution and ensure the participation of individuals who have authority to require corrective action. The vendor should attempt to resolve any complaint in accordance with the complaint resolution process. The vendor should work with all associated parties including the Agency, as necessary, to resolve complaints.

The vendor should submit a final Complaint Policies and Procedures Manual to the Agency at least thirty (30) calendar days prior to the operations start date for the Agency review and approval. The vendor should not begin operations without an Agency approved

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Complaint Policies and Procedures Manual. The vendor should review its complaint policies and procedures every six (6) months and notify the Agency if it determines that an amendment is necessary. The vendor should perform amendments only with the prior written consent of the Agency. The Vendor shall have thirty (30) calendar days post Agency approval to publish and distribute the amended manual to provider and member communities. The vendor's approach to review and amend complaint policies and procedures should be included with the Proposal's description of these policies and procedures.

A. Member Complaint Resolution and Appeal Process

The vendor should have a complaint resolution process for Agency Members. Each complaint should be assigned a unique tracking number. The vendor should respond to a complainant within one (1) business day after receipt of a complaint. The vendor should attempt to resolve complaints in accordance with the complaint resolution process. The vendor should work with all parties and the Agency to resolve the complaint. The Agency will have final approval on Member complaint resolution.

Complaint information provided to the Agency should include, but not be limited to:

1. Documentation or testimony by the Project Manager or other medical or expert consultant who is familiar with and able to testify to the specific case being appealed.
2. Records and documentation regarding a denial of a NEMT Service. Records should be maintained as outlined in Section **Error! Reference source not found.** of this Appendix 1 and information should be reported as outlined in Appendix 3 (Reporting Requirement).
3. Comprehensive documentation specific to the case.

If the Agency overturns the denial and authorizes the NEMT Services, the Vendor should notify the member and the NEMT provider of the appeal decision. The vendor will then approve the NEMT Services and reimburse the NEMT provider.

B. NEMT Provider Complaint Resolution and Grievance Process

The vendor should establish and maintain a procedure to be approved by the Agency for reviewing complaints and grievances made by NEMT providers. Each complaint or grievance should be assigned a unique tracking number. The NEMT provider should be allowed fifteen (15) calendar days to request a review of the decision by the vendor, the Agency, or both. Failure to request a review within fifteen (15) calendar days will forfeit the NEMT provider's right to request a review.

XV. Contract Close-Out and Turnover Procedures

A. Turnover Plan

The vendor should submit a Turnover Plan for Agency approval no later than fourteen (14) calendar days after the date of Contract award. The Turnover Plan should provide

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for an orderly and controlled turnover of the vendor's responsibilities to a successor vendor or to the Agency at the end of the Contract period or upon termination of the Contract and minimize the disruption of NEMT Services to Agency Members.

The Turnover Plan should include, but not be limited to, the following:

1. The vendor's proposed approach to turnover.
2. The tasks and subtasks for turnover.
3. A timeline for turnover, including adjustments for possible variance.
4. Operational resource requirements.
5. Any training provided; and
6. Procedures for the transfer of data, documentation, files, training materials, the Operations Procedures Manual, brochures, pamphlets, and all other written materials and records developed in support of the NEMT Brokerage Program.

B. Turnover Notification and Turnover Period

In the event the Agency requests a turnover of the duties and obligations of the vendor to the Agency or to a new vendor upon termination of the contract, the vendor should expect the Agency to give written notification of the need for turnover at least ninety (90) calendar days prior to the termination date of the contract. The turnover period should begin on the date specified by the Agency in the notice and continue until the Agency determines that all of the vendor's contract duties and obligations have been met, even if that date extends beyond the termination date of the contract. The vendor should expect the Agency's notification to provide written instructions regarding the packaging, documentation, data formats, delivery location, and delivery date of all records, data and information the Agency determines are required to provide for contract turnover.

C. Specific Close-Out Requirements

The vendor should complete all duties required in the contract regarding requests for NEMT Services for dates of service up to and including 11:59 p.m. Eastern Standard Time on the termination date of the contract. These duties should include, but not be limited to, the following:

1. Screening, authorization, scheduling, and provision of NEMT Services.
2. Successful submission to The Agency of all utilization data.
3. Generation and sending of all required notices to providers and Agency Members.
4. Validation Checks as required in Section **Error! Reference source not found.** of Appendix 1.
5. Submission and correction, as necessary, of all reports required by this contract.

D. Agency Access

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During the Turnover Period, the vendor should allow the Agency full remote access during the vendor's regular business hours to all data records as required in the Contract.

E. Specific Turnover Requirements

At any time prior to the Agency's determination that all requirements under the Contract have been completed, the Agency may request, and the vendor should provide, the following information to the Agency:

1. Information including, but not limited to, the number, the review status, and the completion date of all transportation that was scheduled, authorized or provided by the vendor up to and including 11:59 p.m. Eastern Standard Time on the termination date of the contract and that has not been transmitted to the Agency for processing.
2. Information including, but not limited to, the number, the review status and the completion date of all transportation that was scheduled, authorized or provided by vendor up to and including 11:59 p.m. Eastern Standard Time on the termination date of the Contract and that The Agency returned to vendor as unprocessed with an error code.
3. Information on any other deliverables that are pending as of 11:59 p.m. Eastern Standard Time on the termination date of the Contract, including, but not limited to, any outstanding reports, the status of any unresolved complaints or grievances and the status of any Agency hearings that have been scheduled or are in process.

F. Vendor Response to Questions

The vendor should answer any written questions from the Agency for a new vendor regarding the review of the information and data that vendor has transferred to the Agency for a new vendor. The vendor's answers should be in writing and should be submitted to the Agency or the new vendor within five (5) business days after receipt of receiving the question.

G. Turnover Meetings

The vendor should expect the Agency to notify the vendor of the date, time, and location of meeting(s) regarding the close-out or turnover to be held among the Agency, the vendor and new vendor. The vendor should provide two (2) individuals to attend meetings. The individuals attending should be proficient and knowledgeable regarding the paper materials and electronic data to be transferred and delivered to the Agency or a new vendor.

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Appendix 2: Implementation Specifications

The following specifications have been determined by the Agency for the Implementation Phase of this project. The Agency will consider responses to this RFP that propose modifications to the following specifications. Modifications should be clearly stated in the vendor's proposal.

I. Implementation of Work Plan

The vendor's Proposal should include an Implementation Work Plan (IWP) to be approved by the Agency and should be maintained throughout the implementation period that includes all tasks required to successfully begin operation of the NEMT Brokerage Program. The IWP 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 IPW electronically and in hard copy to the Agency no later than fourteen (14) calendar days after the date of contract award.

a. Work Plan Tasks

The IWP should include task-level details, including timeframes, milestones and names of vendor staff members who may be responsible for each task. Each task listed in the IWP should include a description of the activity, a scheduled start date and a scheduled completion date.

The types of tasks described in the IWP should include, but not be limited to, the following:

1. Acquisition of office space, furniture and telecommunications equipment; computer equipment, including software; and installation of utilities.
2. Hiring and training the central office staff, call center staff and all other vendor staff.
3. Recruitment and contracting of NEMT providers.
4. Verification that NEMT provider vehicles meet vendor standards, including inspection and certification requirements.
5. Verification that drivers meet Contract standards.
6. Testing of daily operational requirements, including, but not limited to call center, dispatch and real time communications with drivers, to ensure that all components are functioning adequately prior to the Agency's Readiness Review.
7. Installation of trip scheduling, reservation, and dispatch systems.
8. Member, NEMT provider and medical provider education.
9. Development of required deliverables, including, but not limited to, reports, Operations Procedure Manual, NEMT Provider Manual, eligibility file requirement, utilization data submission procedures, Quality Assurance Plan (as described in Section II of Appendix 2), and Business Continuity and Disaster Recovery Plan (as described in Section V of Appendix 2).

II. Quality Assurance Plan

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At least thirty (30) calendar days prior to the operational start date, the vendor should submit a final Quality Assurance Plan to The Agency for its review and approval. The Quality Assurance Plan (QAP) should include, at minimum, the following:

1. The vendor's procedures for certification that all NEMT Services paid for are properly authorized and rendered.
2. The vendor's plan to develop safeguards against fraud, waste, misuse, or abuse by NEMT providers, medical providers, Agency Members and vendor staff and fulfill Agency reporting requirements regarding such activity, as described in Appendix 3 (Reporting Requirements) of this RFP.
3. The vendor's agreement to indemnify the Agency against any causes of actions or claims of payment brought by NEMT providers or Agency Members.
4. The vendor's plan to ensure that NEMT providers meet standards for vehicle maintenance, operation, and inspection; driver qualifications and training; complaint resolution; and delivery of courteous, safe and timely NEMT Services.
5. The vendor's plan for Quality Control in the vendor's call center as described in Section XI in Appendix 1.

The vendor should not begin operations without an Agency approved QAP. The Agency reserves the right to conduct quality assurance reviews on services provided by the vendor under the contract anonymously and without advance notice.

III. Operational Readiness Review

Two (2) weeks prior to the operational 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's implementation for operational go-live. The vendor should receive written Agency approval of all submission and demonstration requirements prior to the operation's start date.

A. Readiness Review Deliverables

At least thirty (30) calendar days prior to the operational readiness review, the vendor should submit the following deliverables for the Agency review and approval to ensure that each process or item fully and consistently meets the Agency's requirements.

1. The vendor's data systems as described in Appendix 2, Section IV.
2. The vendor's information systems screen prints and logic.
3. The vendor's brokerage process including, but not limited to, authorization, scheduling, dispatch, coordination, management, generation of denial letters, and reimbursement process.
4. The vendor's NEMT Provider Network and Geographic Coverage Report as described in Appendix 1, Section II (D).
5. Proof of the vendor's NEMT provider network sufficiency.

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6. The vendor's Adverse Conditions Plan as described in Appendix 1, Section IV (D).
7. The vendor's Post-Transportation Authorization of NEMT Services Policy as described in Appendix 1, Section IV (F).
8. The vendor's NEMT Service denial criteria and service denial letter as described in Appendix 1, Section V (A, #2).
9. The vendor's Validation Policy as described in Appendix 1, Section VII.
10. The vendor's Vehicle Inspection Plan as described in Appendix 1, Section IX (C).
11. Proof of compliance with vehicle and driver requirements.
12. The vendor's NEMT Provider Monitoring Plan as described in Appendix 1, Section X (E).
13. The vendor's final NEMT Provider Manual as described in Appendix 1, Section XII (A).
14. The vendor's NEMT Provider and Provider Training and Education Plan as described in Appendix 1, Section XII (B).
15. The vendor's final member Outreach and Education Plan as described in Appendix 1, Section XII (C).
16. Verification of the education of Agency Members, NEMT providers, providers, and other agencies occurred as described in Appendix 1, Section XII.
17. The vendor's Operations Procedures Manual as described in Appendix 1, Section XIII.
18. The vendor's final Complaint Policies and Procedures Manual as described in Appendix 1 Section XIV.
19. The vendor's Quality Assurance Plan as described in Appendix 2, Section II.
20. The vendor's Business Continuity Plan and Disaster Recovery Plan as described in Appendix 2, Section V.
21. The vendor's reporting capabilities, including the ability to produce The Agency Specific reports as described in Appendix 3 (Reporting Requirements).

B. Call Center Readiness Requirements

As part of the readiness review, the vendor should demonstrate to the Agency that the vendor's call center meets all contract requirements, including reporting capabilities, compliant with reporting requirements included in Appendix 3 (Reporting Requirements). The vendor's data system should meet and/or demonstrate compliance with all contract requirements, including, but not limited to, the following:

1. The vendor's data collection.

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2. The vendor's method by which member information is recovered by the vendor and displayed on screens used by call center staff at their workstations.
3. The vendor's method by which the Agency overrides and/or special instructions should be displayed on screens.
4. The vendor's ability to determine member eligibility.
5. The vendor's ability to produce denial letters to Agency Members, NEMT providers, and medical providers, as appropriate.
6. The vendor's functionality of the web-based inquiry system for NEMT providers.
7. The vendor's quality control procedures and edits.
8. The vendor's reporting capabilities, including the ability to produce The Agency -specific reports (see call center reporting described in Appendix 3, Reporting Requirements).
9. The vendor's staff is appropriately trained.
10. The vendor's staff is sufficient to meet the timeliness and telephone system requirements as described in Appendix 1, Section XI (H).

C. Remediation & Start-Up

The vendor should have an opportunity to make corrections (if necessary, as determined by the Agency) prior to operational start date and may be required, upon request of the Agency, to submit documentation to the Agency verifying that corrections have been made. Two (2) weeks prior to the scheduled operational start date, the vendor should begin taking calls for requests for NEMT Services that are scheduled to be provided on or after the scheduled operational start date.

IV. Data Systems Requirements

A. Eligibility Verification

Each week, the vendor should expect the Agency Third Party Administrator (TPA) to provide the vendor with member and provider extract files. The member extract file should contain eligibility information for all people enrolled in the Agency programs who are eligible to receive NEMT benefits. The provider extract file should contain eligibility information for all providers enrolled with the Agency. The vendor should upload the weekly member and provider extract files within two (2) business days after receipt. The vendor should expect the Agency to identify a contact person in situations where eligibility needs additional verification or information.

In addition, the vendor should expect the Agency to provide the vendor with limited access to the West Virginia Medicaid Management Information System (MMIS) Automated Voice Response System (AVRS) and/or electronic system to verify member eligibility as needed for eligibility changes made between extract files.

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B. Data Capture

The vendor should capture and retain data used to administer the NEMT Brokerage Program. The data captured and retained should be sufficient to meet contract requirements, including reporting requirements included in Appendix 3 (Reporting Requirements).

The vendor should manually enter eligibility data for Agency Members, including name and member ID number. The vendor should reconcile the information entered manually against the weekly member eligibility extract file to ensure that the information in the vendor's system is accurate.

C. Encounter Data

The vendor should provide the Agency with a monthly aggregate file of detailed encounter data on each trip made on behalf of Agency Members. The transactions should comply with "HIPAA Rules", meaning the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part160.pdf>, and Part 164, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part164.pdf>, and state code/policies referenced in Appendix 1, Section 1, of the RFP.

The file should contain, but not be limited to, the following data elements:

1. Member ID number.
2. Member name.
3. Date of service.
4. NEMT service type.
5. Cost of service.
6. Number of units provided.

The vendor should submit the monthly aggregate file and a summary report to be used for reconciliation purposes to the Agency by the 15th of the following month. The summary report should balance the detailed aggregate file.

D. Audit

The vendor should provide the Agency or their designee and federal personnel with access to the vendor's systems, source code, and facilities to conduct audits and inspections. The Vendor should provide access to data, systems, and documentation required by auditors and inspectors. Access should include, but not be limited to, all equipment, systems, and communications software necessary for the Agency or their designee to obtain utilization information.

The vendor should use software to calculate mileage. The vendor should be responsible for the accuracy of the calculation and should represent such in audit or legal proceedings.

E. Web-Based Inquiry System

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The vendor should establish and maintain a secure, web-based inquiry system for NEMT providers to access NEMT Services trip authorization information. This system should provide access to the status of all trip requests. The vendor should provide technical assistance and training to NEMT providers regarding use of the web-based inquiry system.

The vendor's web-based inquiry system should comply with the following:

1. The web-based inquiry system should conform to the security and privacy policies and standards set by the organization consistent with 45 CFR §155.260(b); define security and privacy roles and responsibilities, which can be found at: <https://www.gpo.gov/fdsys/pkg/CFR-2014-title45-vol1/pdf/CFR-2014-title45-vol1-sec155-260.pdf>, and state code/policies referenced in Appendix 1, Section 1, of the RFP. Web-based screens are to conform to the requirements for readability set forth in the Americans with Disabilities Act (ADA), which can be found at: <https://www.ada.gov/law-and-reg/design-standards>.
2. The screens are to provide the following information.
 - a. Summary of trips for a date range.
 - b. Summary of trips by a member for a date range.
 - c. Details of trips by request tracking number.

V. Business Continuity and Disaster Recovery Plan

The vendor's Proposal should include a Business Continuity and Disaster Recovery Plan to be approved by the Agency that details the vendor's process 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. The plan should include, but not be limited to, 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 describe how its back-up system minimizes the potential for loss of data.

At least thirty (30) calendar days prior to the operational 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 an Agency-approved Business Continuity and Disaster Recovery Plan. The vendor should review, update, and obtain Agency approval of the Business Continuity Plan and Disaster Recovery Plan at least annually.

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Appendix 3: The Agency Specific Reporting Requirements

The vendor should provide the Agency with sample versions of the reports specified below at least thirty (30) calendar days prior to the operational start date for the Agency review and approval. The vendor should not begin operations without the Agency approval of reports. Report formats may include, but not be limited to, paper reports or data files. Upon Agency request, the vendor should supply the underlying data to support any report submitted. The data should be in a format approved by the Agency. All reports should be titled and have data elements as specified per this Appendix 3. Failure to comply with these specifications may result in deductions to invoices being assessed according to the Service Level Agreement specifications contained in Appendix 4.

#	Name	Frequency/Delivery	Description
R1	Broker Monthly Report Card	Monthly, due no later than the 15 th of the month following the report month.	This report should detail the vendor's performance against Contract Service Level Agreements (as described in Appendix 4, Service Level Agreements). The report should include, but not be limited to, the following details for each SLA: 1. Vendor performance for the reporting month. 2. Vendor performance for the reporting month prior to the current reporting month. 3. Vendor performance standard, as defined by the Agency in Appendix 4 of this RFP. 4. Description of corrective action planned or implemented; and 5. Other information as warranted.

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#	Name	Frequency/Delivery	Description
R2	Provider Monthly Report Card	Monthly, due no later than the 15 th of the month following the report month.	This report should detail the following by NEMT Provider: 1. The total trips (less cancellations) assigned to the NEMT provider. 2. The total number of trips for which the NEMT Provider was late. 3. The total number of trips for which the NEMT Provider was a No Show; and 4. The total number of complaints for which the NEMT Provider was at fault. The report should compute the percentage of trips that run complaint free and the percentage of A-leg trips that were completed on time, where an A-leg trip is defined as the trip from the member's residence to their medical appointment.
R3	Monthly County Level Detail Report	Monthly, due no later than the 15 th of the month following the report month.	This report should detail the following by West Virginia counties (out-of-state may be grouped by state name): 1. Total number of trips. 2. Total mileage. 3. Total cost to the vendor by Level of Service. This report should be further broken down by the following mileage tiers: 1. 10 miles or less 2. 11 miles to 25 miles 3. 26 miles to 50 miles 4. 51 miles or greater

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#	Name	Frequency/Delivery	Description
R4	Monthly Call Center Report	Monthly, due no later than the 15 th of the month following the report month.	This report should provide the following for each business day during the reporting period: 1. Total calls received. 2. Total calls answered. 3. Total calls abandoned. 4. Average abandonment time. 5. Average talk time. 6. Average speed answered. 7. Percentage of calls abandoned. 8. Percentage of calls answered. 9. Highest abandonment time. 10. The highest average speed answered.
R5	Monthly Staffing Report	Monthly, due no later than the 15 th of the month following the report month.	This report should provide the total number of full-time customer service representatives (CSRs) who are immediately available to receive phone calls to arrange transportation services, for each business day by hour (starting at 7 a.m. Eastern Time and ending at 6 p.m. Eastern Time).

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#	Name	Frequency/Delivery	Description
R6	Monthly Customer Service Representative (CSR) Monitoring Report	Monthly, due no later than the 15 th of the month following the report month.	This report should detail the vendor's monthly call center CSR monitoring results (as described in Appendix 1, Section XI, Part 0) including, but not limited to, the following 1. The name of the employee. 2. The number of calls monitored. 3. The score assigned to each call. 4. Description of any deficiency. 5. Action taken to correct any deficiency. 6. Name of the supervisor responsible for the employee.
R7	Reservation Summary Report	Monthly, due no later than the 15 th of the month following the report month.	This report should detail the total number of reservations (less cancellations) by the Level of Service for each month in the Fiscal Year, with cumulative Fiscal Year-to-Date totals. In addition, the report should detail by month the number of standing order trips.
R8	Unduplicated Riders by Level of Service Report	Monthly, due no later than the 15 th of the month following the report month.	This report should provide the following information: 1. Total number of unduplicated Agency Members by Level of Service for each month in the Fiscal Year, with cumulative Fiscal Year-to-Date totals. 2. The percentage of Agency Members by month, with cumulative for the Fiscal Year, for each Level of Service. 3. The total number of eligible Agency Members (the vendor should expect this number to be provided by the Agency) by month; and 4. The percentage of unduplicated Agency Members is over the total number of eligible Agency Members.

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#	Name	Frequency/Delivery	Description
R9	Monthly Complaint Summary Report	Monthly, due no later than the 15 th of the month following the report month.	This report should detail the total number of complaints by complaint category for each month in the Fiscal Year, with cumulative State Fiscal Year-to-Date totals and a percentage calculation for each complaint category for each month in the State Fiscal Year with cumulative State Fiscal Year-to-Date totals. The complaint categories should include, but not be limited to, the following: 1. Issue with vendor. 2. NEMT Provider Late. 3. Issue with NEMT Provider's Driver. 4. Issue with NEMT Provider's Vehicle. 5. NEMT Provider No-Show. 6. Complaint by Medical Facility. 7. Member Incident/Injury. 8. Other NEMT Provider Issue.

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#	Name	Frequency/Delivery	Description
R10	Monthly Complaint Detail Report	Monthly, due no later than the 15 th of the month following the report month.	This report should provide for each valid complaint at least with the following information: 1. Complaint number. 2. Member's Name. 3. Member's ID number. 4. Name of Complainant. 5. Complaint receive date. 6. Complaint type. 7. Complaint details. 8. To whom the complaint is against 9. Name of the NEMT Provider. 10. Result of the complaint investigation. 11. Date of complaint resolution.
R11	Monthly Denial Summary Report	Monthly, no later than the 15 th of the month following the report month.	This report should detail the total number of denied transports by denial category for each month in the Fiscal Year, with cumulative Fiscal Year-to-Date totals. The denials categories should include, but not be limited to, those denial reasons detailed in Appendix 1, Section Error! Reference source not found. (Error! Reference source not found.).

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#	Name	Frequency/Delivery	Description
R12	Monthly Denial Detail Report	Monthly, due no later than the 15 th of the month following the report month.	This report should provide the following information for each trip denied during the month: 1. Member's ID number. 2. Member's name. 3. Member's address. 4. Date of denial. 5. Trip ID number. 6. Denial reason. 7. Vendor staff who denied trip.
R13	Monthly Network Report	Monthly, due no later than the 15 th of the month following the report month.	This report should provide a listing of NEMT providers which details the level of service available through the NEMT provider and the counties they serve. This report should also include the address, person of contact, and contact information for all transportation providers enrolled.
R14	NEMT Services Scheduled Trip Requests Report	Within two (2) calendar days of the Agency request.	This report should be provided to the Agency upon request. The report should be formatted as a batch file in an Agency-approved file layout and should contain information regarding each requested trip.
R15	Provider Training Schedule	Monthly (for months during which provider training is to be conducted), due no later than five (5) calendar days before the start of the month in which training to occur.	This report should provide the schedule of NEMT providers and provider training sessions for the report month. Any changes to the scheduled training sessions should be reported immediately to the Agency. This report should not include training conducted prior to the operations start date.

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#	Name	Frequency/Delivery	Description
R16	Accident and Incident Report	For each accident or incident, due within twenty-four (24) hours after an accident or incident with injuries and within seventy-two (72) hours after an accident or incident without injuries.	This report should include the details of accidents or incidents as defined in Appendix 1, Section Error! Reference source not found. (Error! Reference source not found.), including, but not limited to, the following: 1. Date of accident or incident. 2. Description of accident or incident. 3. Member's ID number. 4. Member's name. 5. Attendant's name (if applicable). 6. Driver's name. 7. Vehicle Identification Number (VIN) or other identifying number on file with the vendor. 8. NEMT provider's Name. 9. Trip ID Number. Other information or notes, as applicable (e.g., police report, location of accident or incident, resolution/follow-up, associated complaint).
R17	Biannual Member Satisfaction Survey Report	Bi-annually, due no later than the 30 th calendar day after the end of each six (6) month reporting period.	This report should provide a summary of the results of the member surveys as described in Appendix 1, Section X (F), an analysis of the results and any actions the vendor has initiated or is to initiate based on the survey results. Upon the request of the Agency, the vendor should also provide the Agency with the raw data of the survey results.

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#	Name	Frequency/Delivery	Description
R18	Quarterly Suspected Fraud, Waste, Abuse and/or Misuse Summary Report	Quarterly, due no later than the 30 th calendar day after the end of each calendar quarter.	This report should include, but not be limited to, a summary of all contracted provider cases forwarded to the Agency's Office of Program Integrity (OPI) and copied to the Contract Manager during the previous quarter as specified in Appendix 1, Section Error! Reference source not found. . The report should include, but not be limited to, the member's name and ID number, the NEMT provider's name and provider ID number, and a brief description of the suspected fraud, waste, abuse or misuse.
R19	Annual Report	Annually, due no later than the 60 th day following the end of the twelve (12) month period (operational start date to be used as the start date).	This report should include a narrative summary of all NEMT Brokerage Program activity, vendor accomplishments, remaining challenges, and vendor's recommendations.
R20	Records of Vehicle Inspection	Monthly, due no later than the 15 th of the month following the report month.	This report should include records of all vehicle inspections performed during the month as described in Appendix 1, Section Error! Reference source not found. X (C). The report should include, but not be limited to, the license plate number, vehicle identification number, inspection sticker date, vendor's inspection form, and whether the vehicle passed inspection.

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#	Name	Frequency/Delivery	Description
R21	Monthly NEMT Provider Monitoring Report	Monthly, due no later than the 15 th of the month following the report month.	This report should include the details of all NEMT provider Monitoring performed during the month as described in Appendix 1, Section X (E). The report should include, but not be limited to, a description of monitoring activities, monitoring findings, corrective actions taken, and improvements made by the NEMT provider during the report month.
R22	Excessive Distance Report	Monthly, due no later than the 15 th of the month following the report month.	This report should include the details of all Excessive Distance Monitoring performed during the month as described in Appendix 1, Section IV (A). The report should include, but not be limited to, a case-by-case description of the monitoring activities and findings, and any corrective actions taken in the report month.
R23	Monthly Encounter Data Reconciliation Report	Monthly, due no later than the 20 th of the month following the report month.	This report should be delivered in conjunction with the Monthly Encounter Data File as described in Appendix 2: Section IV (C) and should include, but not be limited to, summary level reporting of the number of trips broken down by NEMT Service type and the number of unduplicated Agency Members.

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#	Name	Frequency/Delivery	Description
R24	Monthly Multi-passenger Trip Report	Monthly, due no later than the 20 th of the month following the report month.	This report should detail the NEMT provider's performance against Contract Service Level Agreements (as described in Appendix 4, Service Level Agreements) for Travel Time on Board of multi-passenger trips. The report should include, but not be limited to, the following details for each SLA: 1. Number of multi-passenger trips for the reporting month. 2. Time of pick-up for each multi-passenger trip. 3. Time of arrival at appointment destination for each multi-passenger trip. 4. Travel distance for each multi-passenger trip.

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#	Name	Frequency/Delivery	Description
R25	Monthly Behavioral Health Transportation Report	Monthly, due no later than the 20 th of the month following the report month.	This report should detail the NEMT provider's performance against Contract Service Level Agreements (as described in Appendix 4, Service Level Agreements) for licensed behavioral health center transport. The report should include, but not be limited to, the following details for each SLA: 1. Total number of trips. 2. Total mileage. 3. Total cost to the vendor by Level of Service. 4. Total service denials and % of which are requests for behavioral health services by Cancellation Reason or Denial Reason. 5. 844-HELP4WV (Helpline) calls, including reasons for incomplete and no-show trips if there are any: a. Complaints submitted against a service provider b. No show passengers c. By MCO, Total/Decline/Gross d. Lacked pre-authorization e. Cannot verify an appointment f. Cannot verify member's physical address.
R26	Monthly MCO Utilization	Monthly, due no later than the 15 th of the month following the report month.	This report should break down member utilization by MCO. This report is to include, but not limited to, a summary of the total number of members that had at least 1 trip in the preceding calendar month, the total number of trips, the total cost associated with those trips (paid claims and pending claims), and complaints received.

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#	Name	Frequency/Delivery	Description
R27	Fraud, Waste, Abuse, and Misuse financial report	Monthly, due no later than the 15th of the month following the report month.	This report should include, but not be limited to, a post audit of 1% or a minimum of 1,000 Gas Mileage Reimbursement (GMR) claims from the previous month's calendar. It should include, but not be limited to, a random selection of claims and any member with documented Fraudulent claims within the last six months. It should present Member name, member address, distance traveled, doctor/facility address visited, the amount paid in error if any, the cases identified for recoupment, the cases in which recoupment was initiated, and the dollar amount of monies collected during the month through the recoupment process. This report should identify those cases that recoupment was not initiated and justification for non-recoupment efforts. This report should be broken down into totals by county and by member.
R28	Service Organizational Control (SOC) audit report	It is due within thirty (30) days of completion date of the Audit.	The Vendor should provide the Agency with the results of any third-party audits related to the services covered under this contract.

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Appendix 4: Service Level Agreements (SLAs)

Because performance failures by the vendor may cause the Agency to incur additional administrative costs, the Agency may assess financial penalties against the vendor pursuant to this section and deduct the amount of the damages from any payments due to the vendor. Unless specified otherwise, The Agency may give written notice to the vendor of the failure that might result in the assessment of damages and the proposed amount of the damages. The vendor shall have thirty (30) calendar days from the date of the notice in which to dispute The Agency's determination and provide documentation to support the vendor's claim. The Agency will review the vendor's response before issuing a final determination.

Prior to commencement of operations, the Agency and the vendor will review all SLAs to determine if revisions are needed. Thereafter, similar reviews will be held annually, upon the implementation of a change that impacts existing SLAs, and/or at the request of the Agency.

Penalties associated with unmet SLAs will continue to accrue until the SLA requirements for the applicable month are fully met, regardless of performance in subsequent months. For example, if a January SLA is not met and corrected only in February, the vendor remains responsible for addressing the January SLA. Penalties for January will continue to accrue until the January report is corrected, and compliance is demonstrated for that specific month.

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NEMT Services

1. On-Time Arrival

No more than five percent (5%) of the scheduled trips should be late or missed per day.

2. Travel Time On Board

For multi-passenger's trips, the NEMT provider should schedule trips so that a member does not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for direct transportation of that member. (This specification does not apply to commercial air or fixed-wing transports.)

3. Average Wait Time

The vendor should ensure that the average waiting time for a pick-up does not exceed fifteen (15) minutes for a scheduled appointment and one (1) hour after notification of a hospital discharge.

4. Authorization & Scheduling Timeliness – Three Day Turn-Around

The vendor should authorize and schedule routine NEMT Services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request.

5. Authorization & Scheduling Timeliness – Ten Day Turn-Around

The vendor should authorize and schedule routine NEMT Services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request.

Up to 4% of the monthly operating fee, as follows:

- Any 2 of 5 not met: 1%
- Any 3 of 5 not met: 2%
- Any 4 of 5 not met: 3%
- Any 5 of 5 not met: 4%

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Transportation Validation Checks

6. Pre-Transportation Validation Checks

The vendor should conduct pre-transportation validation checks prior to authorizing the request as described in Appendix 1, Section **Error! Reference source not found.**, for no fewer than three percent (3%) of the NEMT Service requests received in a month. A busy signal or no answer should not be counted toward the three percent (3%) pre-transportation validation check rate.

7. Post-Transportation Validation Checks

The vendor should conduct post-transportation validation checks as described in Appendix 1, Section **Error! Reference source not found.**, on no fewer than two percent (2%) of the NEMT Service requests. If a post-transportation validation check cannot be completed because the call to the provider resulted in a busy signal or no answer after three (3) attempts, the vendor should enter into its system information to alert call center staff that any future requests to this specific provider are to be validated before it can be authorized.

Up to **5%** of the monthly operating fee, as follows:

- Any 1 of 2 not met: **3%**
- Any 2 of 2 not met: **5%**

8. Utilization Reporting Submission

The vendor should submit the utilization reporting on the day of the week specified by the Agency as described in Appendix 3, Report #R3. The Agency may assess damages for each business day. The complete and accurate report has not been submitted, retroactive to the original due date.

Up to \$1,000 per day for each business day the report is late.

9. Suspected Fraud, Abuse, and Misuse Reporting Submission

The vendor should submit a quarterly provider report (R18) and a monthly member report (R27) showing an audit for fraud, waste, abuse, or misuse by Agency Members, NEMT providers, medical providers, or contractor staff to The Agency's Office of Program Integrity (OPI) and the Agency Contract Manager within three (3) calendar days of the due date. The Agency may assess damages for each business day because the report has not been submitted in addition to any other SLA that may apply.

Up to \$1,000 per day for each business day the report is late.

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10. All Other Vendor Deliverables Submission Unless otherwise specified, all vendor deliverables as required by the Contract are to adhere to the following delivery standards: a) The Agency may give written notice to vendors via fax, e-mail, overnight mail, or through regular mail, of the late report, data, or material. b) Vendor should have thirty (30) calendar days following receipt of the notice in which to cure the failure by submitting the complete accurate report, data or material. c) If the report, data or material has not been submitted within the thirty (30) calendar day period, The Agency without further notice, may assess SLA deductions, and, beginning at each fifteen (15) calendar day period in which the complete and accurate report, data or material has not been submitted, and retroactive to the original due date, The Agency may make a separate SLA deduction assessment for each fifteen (15) calendar day period.	Up to \$1,000 per fifteen (15) calendar day period each report, data or other material is late.
NEMT Provider Reimbursement 11. NEMT Provider Reimbursement - 30 Day Turn-Around The vendor should pay all "clean claims" from NEMT providers within thirty (30) calendar days following receipt.	1% of the monthly operating fee.
12. Call Center Downtime Call Center downtime should be defined as the time during which the call center is not operational due to hardware, operating, or software failure. Negotiated downtime for system or other maintenance during off-peak hours is not to be included in the calculation of call center availability. Downtime due to circumstances outside the vendor's control (e.g., power outages) should not be included in the calculation of call center availability.	Up to 3% of monthly operating fee for downtime of 1% or more (during normal hours of operation).

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Call Center Performance

13. Call Center - Speed of Answer

The ACD system is programmed to answer all calls within three (3) rings.

14. Call Center - Average Wait Time

The average queue time after the initial automatic voice response is five (5) minutes or less.

15. Call Center - Average Call Abandonment Rate

The average abandonment rate is no more than five percent (5%).

Up to 2% of the monthly operating fee, as follows:

- Any 1 of 3 not met: 1%
- Any 2 or 3 not met: 2%

Training, Outreach and Education

16. Provider Training and Education

The vendor should conduct separate NEMT provider and provider training sessions in at least five (5) locations throughout the state, and ensure continued education, training sessions, training materials, and ongoing meetings with NEMT providers and medical providers. Vendor should develop and maintain a Provider Manual which contains all policies and procedures for the NEMT brokerage program. The manual is to be reviewed, updated, and distributed annually and whenever changes in operation are made.

Up to 2% of the monthly operation fee, as follows:

- Any 1 of 2 not met: 1%
- Any 2 of 2 not met: 2%

17. Member Outreach, Education and Satisfaction Surveys

Vendor should develop and implement NEMT member outreach and education for current and future Agency Members and other NEMT program on NEMT services, procedures, and the transition of service administration from county Agency staff to the vendor. Every six (6) months, the vendor conducts a member satisfaction survey regarding the NEMT brokerage program to verify availability, the appropriateness and timeliness of trips provided and the manner in which the vendor's staff and NEMT provider's staff interacted with Agency Members.

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Driver and Vehicle Validation Checks

18. Transportation Provider Driver Requirements Validation Checks

Transportation providers should ensure NEMT Drivers meet all driver requirements including, age and driver's license requirements, criminal background checks, driver impairment and smoking policies, member assistance and safety policies, and driver vehicle operation daily trips logs policies.

Up to 2% of the monthly operation fee, as follows:

- Any 1 of 2 not met:
1%
- Any 2 of 2 not met:
2%

19. Vehicle and Vehicle Inspection Requirements Validation Checks

Vehicle inspections should be performed prior to operations start date and at least every six (6) months thereafter. Providers should ensure compliance with vehicle requirements and should maintain all vehicles to meet or exceed requirements, including ADA Compliance, which can be found at: <https://www.ada.gov/law-and-regs/design-standards/> and manufacturer's safety, mechanical, operating and maintenance standards, and test all communications equipment.

20. Unauthorized changes

All program changes should include, but not limited to, processes, protocols, flowcharts or any other program administration guideline changes/modifications must receive approval from the Agency prior to changes/modifications being implemented by vendor. If the vendor makes any unauthorized changes, they will be assessed SLA deductions on a per incident basis for not complying with a contract provision.

Penalty of \$5,000 per occurrence.

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21. Implementation of Contract Requirements Vendor should implement 100% of contract requirements no later than 3 months post "Go-Live" date of the contract.	\$1,000 per calendar day from contract start date that any and all contract requirements are not implemented. This SLA will be applied to each Contract requirement not implemented independent of other SLA assessments.
22. Annual Financial Report At the conclusion of each state fiscal year (June 30), the vendor should report pre-tax net income, of the West Virginia NEMT Program, to the Agency. Any amount over 7.5% profit will be returned to the state within 30 days of the completion of the audit, which must be completed within 90 days of the end of the state fiscal year.	\$1,000 per calendar day from the 120-day post end of fiscal year deadline that the audit report and rebate refund is not received by the Agency.

OPTIONAL SERVICE- OFFICE OF DRUG CONTROL PREVENTION

Service Level Agreement Description	Penalty
Transportation Services Statewide Coverage Service gaps in rural areas should be identified and trips should be available in every area of WV within a 24-hour timeframe. On-Demand ride response No more than five percent (5%) of the scheduled trips may be delayed more than 24 hours. On-Time arrival The vendor should maintain a monthly average of 80% for on-time arrivals. Travel Time Onboard	Up to 10% of the monthly operating fee, as follows: Any 1 of 5 not met: 2% Any 2 of 5 not met: 4% Any 3 of 5 not met: 6% Any 4 of 5 not met: 8% Any 5 of 5 not met: 10%

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OPTIONAL SERVICE- OFFICE OF DRUG CONTROL PREVENTION

For multi-passenger trips, the provider should schedule trips so that a member does not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for direct transportation of that member.

5. Average Wait Time

The vendor should ensure that the average wait time for a pick-up does not exceed fifteen (15) minutes for a scheduled time of arrival.

Ride Booking Application Services

6. Ride Booking Application Downtime

Ride booking app downtime is defined as the time during which the app is not operational due to hardware, operating, or software failure. Negotiated downtime for system or other maintenance during off-peak hours should not be included in the calculation of ride booking app availability. Downtime due to circumstances outside the vendor's control (e.g., power outages) should not be included in the calculation of call center availability.

1% of the monthly operating fee for each cumulative 24-hour period the application is down.

Training, Outreach and Education

7. Provider Training and Education

The vendor should conduct ride booking application training sessions at least once a year throughout the state.

1% of the monthly operating fee for failing to provide annual statewide training.

8. Unauthorized changes

Any and all program changes to include, but not be limited to, processes, protocols, flowcharts or any other program administration guideline changes/modifications should receive approval from the Agency prior to changes/modifications being implemented by vendor. If the vendor makes any unauthorized changes, they will be assessed SLA deductions on a per incident basis for not complying with a contract provision.

Penalty of \$2,500 per occurrence

9. Implementation of Contract Requirements

The vendor should implement 100% of contract requirements by the "Go-Live" date of the contract.

\$500 per calendar day from contract start date that any

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OPTIONAL SERVICE- OFFICE OF DRUG CONTROL PREVENTION

contract requirements are
not implemented.

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Appendix 5: Implementation Deliverables*, Milestones, and Payments

* Deliverables are due to the Agency for review and approval no later than thirty (30) calendar days prior to the operation's start date, unless noted otherwise.

#	Type	Deliverables and Milestones	% of Total Implementation	Cost
1	MILESTONE	Contract Execution		5%
2	Deliverable	Turnover Plan <i>(Due no later than fourteen (14) calendar days after the date of Contract award.)</i>		-
3	Deliverable	Final Implementation Work Plan <i>(Due in electronic format <u>and</u> hard copy no later than fourteen (14) calendar days after the date of Contract award.)</i>		15%
4	Deliverable	NEMT Provider Network and Geographic Coverage Report <i>(Including information for the final subcontracted network.)</i>		10%
5	MILESTONE	Vendor Call Center Facility Established		5%
6	Deliverable	Adverse Weather Plan <i>(Due no later than two (2) weeks prior to Operation Start Date.)</i>		-
7	Deliverable	Post-Transportation Authorization of NEMT Services Policy		-
8	Deliverable	NEMT Service Denial Criteria and Service Denial Letter		-
9	Deliverable	Validation Plan		-
10	Deliverable	Vehicle Inspection Plan		-
11	Deliverable	NEMT Provider Monitoring Plan		-
12	Deliverable	Final NEMT Provider Manual		-
13	Deliverable	NEMT Provider and Provider Training and Education Plan		-
14	MILESTONE	NEMT Provider and Provider Training Sessions Complete		5%
15	Deliverable	Final Member Outreach and Education Plan		-

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#	Type	Deliverables and Milestones	% of Total Implementation Cost
16	MILESTONE	Member Education and Outreach Materials Mailed	5%
17	Deliverable	Operations Procedures Manual	10%
18	Deliverable	Final Complaint Policies and Procedures Manual	-
19	Deliverable	Quality Assurance Plan	-
20	Deliverable	Business Continuity and Disaster Recovery Plan	-
21	Deliverable	The Agency -Specific Report Samples	-
22	MILESTONE	Completion and the Agency Approval of All Readiness Review Deliverables <i>(Inclusive of Deliverables #2-20.)</i>	15%
23	MILESTONE	Completion and the Agency Approval of Call Center Readiness Review Requirements	15%
24	MILESTONE	Completion and the Agency Approval of Operational Readiness Review <i>(Initiated approximately two (2) weeks prior to scheduled operations start date)</i>	-
25	MILESTONE	Start-Up: Vendor Begins Taking Calls for NEMT Service Requests <i>(Two (2) weeks prior to scheduled operations start date)</i>	-
26	MILESTONE	Start-Up: Implementation Complete (Full Operations Initiated)	15%
TOTAL			100%

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Appendix 6: Glossary

ABUSE: NEMT provider or provider practices that are not medically necessary and consequently result in an unnecessary cost to the Medicaid program; improper or excessive use or treatment (e.g., no shows).

ACCIDENT: An unforeseen and unplanned event or circumstance.

APPEAL: An action initiated by a member to challenge a decision made by the Agency or Contractor.

CAPITATION RATE: Predetermined per-person rate as contracted with the Agency for nonemergency medical transportation services to eligible clients.

COMPLAINT: An oral or written expression of dissatisfaction by a member, a member's family member or other responsible party, or a provider or NEMT provider.

COVERED MEDICAL SERVICE: Any medical service that is eligible for reimbursement under the Agency policy, excluding pharmacy services and any other exclusion designated by the Agency.

CURB-TO-CURB SERVICE: Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver provides assistance according to the members' needs, but assistance does not include the lifting of any member. The driver remains at or near the vehicles and does not enter any buildings.

DOOR-TO-DOOR SERVICE: Transportation provided to Agency Members with disabilities who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver exits the vehicle and assists the member from the door of the pick-up point, e.g., residence, escorting the passenger to the door of the vehicle and assisting the passenger in entering the vehicle. The driver assists the member throughout the trip and to the door of the destination. Drivers, except for ambulance personnel, do not enter a residence.

ENCOUNTER: For the purposes of the NEMT Program, an encounter is a trip leg that has been completed by the NEMT provider and has been reimbursed by the vendor.

EXCESSIVE DISTANCE: For the purpose of the NEMT Program, excessive distance will be determined as any trip to a provider located more than 125 miles from the Agency Member's permanent address.

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FIXED ROUTE MODE OF TRANSPORTATION: Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops.

FRAUD: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person, including any act that constitutes fraud under applicable federal or state law.

FULL-RISK CAPITATION BROKER: Transportation entities prohibited from owning or having any financial interest in organizations that deliver NEMT transportation services to eligible clients. The entity maintains a separate and distinct relationship with any NEMT transportation provider. It also assumes the financial responsibility to provide all covered services for eligible Agency Members at the capitation rate. The full-risk capitated broker is reimbursed based on the per Medicaid enrollee per member per month payment reimbursement methodology (capitation).

HAND-TO-HAND TRANSPORTATION: Transportation of a member with disabilities from an individual at the pick-up point to a facility staff member, family member or other responsible party at the destination.

HOSPITAL DISCHARGE: Notification by a hospital that a member is ready for discharge. A hospital discharge shall be considered an Urgent Trip.

IMPLEMENTATION DATE: The date Contractor begins administration of the NEMT Program.

INCIDENT: An occurrence of an action or situation that is a separate unit of experience.

LEVEL OF SERVICE: Designation used to describe the appropriate type of vehicle that may be used to transport the member. Specific modes of transportation may include the following:

AMBULATORY LEVEL OF SERVICE: An ambulatory member is able to move and pivot without assistance. It may also include a member in a manual wheelchair who is capable of transferring without assistance.

WHEELCHAIR LEVEL OF SERVICE: A member who uses an electric or manual wheelchair and is unable to transfer on their own.

MEDICAID IDENTIFICATION NUMBER/MEDICAID ID NUMBER: A unique number assigned to a member by the Agency.

MEMBER: unless otherwise specified, an individual receiving Agency services; also referred to as Agency recipient.

NEMT: Non-Emergency Medical Transportation; transportation for medical services in a non-emergent situation.

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NEMT PROVIDER: Person or entity that is approved by the Agency and participates in the vendor's network to furnish NEMT services to Agency Members under the medical assistance programs such as WV Medicaid or Foster Care services.

PROVIDER: Person enrolled with the Agency to furnish medical, educational, or rehabilitative services to Agency Members under medical assistance programs such as WV Medicaid or Foster Care services.

ROUTINE: A prescribed, detailed course of action to be followed regularly; a standard procedure.

STANDING ORDER: A request or authorization for NEMT services to multiple recurring medical appointments for the same member with the same provider for the same treatment or condition.

SUBCONTRACTOR: An entity that performs services under the terms of a subcontract and is hired by a prime contractor.

TRIP LEG: One-way transportation from an origin to a destination.

UTILIZATION DATA: Data required to be reported regarding every encounter under the NEMT program.

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 compliant.

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 compliant. 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:

By: _____

By: SNAH Healthcare Software Management

Printed Name: _____

Printed Name: PAULINA WIERZBICKA

Title: _____

Title: President

Date: _____

Date: 9/24/2025

Paulina Wierzbicka

9/24/2025

EXHIBIT A To:
REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY
CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

W. Va. CSR § 148-1-5

West Virginia Code of State Rules
Title 148. Department of Administration
Legislative Rule (Ser. 1)
Series 1. Purchasing

W. Va. Code St. R. § 148-1-5
§ 148-1-5. Remedies.

Currentness

5.1. The Director may require that the spending unit attempt to resolve any issues that it may have with the vendor prior to pursuing a remedy contained herein. The spending unit must document any resolution efforts and provide copies of those documents to the Purchasing Division.

5.2. Contract Cancellation.

5.2.1. Cancellation. The Director may cancel a purchase or contract immediately under any one of the following conditions including, but not limited to:

5.2.1.a. The vendor agrees to the cancellation;

5.2.1.b. The vendor has obtained the contract by fraud, collusion, conspiracy, or is in conflict with any statutory or constitutional provision of the State of West Virginia;

5.2.1.c. Failure to honor any contractual term or condition or to honor standard commercial practices;

5.2.1.d. The existence of an organizational conflict of interest is identified;

5.2.1.e. Funds are not appropriated or an appropriation is discontinued by the legislature for the acquisition;

5.2.1.f. Violation of any federal, state, or local law, regulation, or ordinance, and

5.2.1.g. The contract was awarded in error.

5.2.2. The Director may cancel a purchase or contract for any reason or no reason, upon providing the vendor with 30 days' notice of the cancellation.

5.2.3. Opportunity to Cure. In the event that a vendor fails to honor any contractual term or condition, or violates any provision of federal, state, or local law, regulation, or ordinance, the Director may request that the vendor remedy the contract breach or legal violation within a time frame the Director determines to be appropriate. If the vendor fails to remedy the contract breach or legal violation or the Director determines, at his or her sole discretion, that such a request is unlikely to yield a satisfactory result, then he or she may cancel immediately without providing the vendor an opportunity to perform a remedy.

5.2.4. Re-Award. The Director may award the cancelled contract to the next lowest responsible bidder (or next highest scoring bidder if best value procurement) without a subsequent solicitation if the following conditions are met:

5.2.4.a. The next lowest responsible bidder (or next highest scoring bidder if best value procurement) is able to perform at the price contained in its original bid submission, and

5.2.4.b. The contract is an open-end contract, a one-time purchase contract, or a contract for work which has not yet commenced.

Award to the next lowest responsible bidder (or next highest scoring bidder if best value procurement) will not be an option if the vendor's failure has in any way increased or significantly changed the scope of the original contract. The vendor failing to honor contractual and legal obligations is responsible for any increase in cost the state incurs as a result of the re-award.

5.3. Non-Responsible. If the Director believes that a vendor may be non-responsible, the Director may request that a vendor or spending unit provide evidence that the vendor either does or does not have the capability to fully perform the contract requirements, and the integrity and reliability necessary to assure good faith performance. If the Director determines that the vendor is non-responsible, the Director shall reject that vendor's bid and shall not award the contract to that vendor. A determination of non-responsibility must be evaluated on a case-by-case basis and can only be made after the vendor in question has submitted a bid. A determination of non-responsibility will only extend to the contract for which the vendor has submitted a bid and does not operate as a bar against submitting future bids.

5.4. Suspension.

5.4.1. The Director may suspend, for a period not to exceed 1 year, the right of a vendor to bid on procurements issued by the Purchasing Division or any state spending unit under its authority if:

5.4.1.a. The vendor has submitted a bid and then requested that its bid be withdrawn after bids have been publicly opened.

5.4.1.b. The vendor has exhibited poor performance in fulfilling his or her contractual obligations to the State. Poor performance includes, but is not limited to any of the following: violations of law, regulation, or ordinance; failure to deliver timely; failure to deliver quantities ordered; poor performance reports; or failure to deliver commodities, services, or printing at the quality level required by the contract.

5.4.1.c. The vendor has breached a contract issued by the Purchasing Division or any state spending unit under its authority and refuses to remedy that breach.

5.4.1.d. The vendor's actions have given rise to one or more of the grounds for debarment listed in W. Va. Code § 5A-3-33d.

5.4.2. Vendor suspension for the reasons listed in section 5.4 above shall occur as follows:

5.4.2.a. Upon a determination by the Director that a suspension is warranted, the Director will serve a notice of suspension to the vendor.

5.4.2.b. A notice of suspension must inform the vendor:

5.4.2.b.1. Of the grounds for the suspension;

5.4.2.b.2. Of the duration of the suspension;

5.4.2.b.3. Of the right to request a hearing contesting the suspension;

5.4.2.b.4. That a request for a hearing must be served on the Director no later than 5 working days of the vendor's receipt of the notice of suspension;

5.4.2.b.5. That the vendor's failure to request a hearing no later than 5 working days of the receipt of the notice of suspension will be deemed a waiver of the right to a hearing and result in the automatic enforcement of the suspension without further notice or an opportunity to respond; and

5.4.2.b.6. That a request for a hearing must include an explanation of why the vendor believes the Director's asserted grounds for suspension do not apply and why the vendor should not be suspended.

5.4.2.c. A vendor's failure to serve a request for hearing on the Director no later than 5 working days of the vendor's receipt of the notice of suspension will be deemed a waiver of the right to a hearing and may result in the automatic enforcement of the suspension without further notice or an opportunity to respond.

5.4.2.d. A vendor who files a timely request for hearing but nevertheless fails to provide an explanation of why the asserted grounds for suspension are inapplicable or should not result in a suspension, may result in a denial of the vendor's hearing request.

5.4.2.e. Within 5 working days of receiving the vendor's request for a hearing, the Director will serve on the vendor a notice of hearing that includes the date, time and place of the hearing.

5.4.2.f. The hearing will be recorded and an official record prepared. Within 10 working days of the conclusion of the hearing, the Director will issue and serve on the vendor, a written decision either confirming or reversing the suspension.

5.4.3. A vendor may appeal a decision of the Director to the Secretary of the Department of Administration. The appeal must be in writing and served on the Secretary no later than 5 working days of receipt of the Director's decision.

5.4.4. The Secretary, or his or her designee, will schedule an appeal hearing and serve on the vendor, a notice of hearing that includes the date, time and place of the hearing. The appeal hearing will be recorded and an official record prepared. Within 10 working days of the conclusion of the appeal hearing, the Secretary will issue and serve on the vendor a written decision either confirming or reversing the suspension.

5.4.5. Any notice or service related to suspension actions or proceedings must be provided by certified mail, return receipt requested.

5.5. Vendor Debarment. The Director may debar a vendor on the basis of one or more of the grounds for debarment contained in W. Va. Code § 5A-3-33d or if the vendor has been declared ineligible to participate in procurement related activities under federal laws and regulation.

5.5.1. Debarment proceedings shall be conducted in accordance with W. Va. Code § 5A-3-33e and these rules. A vendor that has received notice of the proposed debarment by certified mail, return receipt requested, must respond to the proposed debarment within 30 working days after receipt of notice or the debarment will be instituted without further notice. A vendor is deemed to have received notice, notwithstanding the vendor's failure to accept the certified mail, if the letter is addressed to the vendor at its last known address. After considering the matter and reaching a decision, the Director shall notify the vendor of his or her decision by certified mail, return receipt requested.

5.5.2. Any vendor, other than a vendor prohibited from participating in federal procurement, undergoing debarment proceedings is permitted to continue participating in the state's procurement process until a final debarment decision has been reached. Any contract that a debarred vendor obtains prior to a final debarment decision shall remain in effect for the current term, but may not be extended or renewed. Notwithstanding the foregoing, the Director may cancel a contract held by a debarred vendor if the Director determines, in his or her sole discretion, that doing so is in the best interest of the State. A vendor prohibited from participating in federal procurement will not be permitted to participate in the state's procurement process during debarment proceedings.

5.5.3. If the Director's final debarment decision is that debarment is warranted and notice of the final debarment decision is mailed, the Purchasing Division shall reject any bid submitted by the debarred vendor, including any bid submitted prior to the final debarment decision if that bid has not yet been accepted and a contract consummated.

5.5.4. Pursuant to W.Va. Code § 5A-3-33e(e), the length of the debarment period will be specified in the debarment decision and will be for a period of time that the Director finds necessary and proper to protect the public from an irresponsible vendor.

5.5.5. List of Debarred Vendors. The Director shall maintain and publicly post a list of debarred vendors on the Purchasing Division's website.

5.5.6. Related Party Debarment. The Director may pursue debarment of a related party at the

same time that debarment of the original vendor is proceeding or at any time thereafter that the Director determines a related party debarment is warranted. Any entity that fails to provide the Director with full, complete, and accurate information requested by the Director to determine related party status will be presumed to be a related party subject to debarment.

5.6. Damages.

5.6.1. A vendor who fails to perform as required under a contract shall be liable for actual damages and costs incurred by the state.

5.6.2. If any commodities delivered under a contract have been used or consumed by a spending unit and on testing the commodities are found not to comply with specifications, no payment may be approved by the Spending Unit for the merchandise until the amount of actual damages incurred has been determined.

5.6.3. The Spending Unit shall seek to collect damages by following the procedures established by the Office of the Attorney General for the collection of delinquent obligations.

Credits

History: Filed 4-1-19, eff. 4-1-19; Filed 4-16-21, eff. 5-1-21.

Current through register dated May 7, 2021. Some sections may be more current. See credits for details.

W. Va. C.S.R. § 148-1-5, WV ADC § 148-1-5

End of Document

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Government Works.

EXHIBIT B To:
REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY
CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

Prevailing Wage Determination

☒ – Not Applicable Because Contract Not for Construction

☐ – Federal Prevailing Wage Determination on Next Page

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. Definitions. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

- a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: <http://www.state.wv.us/admin/purchase/vrciagencyvli.html>.
- b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).
- c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.
- d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.
- e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

- f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.
- g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.
- h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.
- i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.
- J. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. Permitted Uses and Disclosures.

- a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.
- b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.
- c. **Further Uses and Disclosures.** Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. Obligations of Associate.

- a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.
- b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.
- c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:
 - i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;
 - ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;
 - iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;
 - iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.
- d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.
- e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. Support of Individual Rights.

- i. Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.
- ii. Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.
- iii. Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

 - the date of disclosure;
 - the name of the entity or person who received the PHI, and if known, the address of the entity or person;
 - a brief description of the PHI disclosed; and
 - a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.
- iv. Request for Restriction.** Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."
- v. Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

- g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.
- h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.
- J **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.
- k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.
- l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incidentwv.gov or <https://apps.wv.doh/other/Default.aspx>.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

- m. Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is named as an adverse party.

4. Addendum Administration.

- a. Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.
- b. Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

- c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.
- d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.
- e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. General Provisions/Ownership of PHI.

- a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.
- b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.
- c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.
- d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.
- e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.
- g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.
- h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

Name of Agency: _____ Name of Associate: Paulina Wierzbicka

Signature: _____ Signature: Pauline Wierzbicka

Title: _____ Title: President

Date: _____ Date: 9/24/2025

Form - VVBAA-012004
Amended 06.26.2013

APPROVER TO FORM THIS^{210°}
DAY OF _____ 20 __LL


Patrick Morrissey
Attorney General

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: WV DHHR _____

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

All types of PHI in paper, electronic, verbal or any other form.
Including, but not limited to:
Member Eligibility Verification Extract File
Member Name
member ID Number



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
Service - Misc

Proc Folder: 1544503

Doc Description: NON EMERGENCY MED TRANSPORT/STATEWIDE TRANSPORT PROGRAM

Reason for Modification:

ADDENDUM 1
TO EXTEND PROPOSAL
OPENING DATE

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2025-09-08	2025-10-01 13:30	CRFP 0511 BMS2600000001	2

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: VS0000049850

Vendor Name : SNAH Healthcare Software Management

Address : 9440 Santa Monica Blvd, Beverly Hills, CA 90210

Street : 9440 Santa Monica Blvd

City : Beverly Hills

State : California

Country : USA

Zip : 90210

Principal Contact : Paulina Wierzbicka

Vendor Contact Phone: 1-800-666-6293

Extension: 810

FOR INFORMATION CONTACT THE BUYER

Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor

Signature X *Paulina Wierzbicka* FEIN# 93-2289829

DATE 9/24/2025

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

ADDITIONAL INFORMATION

THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES, BUREAU FOR MEDICAL SERVICES, IS SOLICITING PROPOSALS TO ESTABLISH AN OPEN-END CONTRACT TO PROVIDE FULL-RISK CAPITATION BROKER SERVICES TO DIRECTLY COORDINATE A STATEWIDE NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) PROGRAM AND A STATEWIDE TRANSPORTATION PROGRAM (STP) UNDER JOBS AND HOPE (OFFICE OF DRUG CONTROL POLICY) AND THE BUREAU FOR BEHAVIORAL HEALTH 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	Implementation Cost-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:

Implementation Cost-NEMT (3 months)

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
2	Base Year 1 Cost Per Member Per Month-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:

Base Year 1 Cost Per Member Per Month \$-NEMT (9 months)

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
3	Optional Renewal Year 1 Cost Per Member Per Month \$-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Optional Renewal Year 1 Cost Per Member Per Month \$-NEMT

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
4	Optional Renewal Year 2 Cost Per Member Per Month \$-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Optional Renewal Year 2 Cost Per Member Per Month \$-NEMT

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
5	Optional Renewal Year 3 Cost Per Member Per Month \$-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Optional Renewal Year 3 Cost Per Member Per Month \$-NEMT

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
6	Optional Renewal Year 4 Cost Per Member Per Month \$-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Implementation Cost-Other

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
7	Optional Renewal Year 5 Cost Per Member Per Month \$-NEMT				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Optional Renewal Year 5 Cost Per Member Per Month \$-NEMT

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
8	Implementation Cost-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Implementation Cost-STP

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
9	Opt. Base Year 1:0-50,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Base Year 1:0-50,000 miles (multiplier of 50,000)-STP

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
10	Opt. Base Year 1:50,001--150,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Base Year 1:50,001--150,000 miles-STP/Multiplier of 150,000

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
11	Opt. Base Year 1:150,001--250,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Base Year 1:150,001--250,000 miles-STP/Multiplier of 250,000

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
12	Opt. Base Year 1:250,001--350,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Base Year 1:250,001--350,000 miles-STP/Multiplier of 350,000

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
13	Opt. Base Year 1:350,001--450,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Base Year 1:350,001--450,000 miles-STP/Multiplier of 450,000

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
14	Opt. Base Year 1:450,001--500,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Base Year 1:450,001--500,000 miles-STP/Multitplier of 500,000

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
15	Opt. Base Year 1:500,001+ miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Base Year 1:500,001+ miles-STP/Multiplier of 500,001

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
16	Opt. Renewal Year 1:0-50,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:0-50,000 miles-STP/Multiplier of 50,000

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
17	Opt. Renewal Year 1:50,001--150,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:50,001--150,000 miles-STP/Multiplier of 150,000

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
18	Opt. Renewal Year 1:150,001--250,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:150,001--250,000 miles-STP/Multiplier of 250,000

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
19	Opt. Renewal Year 1:250,001--350,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:250,001--350,000 miles-STP/Multiplier of 350,000

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
20	Opt. Renewal Year 1:350,001--450,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:350,001--450,000 miles-STP/Multiplier of 450,000

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
21	Opt. Renewal Year 1:450,001--500,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:450,001--500,000 miles-STP/Multiplier of 500,000

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
22	Opt. Renewal Year 1:500,001+ miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 1:500,001+ miles-STP/Multiplier of 500,001

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
23	Opt. Renewal Year 2:0-50,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:0-50,000 miles-STP/Multiplier of 50,000

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
24	Opt. Renewal Year 2:50,001--150,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:50,001--150,000 miles-STP/Multiplier of 150,000

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
25	Opt. Renewal Year 2:150,001--250,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:150,001--250,000 miles-STP/Multiplier of 250,000

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
26	Opt. Renewal Year 2:250,001--350,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:250,001--350,000 miles-STP/Multiplier of 350,000

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
27	Opt. Renewal Year 2:350,001--450,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:350,001--450,000 miles-STP/Multiplier of 450,000

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
28	Opt. Renewal Year 2:450,001--500,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:450,001--500,000 miles-STP/Multiplier of 500,000

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
29	Opt. Renewal Year 2:500,001+ miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 2:500,001+ miles-STP/Multiplier of 500,001

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
30	Opt. Renewal Year 3:0-50,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 3:0-50,000 miles-STP/Multiplier of 50,000

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
31	Opt. Renewal Year 3:50,001--150,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 3:50,001--150,000 miles-STP/Multiplier of 150,000

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
32	Opt. Renewal Year 3:150,001--250,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 3:150,001--250,000 miles-STP/Multiplier of 250,000

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
33	Opt. Renewal Year 3:250,001--350,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 3:250,001--350,000 miles-STP/Multiplier of 350,000

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
34	Opt. Renewal Year 3:350,001--450,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 3:350,001--450,000 miles-STP/Multiplier of 450,000

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
35	Opt. Renewal Year 3:450,001--500,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 3:450,001--500,000 miles-STP/Multiplier of 500,000

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
36	Opt. Renewal Year 3:500,001+ miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 3:500,001+ miles-STP/Multiplier of 500,001

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
37	Opt. Renewal Year 4:0-50,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 4:0-50,000 miles-STP/Multiplier of 50,000

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
38	Opt. Renewal Year 4:50,001--150,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 4:50,001--150,000 miles-STP/Multiplier of 150,000

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
39	Opt. Renewal Year 4:150,001--250,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 4:150,001--250,000 miles-STP/Multiplier of 250,000

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
40	Opt. Renewal Year 4:250,001--350,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 4:250,001--350,000 miles-STP/Multiplier of 350,000

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
41	Opt. Renewal Year 4:350,001--450,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:

Opt. Renewal Year 4:350,001--450,000 miles-STP/Multiplier of 450,000

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
42	Opt. Renewal Year 4:450,001--500,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:

Opt. Renewal Year 4:450,001--500,000 miles-STP/Multiplier of 500,000

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
43	Opt. Renewal Year 4:500,001+ miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 4:500,001+ miles-STP/Multiplier of 500,001

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
44	Opt. Renewal Year 5:0-50,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 5:0-50,000 miles-STP/Multiplier of 50,000

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
45	Opt. Renewal Year 5:50,001--150,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 5:50,001--150,000 miles-STP/Multiplier of 150,000

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
46	Opt. Renewal Year 5:150,001--250,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 5:150,001--250,000 miles-STP/Multiplier of 250,000

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
47	Opt. Renewal Year 5:250,001--350,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 5:250,001--350,000 miles-STP/Multiplier of 350,000

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
48	Opt. Renewal Year 5:350,001--450,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
Opt. Renewal Year 5:350,001--450,000 miles-STP/Multiplier of 450,000

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
49	Opt. Renewal Year 5:450,001--500,000 miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 5:450,001--500,000 miles-STP/Multiplier of 500,000

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
50	Opt. Renewal Year 5:500,001+ miles-STP				

Comm Code	Manufacturer	Specification	Model #
81141604			

Extended Description:
 Opt. Renewal Year 5:500,001+ miles-STP/Multiplier of 500,001

SCHEDULE OF EVENTS		
Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2025-08-20

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS2600000001

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

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

Addendum Numbers Received:

(Check the box next to each addendum received)

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

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that 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.

SNAH HEALTHCARE SOFTWARE MANAGEMENT
Company


Authorized Signature

9/24/2025
Date

NOTE: This addendum acknowledgment should be submitted with the bid to expedite document processing.
Revised 6/8/2012

SOLICITATION NUMBER: CRFP BMS2600000001

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 proposal opening date to 10/01/2025 at 1:30 PM ET

Answers to vendor questions will be provided 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.

Pitch Deck

SNAH Healthcare Software Management

SNAH

Transforming Healthcare at Scale

SNAH seamlessly connects patients, providers, and pharmacies through a single, integrated platform—offering transportation, telemedicine, home healthcare, and medication management—available anytime, anywhere.



PROBLEM

Fragmented Healthcare System



Missed Appointments

3.6 million missed annually



\$150 billion lost revenue for healthcare providers

(AHA)

Care Coordination Failures

45% of chronic patients face care coordination issues



\$240 billion wasted in resources

(JAMA)

Medication Non-Adherence

50% of patients don't adhere to medications



\$300 billion in preventable healthcare costs

(AHA)

NEMT (Non-Emergency Medical Transportation) Delays

20% of NEMT services delayed



\$1.5 billion in lost revenue

(NCSL)

Home Care Access Issues

Disconnected systems, high costs, and rigid long-term contracts



20% higher costs and delayed care

(Industry Data)

Due to these inefficiencies, the healthcare system loses **over \$500 billion annually**

SNAH has the solution

Sources: American Hospital Association (AHA), JAMA Network, National Conference of State Legislatures (NCSL), Industry Data

PROBLEM

NEMT: Inefficient, Costly, and Unchecked

Rampant Fraud

Fake trips, irresponsible drivers—**costing billions**.



Inefficiencies Bleed Money

Outdated systems waste



Systemic Non-Compliance

Unchecked practices and ignored regulations.



No Real-Time Oversight

Manual processes



\$1.5 Billion wasted annually on preventable issues in NEMT services.

SOLUTION

SNAH: Transforming NEMT

SNAH



SNAH Wallet:

Cost Control & Fraud Prevention

- Requires OTP codes to start and complete each ride.
- Automated fraud detection flags overbilling.



Integrated NEMT Platform

- Connects patients, drivers, and providers seamlessly.
- Automated scheduling with real-time updates.



Standardized Safety Protocols

1099 vetted drivers and safety-checked vehicles
—safety guaranteed.



Real-Time Data & Analytics

Instant insights to optimize NEMT operations.

Current NEMT Process



State Insurance



Broker



Third-Party Transportation Companies



Underpaid W2 Drivers

Delays. Fake rides. Inefficiency.



SNAH Process



Patients



Book Medical Appointment on SNAH App



Instant Confirmation

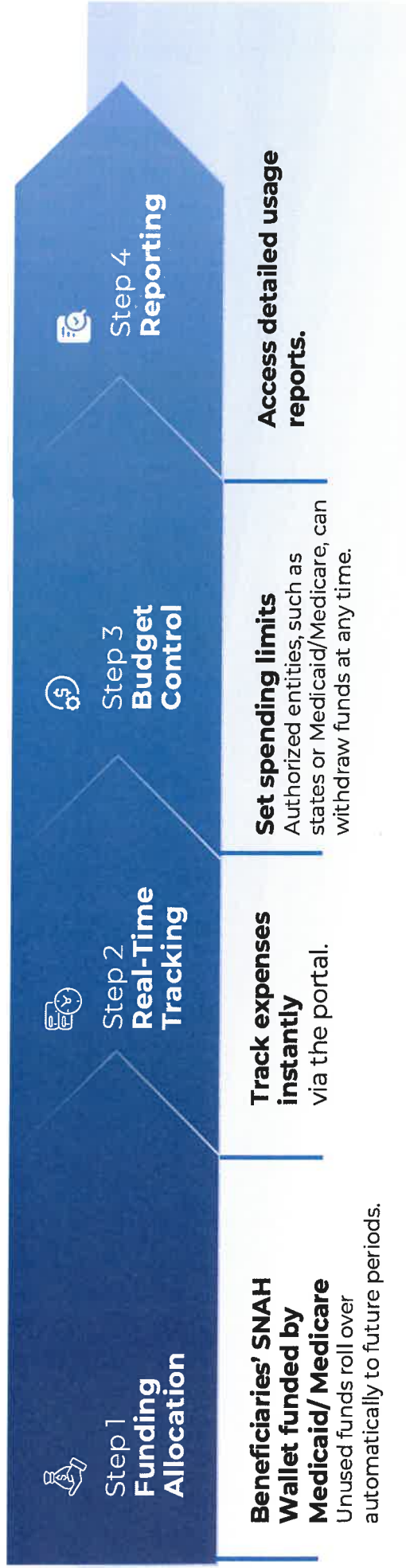


1099 Drivers Receive and Confirms Booking

Seamless. Fast. Real-Time.



SNAH Wallet: Controlling Medicaid & Medicare Cost Management



Real-time monitoring	Controlled budgets	Streamlined administration	Compliance-ready reports
Efficiently manage NEMT and home healthcare costs			
5			

PROBLEM



Home Care: High Costs, Inefficiencies, and Quality Gaps

			
Rigid Rules	Fragmented Systems = Poor Care	Low Standards = Unsafe Care	Manual Processes = No Real-Time Insight
20% higher costs due to mandatory service hours. Unaffordability for Medicaid/ Medicare beneficiaries.	Disconnected services increase hospital visits.	40% of agencies fail basic safety checks.	Frequent billing errors and hidden compliance risks.

SOLUTION

SNAH: Revolutionizing Home Care



Instant Access
to Care

1099 Caregivers in
30 minutes—
no waiting.



Guaranteed Safety
Standards

**Vetted
caregivers**
meet the highest safety
requirements.



All-in-One
Platform

Home care, telehealth,
and medication
in one place.

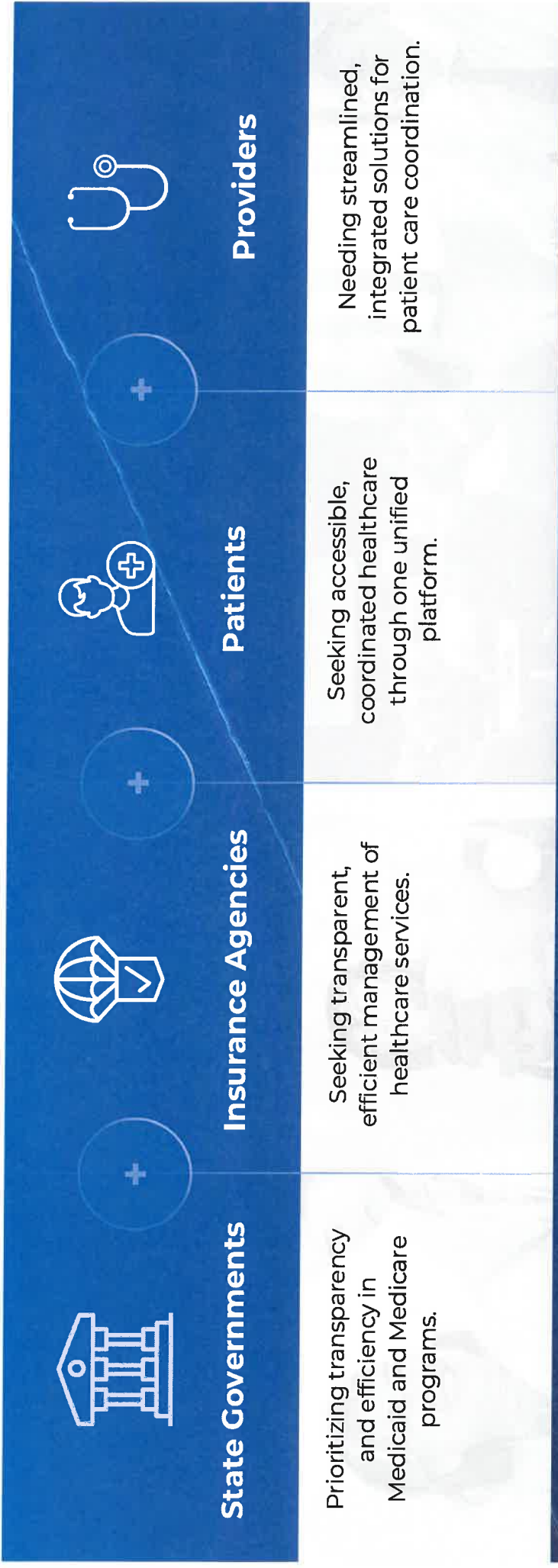


Full
Transparency

Real-time tracking
and clear costs—
no surprises.

OPPORTUNITY

SNAH's Audience



SNAH delivers **integrated solutions** tailored to the needs of all key healthcare stakeholders.

TEAM



Our Leadership Team and Advisors

Our team combines expertise in healthcare, technology, and business to drive SNAH's mission forward.



Hans Lindor
CEO/ Co-Founder

- Managed NEMT dept
- Partners Main Contact
- Published Author
- Motivational Speaker



Elena Lopez
COO/ Co-Founder

- Managed Home-care agency & Assisted Living Facility
- HIPAA certified
- State Certified



Paulina Wierzbicka
President

- Board Member



Michael Earley
Board Member

- Managing Director – Earley Group, LLC.



Lumana Joseph
Board Member

- Private Practice
- Chairwoman of Haitian American Chamber Commerce of Florida



William Nerestant
DDS - Midtown Dental

- Advisor



Nastane Le Bec
MD - OSG Healthcare

- Advisor



Carmen Atkins - Esq.
Attorney, Law Offices of Robert M. Bell

- Advisor



David Clark
President, SkyTrace Ventures

- Advisor/Consultant

THANK YOU!

Detailed financials
available upon
request

Contact

Paulina Wierzbicka
President

paulina.wierzbicka@snah.org



W-9

SNAH Healthcare Software Management

**Request for Taxpayer
Identification Number and Certification**

Go to www.irs.gov/FormW9 for instructions and the latest information.

**Give form to the
requester. Do not
send to the IRS.**

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.) SNAH Healthcare Software MGT	
	2 Business name/disregarded entity name, if different from above.	
	3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. ☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate ☒ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. ☐ Other (see instructions)	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ (Applies to accounts maintained outside the United States.)
	3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions ☐	
	5 Address (number, street, and apt. or suite no.). See instructions. 9440 Santa Monica Blvd	Requester's name and address (optional)
6 City, state, and ZIP code Beverly Hills, CA 90210		
7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number	
or	
Employer identification number	
93	2289829

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person Hans Lindor	Date 07/04/2025
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

must obtain your correct taxpayer identification number (TIN), which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid).
- Form 1099-DIV (dividends, including those from stocks or mutual funds).
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds).
- Form 1099-NEC (nonemployee compensation).
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers).
- Form 1099-S (proceeds from real estate transactions).
- Form 1099-K (merchant card and third-party network transactions).
- Form 1098 (home mortgage interest), 1098-E (student loan interest), and 1098-T (tuition).
- Form 1099-C (canceled debt).
- Form 1099-A (acquisition or abandonment of secured property).

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

Caution: If you don't return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding*, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued);
2. Certify that you are not subject to backup withholding; or
3. Claim exemption from backup withholding if you are a U.S. exempt payee; and
4. Certify to your non-foreign status for purposes of withholding under chapter 3 or 4 of the Code (if applicable); and
5. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting is correct. See *What Is FATCA Reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding. Payments made to foreign persons, including certain distributions, allocations of income, or transfers of sales proceeds, may be subject to withholding under chapter 3 or chapter 4 of the Code (sections 1441–1474). Under those rules, if a Form W-9 or other certification of non-foreign status has not been received, a withholding agent, transferee, or partnership (payor) generally applies presumption rules that may require the payor to withhold applicable tax from the recipient, owner, transferor, or partner (payee). See Pub. 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

The following persons must provide Form W-9 to the payor for purposes of establishing its non-foreign status.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the disregarded entity.
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the grantor trust.
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust and not the beneficiaries of the trust.

See Pub. 515 for more information on providing a Form W-9 or a certification of non-foreign status to avoid withholding.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person (under Regulations section 1.1441-1(b)(2)(iv) or other applicable section for chapter 3 or 4 purposes), do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515). If you are a qualified foreign pension fund under Regulations section 1.897(l)-1(d), or a partnership that is wholly owned by qualified foreign pension funds, that is treated as a non-foreign person for purposes of section 1445 withholding, do not use Form W-9. Instead, use Form W-8EXP (or other certification of non-foreign status).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a saving clause. Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.–China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if their stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.–China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first Protocol) and is relying on this exception to claim an exemption from tax on their scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include, but are not limited to, interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third-party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester;
2. You do not certify your TIN when required (see the instructions for Part II for details);
3. The IRS tells the requester that you furnished an incorrect TIN;
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only); or
5. You do not certify to the requester that you are not subject to backup withholding, as described in item 4 under "*By signing the filled-out form*" above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier.

What Is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all U.S. account holders that are specified U.S. persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you are no longer tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

• **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note for ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040 you filed with your application.

• **Sole proprietor.** Enter your individual name as shown on your Form 1040 on line 1. Enter your business, trade, or "doing business as" (DBA) name on line 2.

• **Partnership, C corporation, S corporation, or LLC, other than a disregarded entity.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

• **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. Enter any business, trade, or DBA name on line 2.

• **Disregarded entity.** In general, a business entity that has a single owner, including an LLC, and is not a corporation, is disregarded as an entity separate from its owner (a disregarded entity). See Regulations section 301.7701-2(c)(2). A disregarded entity should check the appropriate box for the tax classification of its owner. Enter the owner's name on line 1. The name of the owner entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For

example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2. If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, enter it on line 2.

Line 3a

Check the appropriate box on line 3a for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3a.

IF the entity/individual on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation.
• Individual or • Sole proprietorship	Individual/sole proprietor.
• LLC classified as a partnership for U.S. federal tax purposes or • LLC that has filed Form 8832 or 2553 electing to be taxed as a corporation	Limited liability company and enter the appropriate tax classification: P = Partnership, C = C corporation, or S = S corporation.
• Partnership	Partnership.
• Trust/estate	Trust/estate.

Line 3b

Check this box if you are a partnership (including an LLC classified as a partnership for U.S. federal tax purposes), trust, or estate that has any foreign partners, owners, or beneficiaries, and you are providing this form to a partnership, trust, or estate, in which you have an ownership interest. You must check the box on line 3b if you receive a Form W-8 (or documentary evidence) from any partner, owner, or beneficiary establishing foreign status or if you receive a Form W-9 from any partner, owner, or beneficiary that has checked the box on line 3b.

Note: A partnership that provides a Form W-9 and checks box 3b may be required to complete Schedules K-2 and K-3 (Form 1065). For more information, see the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

If you are required to complete line 3b but fail to do so, you may not receive the information necessary to file a correct information return with the IRS or furnish a correct payee statement to your partners or beneficiaries. See, for example, sections 6698, 6722, and 6724 for penalties that may apply.

Line 4 Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third-party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space on line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).

- 2—The United States or any of its agencies or instrumentalities.
- 3—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities.
- 5—A corporation.
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or territory.
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission.
- 8—A real estate investment trust.
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940.
- 10—A common trust fund operated by a bank under section 584(a).
- 11—A financial institution as defined under section 581.
- 12—A middleman known in the investment community as a nominee or custodian.
- 13—A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
• Interest and dividend payments	All exempt payees except for 7.
• Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
• Barter exchange transactions and patronage dividends	Exempt payees 1 through 4.
• Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5. ²
• Payments made in settlement of payment card or third-party network transactions	Exempt payees 1 through 4.

¹ See Form 1099-MISC, Miscellaneous Information, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) entered on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37).

B—The United States or any of its agencies or instrumentalities.

C—A state, the District of Columbia, a U.S. commonwealth or territory, or any of their political subdivisions or instrumentalities.

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i).

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i).

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state.

G—A real estate investment trust.

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I—A common trust fund as defined in section 584(a).

J—A bank as defined in section 581.

K—A broker.

L—A trust exempt from tax under section 664 or described in section 4947(a)(1).

M—A tax-exempt trust under a section 403(b) plan or section 457(g) plan.

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, enter "NEW" at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have, and are not eligible to get, an SSN, your TIN is your IRS ITIN. Enter it in the entry space for the Social security number. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.SSA.gov. You may also get this form by calling 800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/EIN. Go to www.irs.gov/Forms to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to www.irs.gov/OrderForms to place an order and have Form W-7 and/or Form SS-4 mailed to you within 15 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and enter "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, you will generally have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon. See also *Establishing U.S. status for purposes of chapter 3 and chapter 4 withholding*, earlier, for when you may instead be subject to withholding under chapter 3 or 4 of the Code.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third-party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor ²
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
6. Sole proprietorship or disregarded entity owned by an individual	The owner ³
7. Grantor trust filing under Optional Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))**	The grantor ⁴

For this type of account:	Give name and EIN of:
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity ⁴
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing Form 1041 or under the Optional Filing Method 2, requiring Form 1099 (see Regulations section 1.671-4(b)(2)(i)(B))**	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name on line 1, and enter your business or DBA name, if any, on line 2. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

***Note:** The grantor must also provide a Form W-9 to the trustee of the trust.

****** For more information on optional filing methods for grantor trusts, see the Instructions for Form 1041.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information, such as your name, SSN, or other identifying information, without your permission to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax return preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity, or a questionable credit report, contact the IRS Identity Theft Hotline at 800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 877-777-4778 or TTY/TDD 800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the FTC at www.ftc.gov/idtheft or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see www.IdentityTheft.gov and Pub. 5027.

Go to www.irs.gov/IdentityTheft to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their laws. The information may also be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payors must generally withhold a percentage of taxable interest, dividends, and certain other payments to a payee who does not give a TIN to the payor. Certain penalties may also apply for providing false or fraudulent information.



Secretary of State Certificate of Status

I, SHIRLEY N. WEBER, PH.D., California Secretary of State, hereby certify:

Entity Name: SNAH Healthcare Software MGT, LLC
Entity No.: 202358116477
Registration Date: 07/11/2023
Entity Type: Limited Liability Company - CA
Formed In: CALIFORNIA
Status: Active

The above referenced entity is active on the Secretary of State's records and is authorized to exercise all its powers, rights and privileges in California.

This certificate relates to the status of the entity on the Secretary of State's records as of the date of this certificate and does not reflect documents that are pending review or other events that may impact status.

No information is available from this office regarding the financial condition, status of licenses, if any, business activities or practices of the entity.



IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of September 16, 2025.

SHIRLEY N. WEBER, PH.D.
Secretary of State

Certificate No.: 368671127

To verify the issuance of this Certificate, use the Certificate No. above with the Secretary of State Certification Verification Search available at bizfileOnline.sos.ca.gov.



SNAH EMPLOYEE HANDBOOK & POLICY MANUAL

www.snah.org

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SNAH Healthcare Software Management

SNAH Healthcare Software Management is an American healthcare technology company that offers an integrated digital platform combining telemedicine, mobile doctor house calls, non-emergency medical transportation (NEMT), home healthcare services, medication management, and prescription delivery.

The company was founded by Hans Lindor (Chief Executive Officer and Co-founder) and Elena Lopez (President and Co-founder), with Paulina Wierzbicka serving as Executive Director and Minority Owner. The platform launched in 2024 and is available across all 50 U.S. states.

Overview

SNAH was founded in July 2023 with the goal of simplifying healthcare delivery and improving patient outcomes through integrated digital infrastructure. The platform was created to address inefficiencies in the U.S. healthcare system, including missed appointments, limited access to home-based care, fragmented care coordination, and transportation barriers.

The company's mission is to streamline access to care and ensure that individuals—regardless of geography or socioeconomic status—can receive timely, affordable, and high-quality healthcare. SNAH combines technology with on-demand and scheduled services across telehealth, caregiving, transportation, and medication support.

Who We Are

SNAH is a modern, tech-driven healthcare company committed to reshaping how individuals and families access care. With a user-friendly platform and nationwide network, we connect people with licensed providers, caregivers, and essential health services — anytime, anywhere.

Our mission is simple: to make quality healthcare accessible, seamless, and responsive for every patient, regardless of age or condition. Whether you're recovering from surgery, managing a chronic illness, or supporting a loved one, SNAH puts trusted care within reach.

What We Offer

From mobile doctor visits and medication delivery to home health aides and telehealth consultations, SNAH covers a wide range of essential services. We work with insurance providers, caregivers, and healthcare professionals to ensure real-time coordination and peace of mind.

Our technology supports:

- **Real-time scheduling and service tracking**
- **HIPAA-compliant communication and data protection**
- **Transparent pricing and insurance integration**
- **A single platform for patients, families, and providers**

Our Mission

At SNAH, we're dedicated to offering an inclusive healthcare solution that's accessible and affordable, especially for underserved communities. Our goal is to alleviate healthcare cost burdens for providers and state agencies while ensuring patients receive efficient, safe, and high-quality care.

Our Vision

We envision a future where healthcare is accessible, convenient, and personalized. SNAH aspires to be the go-to platform for individuals and healthcare providers, fostering a collaborative ecosystem that prioritizes patient well-being.

Our Core Values

1. Accessibility

We believe healthcare should be easy to reach — for everyone, everywhere. Our services break down barriers to access, especially for vulnerable and underserved populations.

2. Compassion

At the heart of what we do is empathy. We treat every patient, partner, and provider with kindness, understanding, and respect.

3. Innovation

We embrace technology to simplify care delivery. Our solutions are forward-thinking, user-friendly, and built for real-world needs.

4. Reliability

You can count on SNAH. We deliver consistent, timely, and high-quality support — from transportation to telemedicine.

Policy Against Workplace Harassment

SNAH is committed to maintaining a workplace that is respectful, inclusive, and free from any form of harassment. We do not tolerate harassment of any kind—whether verbal, physical, visual, or digital—by or against employees, contractors, clients, or visitors.

What Constitutes Harassment?

Harassment includes, but is not limited to:

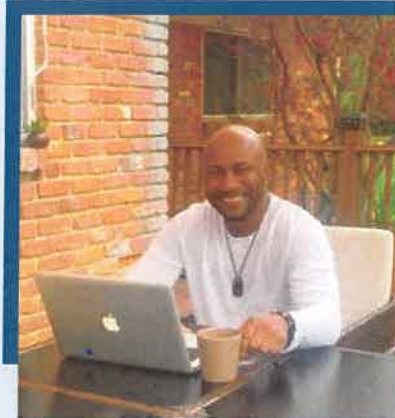
- **Offensive or unwelcome comments related to race, gender, age, religion, sexual orientation, disability, or any protected status**
- **Inappropriate jokes, gestures, emails, or visual displays**
- **Sexual harassment, including unwanted advances, comments, or physical contact**
- **Bullying, intimidation, or any behavior that creates a hostile or threatening work environment**

Reporting Harassment

If you experience or witness harassment:

- **Speak up if you feel safe doing so**
- **Report immediately to your supervisor, Human Resources, or via the SNAH confidential reporting system**
- **All complaints will be investigated promptly, thoroughly, and confidentially**

MEET THE TEAM



Hans Lindor

CEO/ Co-Founder



Elena A. Lopez

Co-founder/President



Michael Earley

Board Chairman



Mohammed Alihasan

Sales Director



Paulina Wierzbicka

Executive Director

Platform Applications

SNAH Healthcare Software Management offers a suite of mobile applications, each designed to serve a specific role in the healthcare delivery system:

- **SNAH User** – A mobile application that allows patients to schedule appointments, attend virtual visits, request non-emergency medical transportation (NEMT), arrange home healthcare services, and receive prescription deliveries.
- **SNAH Ride** – A mobile application that connects patients with drivers for scheduled and on-demand non-emergency medical transportation. It provides real-time dispatching, route optimization, and navigation.
- **SNAH Ride** – A mobile application that connects patients with drivers for scheduled and on-demand non-emergency medical transportation. It provides real-time dispatching, route optimization, and navigation.
- **SNAH Caregiver** – A mobile application that enables caregivers to manage service assignments, track shifts, and provide support such as mobility assistance, companionship, post-operative recovery, and long-term care.
- **SNAH MP** – A mobile application for healthcare providers to conduct virtual consultations, manage house calls, coordinate prescriptions, access electronic medical records (EMRs), and submit medical claims. It integrates with hospital and private practice systems to support continuity of care.

Our Services

SNAH provides the following healthcare services through its integrated platform:

- **Telemedicine** – Remote consultations with licensed providers, including follow-ups, chronic care, and preventive services.
- **Mobile Doctor House Calls** – 24/7 dispatch of licensed physicians to patients' homes for urgent or routine care.
- **Home Healthcare** – Scheduled or on-demand services for recovery, elder care, dementia support, and assistance with daily living activities.
- **Non-Emergency Medical Transportation (NEMT)** – Certified transportation to medical appointments, covered by Medicaid, Medicare, and private insurance plans.
- **Medication Delivery** – Same-day prescription delivery, with refill coordination and secure tracking.
- **Appointment Scheduling & Coordination** – Integrated scheduling with real-time reminders, care notifications, and service updates.

SNAH goes beyond a healthcare app; it's your personalized health hub. We understand that navigating the healthcare landscape can be overwhelming. SNAH simplifies things by offering a suite of features to manage your well-being, all in one convenient place

Some Of Our Features



Appointment Booking



Caregiver Booking



Medicine Delivery



Ride Booking

Review of Personnel and Work Practices

SNAH is committed to upholding the highest standards in employment, performance, and professional conduct. To ensure accountability, consistency, and continuous improvement across our organisation, we regularly review all personnel and work practices.

Performance Evaluations

We conduct scheduled performance evaluations to:

- **Provide constructive feedback and recognise achievements**
- **Identify training needs and growth opportunities**
- **Align individual goals with departmental and organisational objectives**
- **Promote fairness in promotions, rewards, and discipline**

Work Practice Standards

Employees and contractors are expected to:

- **Maintain punctuality and adhere to scheduled hours**
- **Follow all company policies and standard operating procedures (SOPs)**
- **Use technology and resources responsibly and ethically**
- **Communicate professionally with colleagues, clients, and partners**
- **Protect patient confidentiality and sensitive data**

Guidelines for Outside Employment

- **No Conflict of Interest:** Outside work must not interfere with your duties at SNAH or present a conflict of interest with our mission, operations, or clients.
- **Maintain Job Performance:** Employees are expected to meet all performance expectations and responsibilities at SNAH, regardless of any secondary employment.
- **Use of Company Resources:** Employees may not use SNAH resources (e.g., time, equipment, systems, or proprietary information) for any outside employment purposes.
- **Disclosure Requirement:** Employees are required to disclose any outside employment to their supervisor or HR to ensure no conflicts exist.
- **Healthcare Industry Restrictions:** Employees may not work for a competitor, vendor, or any entity that could compromise SNAH's business interests without written approval from executive leadership.

Violation of Policy

Failure to comply with this policy may result in disciplinary action, up to and including termination. Each situation will be assessed individually to ensure fairness and transparency.

SNAH Wallet

SNAH Wallet functions as a prepaid digital health card designed for Medicaid, Medicare, and state healthcare programs. Each beneficiary receives preloaded monthly funds, which can be used exclusively for approved services such as transportation or in-home healthcare. Transactions are tracked in real time, and the wallet connects directly to patients' healthcare benefits. Medicare-covered services are automatically managed through the wallet, offering budget visibility and cost controls for agencies and payers.

Technology

SNAH's technology infrastructure supports an integrated, multi-service platform with capabilities across patient, provider, caregiver, and driver workflows. The system includes:

- **Unified access via mobile and web applications for all user types**
- **Real-time dispatch and service tracking for transportation and care delivery**
- **HIPAA-compliant data storage and transmission**
- **Electronic data interchange (EDI) and API integrations with providers, pharmacies, and insurers**
- **Budget management and fund tracking via the SNAH Wallet**
- **In-app notifications, reminders, and service updates**
- **Centralized tools designed to support patients, families, caregivers, and healthcare institutions**

SNAH Services and Rates

All visits are provided by licensed Nurse Practitioners and available 24/7.

In-Home Visit – \$320

A full urgent or primary care evaluation, including vitals, diagnosis, treatment plan, and prescription if needed.

After-Hours Visit (8 PM – 7 AM) – \$575

Urgent evening or weekend in-home care provided by a licensed Nurse Practitioner.

Telehealth Consultation – \$150

15–30 minute video visit for diagnosis, medication management, mental health support, or follow-up care.

Post-Hospital Discharge Visit – \$320

Follow-up visit focused on reducing readmission risk; includes vitals assessment, medication reconciliation, and wound check.

Annual Physical / Wellness Exam – \$320

Comprehensive preventive exam with screenings and ongoing care recommendations.

Monthly Chronic Care Plan – \$850/month

Includes two in-home visits, two telehealth sessions, and remote vitals monitoring — ideal for high-risk or complex care patients.

Palliative / Senior Home Care Visit – \$320

Routine or urgent in-home medical support for elderly, homebound, or end-of-life patients.

Add-On Services

- **Mobile Lab Testing (CBC, CMP, A1C, Lipid Panels, etc.): \$120–\$240**
- **Blood Draw (Standalone): \$90**
- **Wound Care / Dressing Changes: \$95**
- **In-Home Injections (e.g., B12, allergy, other prescribed meds): \$50**
- **IV Therapy (e.g., fluids, vitamin blends): \$90**
- **Remote Monitoring Setup (blood pressure, glucose, pulse ox): \$165**
- **Vaccinations (flu, COVID, tetanus, etc.): \$70 + cost of vaccine**

CONTACT INFORMATION



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<https://www.youtube.com/@snah-software>



<https://x.com/NBUCare>



<https://www.linkedin.com/company/snahinc/>



SNAH Ride



DRIVER'S TRAINING





Driver Training

- The Human Connection

You will be engaging directly with SNAH Users and in some cases, SNAH Users who are elderly, have mobility restrictions and/or chronic medical conditions. These SNAH Users can be very sensitive and are influenced significantly by the interaction and services of the transportation provider.

We touch our SNAH Users in a unique and personal way. By the end of this training, you will better understand the special circumstances and conditions of the SNAH User you are servicing.



What a SNAH User most of the times may be:

- Typical profile: 78 year old female, frail, multiple conditions requiring transportation to appointments – may have caretaker accompanying
- Common ailments and concerns: arthritis, overweight, compromised sight, hard of hearing, difficulty walking/moving, possibly easily confused with new experiences.



C.L.E.A.R.

Connect

Recommendations for greeting and treating SNAH Users in a special way

Listen

Techniques for making SNAH Users feel as if you are paying attention

Explain

Strategies for SNAH Users understanding what's going to happen, and why

Ask

Patiently responding to questions

Re-connect

Techniques for ending the transport on a positive note



Connect

Recommendations for greeting and treating SNAH Users in a special way

Step out of the car and signal the SNAH User.

“Good morning/afternoon Mr. or Ms.”

Escort the SNAH User to the vehicle and open the car door and/or offer to assist putting any equipment away appropriately.

Always address SNAH User by first name.

Smile when you talk...it affects your tone.

Make the SNAH User the center of focus.

Make eye contact; Avoid being distracted

Be always respectful. Apologize if there was a wait. Be aware of time.

In the vehicle, manage polite conversation as appropriate.

Treat with respect i.e. open door, help with the equipment



Listen

Techniques for making SNAH Users feel as if you are paying attention

Prohibits:

Use active listening skills:

Ask for understanding on what you've said to them.

Example: "Dropping you at the front door?" "No, X-Ray is around the back."

Answer questions the SNAH User might have.

Example:

- "How long will it take to get there?"
- "What route are you taking?"

Summarize what the SNAH User says before moving on.

Example: "Yes, Mrs. Jane, you are going to the Downey Care Center for a 1pm appointment, located at"

Use simple words when responding

- Example: Instead of 'destination' use 'going to



Explain

Strategies for SNAH User's understanding what's going to happen and why

Best Practice and Special Situations

Transparent about destination

Assess current situation and offer assistance

i.e. "May I help you get into the car?" "May I put your cane in the back seat for you?"

Special assistance for certain conditions – again, ask if the SNAH User wants help and get permission to help. i.e. "What help can I be to get you in the car comfortably?"



Ask

SNAH User respond to questions

Always ask the SNAH User if there are any questions.

SNAH User may ask: "Will you be picking me up?"

Driver response: "Possibly, however, it might be someone different". Ask the SNAH User if the temperature is comfortable in the car.

Are there other questions that current passengers ask? What's your normal response?



Reconnect

Techniques for ending the transport on a positive note

- Reassurance of destination
- Tell SNAH User what you are doing
- Inform SNAH User about any road work/detour
- Reiterating SNAH User's first name
- Exiting vehicle, open SNAH User's door:
- Wait to see if SNAH User can get out of the vehicle safely and then escort into location
- End transport with "Hope your appointment goes/went well. And Thank for riding with SNAH Ride today."



As opposed to other transportation services that provide only handoff or curb-to-curb service, we provide door-through-door service to ensure our client's safety. We help our elderly enjoy an independent life by giving them the ability to get out and about, whether for medical appointment, shopping or social events. This experience helps them reduce stress and live happier, healthier, longer lives.

We specialize in transporting our customers to medical appointment, physical therapy, chemotherapy, dialysis, pulmonary and cardio rehabilitation, shopping, errands, recreational and social functions and more.

We are active individuals who love helping others! Mature drivers are more in touch with the needs and desires of seniors. They are patient and positive, with great people skills, dependable, honest and caring. This in turn gives our clients a peace of mind and the highest quality of service.



Welcome to SNAH Ride

Thanks to improved elderly care, more seniors are living well into their 80's and 90's. Most are capable of maintaining self-reliance with transportation help and assistance. That's what we do. We offer affordable, trustworthy, and caring transportation services for seniors.



SMALL BUSINESS

The Cost Of Upcoding: What Industry Leaders Can Do To Combat Healthcare Fraud

By **Paulina Wierzbicka**, Forbes Councils Member.

for **Forbes Business Council**, **COUNCIL POST** | Membership (fee-based)

Published Jun 26, 2025 at 07:00am EDT

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Paulina Wierzbicka | *Executive Director of SNAH Healthcare Software Management.*



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The U.S. Department of Justice has launched an investigation into UnitedHealth Group, the nation's largest health insurance provider, over allegations of Medicare fraud. According to [an article from *The Wall Street Journal*](#) (registration required), the investigation focuses on suspicions that UnitedHealth engaged in upcoding. This is a practice in which insurers record diagnoses that allow them to collect larger reimbursements from Medicare.

While UnitedHealth has denied any wrongdoing, the implications of a probe like this stretch far beyond one corporation's reputation. It brings attention to what I see as a deeply flawed healthcare system, one that is riddled with loopholes, obscured by bureaucracy and increasingly out of reach for the average American. This system has the potential to leave patients behind and inflate the cost of care for everyone.

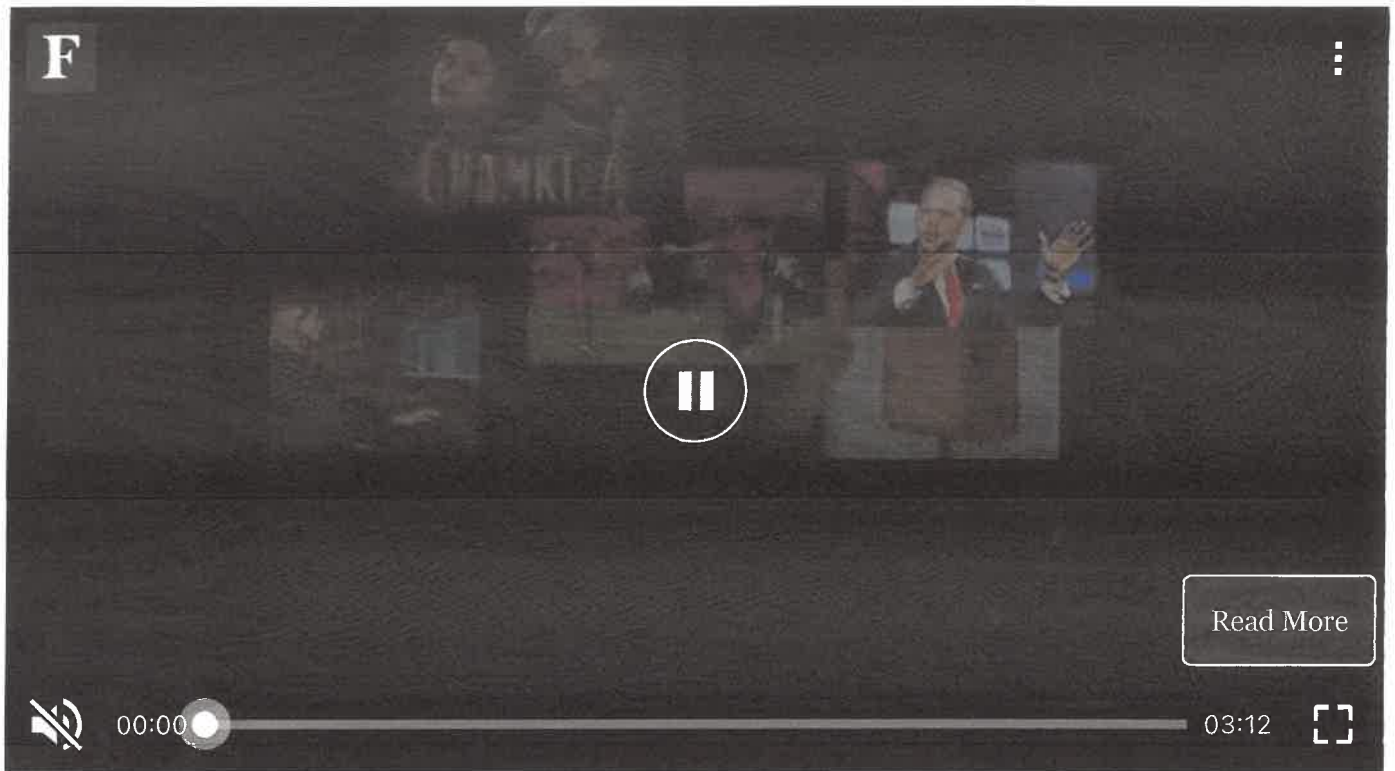
The Real Price Of Upcoding

Medicare Advantage, a program originally designed to offer a cost-effective and flexible alternative to traditional Medicare, can be exploited. Through upcoding, insurers can extract [billions](#) in overpayments from the government. In fact, while the billing codes may make patients look sicker on paper, the services they receive likely remain unchanged.

The U.S. Department of Justice has said that healthcare fraud, waste and abuse could cost over **\$100 billion** annually. A study from RAND ([via Axios](#)) also suggested that billions of dollars of hospital payments in 2019 were made due to an increase in upcoding. Money lost to fraud could be going toward better treatments, staffing or innovation.

The Costs To Patients

Statistics like these underscore to me how broken the U.S. healthcare system has become, especially for those who need it most. Patients are drowning in complexity. They must navigate multiple apps just to schedule appointments, understand their coverage or check medical records. Each insurance company seems to have its own labyrinth of portals and billing procedures.



Transparency is another issue: Pricing for procedures varies wildly and is often hidden until the bill arrives. Meanwhile, insured individuals may be hesitant to seek care due to expensive co-pays, high deductibles, unpredictable out-of-pocket charges, surprise bills and bureaucratic hurdles. The system isn't just failing—it's actively discouraging people from getting the care they need.

The Relationship Between Fraud And Healthcare Costs

In 2024, medical inflation [rose to 3.3%](#), outpacing general consumer inflation. Fraud like upcoding doesn't just skim money off the top—it sets inflated benchmarks that could drive future cost increases. When insurers game the system, they can distort payment models and inflate the entire marketplace.

Every fraudulent claim becomes part of the data used to set next year's rates, creating a feedback loop where today's deceit has the potential to become tomorrow's financial burden. I believe this is one reason why healthcare in America continues to grow more expensive and less accessible, especially for vulnerable populations.

Resistance To Reform

There are solutions. A number of tools and platforms are available that can help streamline administrative processes, integrate billing systems and improve transparency. (Full disclaimer: My company offers a platform like this, as do others.) These tools have the potential to reduce inefficiencies and curb fraudulent practices.

But real change is hard to achieve. Why? The U.S. healthcare system was [worth trillions of dollars](#) (by spending) as of 2023 and in my experience, is affected by a mix of corporate power, slow-moving politics and rules, as well as a focus on making money. Even the best new ideas often struggle to make progress in Washington or with major insurance companies.

What Industry Leaders Can Do

If wrongdoing in this case is proven, I believe it could lead not only to fines and stricter oversight, but also to a shift in how Medicare Advantage is monitored and paid. Regardless of the outcome, industry players can take a few important steps to

support change:

- **Strengthen oversight.** Fraud shouldn't take years to detect. If you're building tech in this space, partner with regulators and integrate real-time fraud detection into your infrastructure. AI, automation, pattern recognition—use the tools we already have to flag abuse before it spirals. This isn't about compliance. It's about responsibility.
- **Reform payment models.** I think we need to stop paying for codes and start paying for care. This shift starts at the top. If you're leading a hospital system, an insurer or a healthtech platform, ask yourself: Are we rewarding results or rewarding manipulation? Build systems that measure outcomes. Incentivize recovery. The future belongs to leaders who put value over volume—and mean it.

• **Enhance transparency.** Patients shouldn't have to play a guessing game. They should know what care costs, what's covered and what to expect. Leaders should stop hiding behind complexity and start leading with clarity. Publish your pricing. Share your audit data. Make it simple. Trust isn't something you demand. It's something you earn.

• **Protect whistleblowers.** Fraud isn't usually uncovered by audits—it's exposed by people. However, those people won't speak up unless you make it safe for them to do so. If you lead a healthcare company or tech platform, your culture should encourage integrity, not fear. Protect your whistleblowers. Back them. Because the real signals that something's wrong rarely come from the outside—they come from within.

• **Support innovation.** We don't need more apps. We need real solutions. Innovation has to scale. It has to simplify care, close gaps and put patients first. If you're in a position to build or fund the next generation of healthcare tools, focus on what actually reduces friction and improves access. Anything else is noise.

Healthcare fraud isn't just a financial crime—it's a betrayal of public trust. It can jeopardize care that the elderly have earned, inflate premiums for working families and drain critical resources from an already strained system.

We have a rare opportunity to examine the dark corners of a healthcare system that too often prioritizes profits over patients. Whether lawmakers, regulators and industry leaders seize this moment or squander it could help determine whether the U.S. healthcare system sinks further or finally begins to heal.

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By [Paulina Wierzbicka](#) , **COUNCIL POST** | Membership (fee-based). Paulina Wierzbicka | Executive Director of [SNAH Healthcare Software Management](#). Read Paulina Wierzbicka's full executive profile [here](#).

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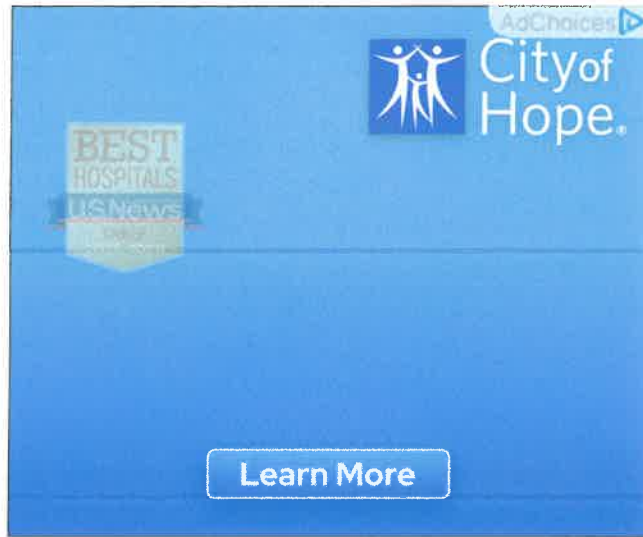


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September 2022

MEDICAID

Efforts to Address Fraud in Nonemergency Medical Transportation

Why GAO Did This Study

The Centers for Medicare & Medicaid Services (CMS) oversees the design and operation of state Medicaid programs, including nonemergency medical transportation. This Medicaid benefit is essential to ensuring beneficiaries' access to necessary health care. CMS has identified it as a program area at risk for fraud.

Congress included a provision in the Consolidated Appropriations Act, 2021 for GAO to examine Medicaid nonemergency medical transportation. This report describes (1) states' approaches to administer this benefit; (2) outcomes and findings of related fraud investigations and program audits; and (3) strategies selected states used to address related fraud.

GAO reviewed relevant federal statutes, regulations, and guidance, as well as documentation across 50 states and the District of Columbia to determine their approaches to administering this benefit. GAO also reviewed related fraud investigations and program audits conducted by Medicaid Fraud Control Units, the Department of Health and Human Services' Office of Inspector General, and state audit organizations.

In eight states, GAO interviewed Medicaid officials. In seven of these states, GAO also interviewed officials from Medicaid Fraud Control Units and contractors that administered the benefit, such as brokers or managed care organizations. The eight states were selected based on variation in benefit approaches and geography.

View [GAO-22-105447](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

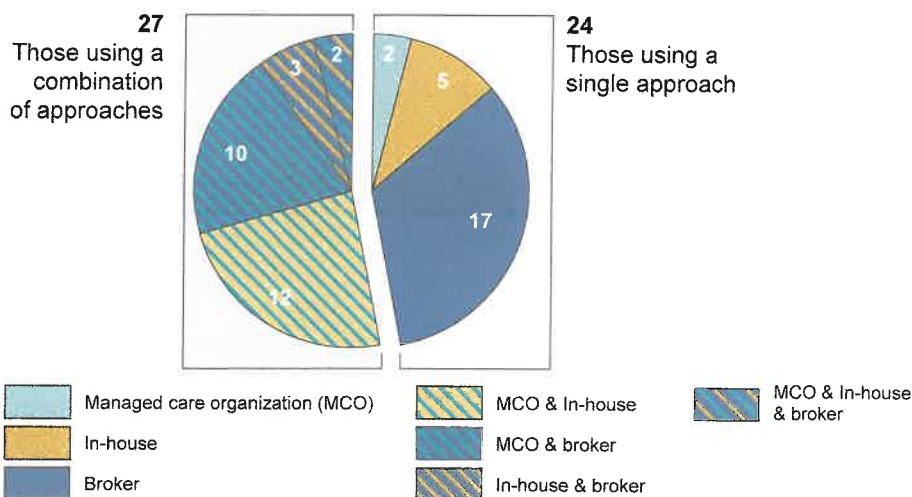
MEDICAID

Efforts to Address Fraud in Nonemergency Medical Transportation

What GAO Found

State Medicaid programs are required to provide nonemergency medical transportation to beneficiaries who are unable to provide their own transportation to medical appointments. Within broad federal guidelines, states have flexibility in how they administer this benefit; GAO found that states used three broad approaches to do so. These approaches included administering the benefit directly (in-house), contracting with third-party transportation brokers, or contracting with managed care organizations. Most states used a combination of these approaches.

Approaches to Administer Medicaid Nonemergency Medical Transportation in 50 States and the District of Columbia, December 2021



Source: GAO analysis of Medicaid nonemergency medical transportation in 50 states and the District of Columbia. | GAO-22-105447

Federal and state agencies have identified fraud and non-compliance with requirements related to Medicaid nonemergency medical transportation. From fiscal years 2015 to 2020, state Medicaid Fraud Control Unit investigations resulted in nearly 200 criminal convictions, civil settlements, and judgments against transportation providers in 25 states. Officials in three selected states said that credible allegations of fraud included providers billing for trips that were not provided or providing trips with unauthorized drivers or vehicles.

State officials and their contractors in seven selected states identified a variety of strategies to address fraud, including the following:

- **Provider and vehicle screening**, such as enrolling providers and monitoring driver and vehicle credentials.
- **Pre-trip approval**, such as verifying eligibility prior to scheduling a trip.
- **Post-trip validation**, such as validating that trips occurred through trip logs, GPS data, and claims reviews.

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Figure 1: Approaches to Administer Medicaid Nonemergency Medical Transportation (NEMT) in 50 States and the District of Columbia, December 2021

9

Abbreviations

CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services' Office of Inspector General
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
NEMT	nonemergency medical transportation
UPIC	Unified Program Integrity Contractor

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September 28, 2022

The Honorable Ron Wyden
Chairman
The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy and Commerce
House of Representatives

A lack of transportation can be a barrier to accessing health care. A recent study found that across the United States in 2017, 5.8 million individuals delayed medical care because they did not have transportation.¹ States are required to provide Medicaid's nonemergency medical transportation (NEMT) benefit to beneficiaries who are unable to provide their own transportation to medical appointments.² As such, NEMT is essential to helping millions of low income and disabled beneficiaries access vital health care services.

Both the federal government and states share responsibility for ensuring Medicaid beneficiaries' access to quality services, including NEMT, and for ensuring the integrity of the program. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), monitors states' compliance with federal Medicaid requirements, including efforts to identify fraudulent or improper payments. Since 2003, we have identified Medicaid as a high-risk program due to a number of concerns, including improper payments and

¹See M.K. Wolfe, N.C. McDonald, and G.M. Holmes, "Transportation Barriers to Health Care in the United States: Findings from the National Health Interview Survey, 1997–2017," *American Journal of Public Health*, vol. 110, no. 6 (2020).

²Medicaid is a federal-state health financing program for certain low-income and medically needy individuals.

the need for more accurate and complete data.³ Specific to Medicaid NEMT, we previously reported that CMS guidance to states on administering the benefit was outdated or may be of limited use, because of legislative and other changes.⁴ The Consolidated Appropriations Act, 2021 required CMS to review and update existing NEMT guidance, and mandated several other NEMT program integrity requirements.⁵ For example, the act included provisions to ensure NEMT providers meet certain minimum standards, such as having a valid driver's license. It also required CMS to hold listening sessions to gather information from stakeholders about leading practices to improve NEMT.⁶

Further, the act included a provision for us to examine Medicaid coverage of NEMT, including states' efforts to prevent and detect NEMT-related fraud and incidents of such fraud that have been identified.⁷ This report describes

1. approaches states have used to administer Medicaid NEMT;
2. outcomes and findings of Medicaid NEMT fraud investigations and program audits; and
3. strategies selected states have used to address fraud in Medicaid NEMT.

For all three objectives, we reviewed relevant federal laws, regulations, and CMS guidance, as well as interviewed and reviewed written responses from CMS officials on the agency's administration and oversight of Medicaid NEMT. We also interviewed five organizations that

³See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, [GAO-21-119SP](#) (Washington, D.C.: Mar. 2, 2021).

⁴See GAO, *Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States*, [GAO-16-238](#) (Washington, D.C.: Feb. 2, 2016).

⁵Pub. L. No. 116-260, div. CC, title II, § 209(b), 134 Stat. 1182, 2987 (2020).

⁶In March and April 2022, CMS held four public sessions on topics such as program integrity, documentation and data requirements, and provider enrollment requirements, among others. For more information, see Centers for Medicare & Medicaid Services, "Assurance of Transportation" (Baltimore, Md.), accessed July 7, 2022, <https://www.medicaid.gov/medicaid/benefits/assurance-of-transportation/index.html>.

⁷For Medicaid program integrity purposes, fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." 42 C.F.R. § 455.2 (2021). The definition also includes any act that constitutes fraud under applicable federal or state law.

represent a range of perspectives on NEMT, including beneficiary advocates and transportation providers.

To describe the approaches states have used to administer Medicaid NEMT, we reviewed state Medicaid program documentation—including any applicable state plans, beneficiary handbooks, provider manuals, and contracts with brokers and managed care organizations (MCO)—from all 50 states and the District of Columbia.⁸ For more in-depth information on states' NEMT approaches, we interviewed Medicaid officials from a non-generalizable sample of eight states: Alabama, Colorado, Louisiana, New York, Ohio, Oklahoma, Washington, and Wisconsin. We selected these states based on variation in their geography, approach to administering NEMT, and the number of recent NEMT fraud cases. Seven of the selected states contracted with other entities, such as brokers and MCOs, to administer NEMT. We also interviewed officials from nine such entities.⁹

To describe the outcomes and findings of Medicaid NEMT fraud investigations and program audits, we obtained data from HHS's Office of Inspector General's (HHS-OIG) Annual Statistical Report, which includes information on fraud cases related to NEMT providers reported by states' Medicaid Fraud Control Units (MFCU). We analyzed data on the number of criminal convictions, civil settlements, and judgments against NEMT providers reported by 53 MFCUs from fiscal years 2015 through 2020.¹⁰ To assess the reliability of these data, we reviewed information about the data provided by relevant HHS-OIG officials and performed checks to identify missing or incorrect data. Based on these steps, we determined that the data were sufficiently reliable for the purposes of our reporting

⁸This report describes the Medicaid NEMT requirements and approaches as they apply to all states and the District of Columbia, which we refer to collectively as "states" in this report.

⁹These contractors included five brokers, two MCOs, and one transportation manager. In addition, one state delegated NEMT administration to its counties, and we interviewed officials from one such county. For the purposes of this report, we also refer to this county as a contractor. The contractors we interviewed generally administered NEMT to the largest share of Medicaid beneficiaries in these seven selected states.

¹⁰MFCUs—which generally operate within the state attorney general's office—are responsible for, among other things, investigating and prosecuting Medicaid provider fraud, including for NEMT. In fiscal year 2020, there were 53 MFCUs: one in each of the 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Data from this 6-year period were the most recent, comparable data available at the time we conducted our analysis.

objective. To supplement our understanding of MFCU operations and NEMT fraud cases, we interviewed or obtained written responses from MFCU officials in seven selected states and reviewed fraud allegations in three selected states that had investigations resulting in criminal convictions, or civil judgments or settlements during this time period.¹¹ We also reviewed seven HHS-OIG and four state audit organization program audits on Medicaid NEMT issued from 2017 through 2021.¹²

To describe strategies selected states have used to address fraud in Medicaid NEMT, we reviewed selected states' documentation, including their NEMT policies and procedures, contracts with any NEMT administrators, and provider manuals. We also relied on our interviews with Medicaid officials from all eight selected states; MFCU officials from seven selected states; and officials from nine entities that administered NEMT, in full or in part, for seven selected states.

We conducted this performance audit from September 2021 to September 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹¹The Colorado MFCU did not respond to our requests for an interview or provide written responses.

¹²The HHS-OIG audits we examined include all those that resulted in reports issued between 2017 and 2021, the most recent 5-year period at the time we conducted our review. We contacted the state audit organization in all 50 states and the District of Columbia through the National Association of State Auditors, Comptrollers, and Treasurers to identify any NEMT-related audits conducted during this time period; four states provided reports related to such audits. The 11 HHS-OIG and state auditor reports we reviewed examined NEMT benefits in 10 states: Colorado, Connecticut, Indiana, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, and Oklahoma.

Background

Administering NEMT

States have flexibility, within broad federal guidelines, in how they design, administer, and oversee their Medicaid programs, including NEMT.¹³ As such, states may vary the administration of NEMT to account for geography, transportation infrastructure, and the Medicaid population being served. The benefit typically covers the most appropriate, least costly mode of transportation to and from Medicaid-eligible health care services for Medicaid beneficiaries.

- **Eligibility.** NEMT is available to beneficiaries with no other means of accessing services; for example, beneficiaries who are unable to provide their own transportation due to age, disability, or low income. Additionally, an eligible trip must be to necessary Medicaid-approved health care, such as a doctor's appointment, or—depending on the state—trips to the pharmacy.
- **Modes of transportation.** States may cover various modes of transportation, such as public transportation, taxis, mileage reimbursement for use of personal vehicles (including those of friends and family), transportation network companies (such as Uber or Lyft), and wheelchair vans.

As with other Medicaid services, the NEMT benefit can be provided under both fee-for-service (FFS)—in which the state Medicaid agency pays providers on a per-service basis—and managed care—in which the state Medicaid agency pays MCOs a periodic payment per beneficiary to provide Medicaid benefits. In addition, states can administer NEMT directly (referred to as in-house), or contract with a broker or MCO to administer the benefit.

- **In-house.** State manages the benefit directly and generally pays for rides on a FFS basis. In some instances, a state may delegate certain

¹³While states may not exclude coverage of mandatory benefits such as NEMT under their state plans, they may place appropriate limits on a service based on such criteria as medical necessity or may adopt utilization control procedures. See 42 C.F.R. § 440.230(d) (2021). They may also seek a waiver of the NEMT requirement in connection with a Medicaid demonstration project under section 1115 of the Social Security Act. See 42 U.S.C. § 1315(a). This provision authorizes the Secretary of HHS to waive certain federal Medicaid requirements for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to assist in promoting Medicaid objectives.

aspects of administering the benefit, for example, to local government agencies.

- **Broker.** State contracts with a third-party transportation broker to administer NEMT. While broker functions may vary across states, brokers generally act as a single point of contact for the beneficiary and arrange transportation.¹⁴
- **Managed care organizations.** State contracts with MCOs to administer comprehensive Medicaid benefits, including NEMT. In turn, the MCO may contract with a broker to arrange NEMT for beneficiaries.

In fiscal year 2018, NEMT represented upwards of \$2.6 billion of the approximately \$629 billion in Medicaid spending.¹⁵ This spending estimate does not include spending on NEMT provided through MCOs, because payments for NEMT services are not separately reported from other services. In fiscal year 2018, managed care represented about half of all Medicaid spending and enrolled about 70 percent of all beneficiaries.¹⁶

NEMT Oversight

CMS uses a range of regular oversight activities to oversee states' operations of their Medicaid programs, including NEMT, such as reviewing state plans, conducting State Program Integrity Reviews, measuring improper payments, issuing guidance, and providing technical assistance to states upon request. For example:

- **State plans.** Each state must have a plan that describes how it will administer its Medicaid program, including the design and administration of NEMT. A state that makes material changes to any Medicaid policy must amend their state plan and submit updated sections to CMS for approval.¹⁷ CMS officials said that as of June 2022, 46 states had submitted plan amendments describing how they will meet the NEMT provider and driver requirements established under the Consolidated Appropriations Act, 2021. Of these, the agency had approved the amendments submitted by 45 states.

¹⁴For the purposes of this report, brokers include transportation brokers with whom states contract and NEMT Prepaid Ambulatory Health Plans. See 42 C.F.R. §§ 438.9(a), 440.170(a)(4) (2021).

¹⁵See Medicaid and CHIP Payment and Access Commission, *Chapter 5: Mandated Report on Non-Emergency Medical Transportation* (Washington, D.C.: June 2021).

¹⁶This reflects enrollment in comprehensive managed care as of July 1, 2018.

¹⁷42 C.F.R. § 430.12(c) (2021).

-
- **State Program Integrity Reviews.** CMS conducts State Program Integrity Reviews of high-risk areas by assessing the effectiveness of program integrity efforts to identify vulnerabilities and areas of non-compliance in state operations, as well as to assist states in strengthening program integrity operations. According to CMS officials, the agency last conducted State Program Integrity Reviews of NEMT in 2015 in three states (Delaware, North Carolina, and Vermont). Through these audits, CMS identified opportunities to improve NEMT oversight in North Carolina and Vermont. For example, CMS recommended that North Carolina develop policies and procedures to better monitor NEMT providers.¹⁸ In June 2022, CMS indicated it was working on reviews of NEMT in North Carolina and South Dakota.

In addition to its direct oversight activities, CMS provides states access to the agency's Unified Program Integrity Contractors (UPIC). CMS contracts with UPICs to perform certain program integrity functions for Medicaid. For instance, UPICs provide states with analytic and audit support and assistance, and work collaboratively with states to determine areas of audit, including NEMT. Between fiscal years 2018 and 2021, nine states requested UPIC assistance to investigate certain NEMT providers; these investigations resulted in the identification of nearly \$1 million in overpayments.

Beyond state-specific efforts, CMS has outlined plans to undertake an assessment of the fraud risk across Medicaid to help inform its approach to managing fraud risk.¹⁹ As part of this effort, CMS has prioritized risk assessments for program areas the agency has identified as high-risk areas, including NEMT. According to CMS officials, their risk assessment of NEMT aims to comprehensively identify relevant vulnerabilities, assess the risk levels of these vulnerabilities, and identify strategies to mitigate these risks, among other things. As of June 2022, CMS officials indicated that the NEMT risk assessment was in progress.

¹⁸CMS made no recommendations related to NEMT administration in Delaware.

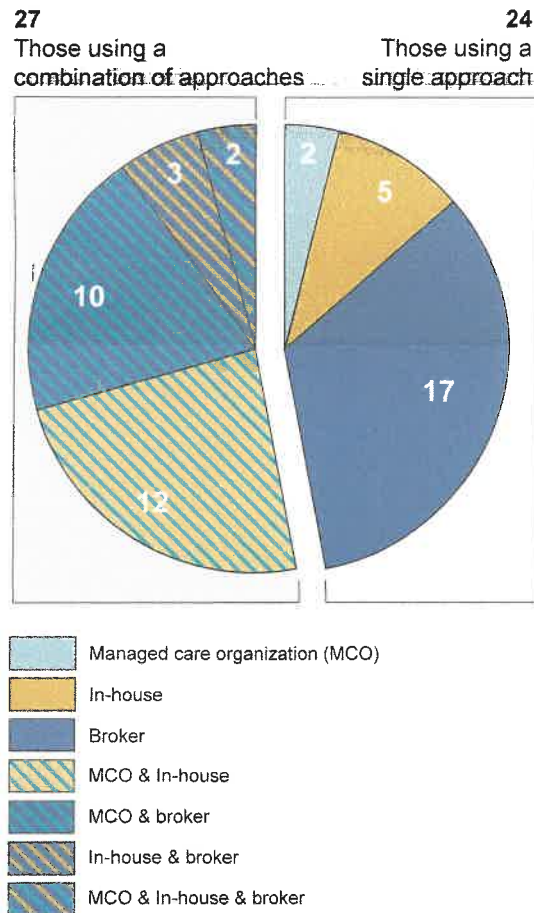
¹⁹In December 2017, we found that CMS had not conducted a fraud risk assessment for Medicaid, and had not designed and implemented a risk-based antifraud strategy. We recommended that CMS conduct a fraud risk assessment for Medicaid. A fraud risk assessment allows managers to fully consider fraud risks to their programs, analyze their likelihood and impact, and prioritize risks. As of March 2022, CMS outlined an approach to conducting a Medicaid fraud risk assessment. For more information, see GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, [GAO-18-88](#) (Washington, D.C.: Dec. 5, 2017).

Most States Used Multiple Approaches to Administer Medicaid Nonemergency Medical Transportation

Our review of program documentation shows that states have adopted various approaches to administer Medicaid NEMT to their beneficiaries. These approaches included administering the benefit in-house, contracting with a broker, contracting with an MCO, or through a combination of these approaches.²⁰ Most states contracted with brokers and MCOs to administer all or a portion of NEMT, while five states administered the benefit solely in-house. Overall, 26 states and the District of Columbia used a combination of approaches to administer NEMT, while 24 states used a single approach to do so. (See fig. 1.)

²⁰In some cases, states using an in-house approach may delegate aspects of administering NEMT—for example, prior authorization activities—to other entities, such as local government agencies.

Figure 1: Approaches to Administer Medicaid Nonemergency Medical Transportation (NEMT) in 50 States and the District of Columbia, December 2021



Source: GAO analysis of Medicaid nonemergency medical transportation in 50 states and the District of Columbia. | GAO-22-105447

Note: Figure totals 51, which includes the NEMT approaches used by 50 states and the District of Columbia. These approaches included administering the benefit directly (in-house), contracting with a broker, contracting with an MCO, or a combination of these approaches.

Selected states also varied in how they administered NEMT. The eight selected states provided examples of the different ways they administered NEMT.

- **Broker.** Officials from five of the selected states told us that the state contracted with brokers to administer NEMT to varying degrees. For example, three states relied exclusively on brokers to administer the benefit. Two of these states—Oklahoma and Wisconsin—used a single, statewide broker, while Washington contracted with six

Appendix II: GAO Contact and Staff Acknowledgments

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In addition to the contact named above, Susan Anthony (Assistant Director), Kelly Krinn (Analyst-in-Charge), Drew Long, Sean Miskell, Melissa Trinh-Duong Ostergard, Monica Scott, and Jennifer Whitworth made key contributions to this report.

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regional brokers in separate geographic regions. The two remaining states—Colorado and Louisiana—used a broker to administer NEMT to specified populations, either based on a beneficiary’s county of residence or enrollment in FFS Medicaid, respectively. The five selected states also varied in how they paid brokers for their services. Oklahoma paid its broker through a capitated arrangement—under which the broker assumed the full financial risk associated with administering NEMT and paying NEMT providers. In contrast, Colorado, Louisiana, Washington, and Wisconsin contracted with their brokers on an administrative-services only basis—under which the state paid brokers a fee to administer NEMT, but assumed the full financial risk associated with the benefit.

- In-house. Officials from the four selected states that administered at least a portion of NEMT in-house shared how their in-house administration of NEMT varied. For example, officials from Alabama noted that the Medicaid agency exclusively used an in-house approach and directly managed all aspects of NEMT. By contrast, officials from three other selected states—Colorado, New York, and Ohio—said that their states combined their in-house administration with the broker or MCO approaches. In addition, two of these states—New York and Ohio—contracted or delegated certain aspects of their in-house administration. For example, Ohio’s Medicaid agency directly managed wheelchair van benefits for FFS beneficiaries and delegated the administration of other NEMT services to its 88 counties. In addition, while New York directly managed payments to NEMT providers, it contracted with transportation managers to arrange transportation. (See table 1.)

Table 1: Summary of Selected States’ Approaches to Administering Medicaid Nonemergency Medical Transportation (NEMT), December 2021

State	Approach	Entity responsible for arranging transportation		Share of beneficiaries (percentage)
Alabama	Single	In-house	The state Medicaid agency authorized transportation, and beneficiaries arranged transportation directly with NEMT providers.	100
Colorado	Combination	In-house	Beneficiaries residing in 55 rural counties arranged transportation directly with NEMT providers.	37
		Broker	One broker arranged transportation for beneficiaries residing in nine metro counties.	63
Louisiana	Combination	Broker	One broker arranged transportation for fee-for-service (FFS) beneficiaries.	15
		MCO	Five managed care organizations (MCO) contracted with five different brokers to arrange transportation for their members.	85

State	Approach	Entity responsible for arranging transportation		Share of beneficiaries (percentage)
New York	Combination	In-house	Two regional transportation managers arranged transportation for beneficiaries in FFS and most MCO plans.	97
		MCO	Twenty-eight long-term care MCOs arranged transportation for their members.	3
Ohio	Combination	In-house	The state Medicaid agency arranged wheelchair van transportation for FFS beneficiaries. The state's 88 counties arranged for less acute modes of transportation for all FFS beneficiaries and for MCO members whose trips were within 30 miles.	11 ^a
		MCO	Six MCOs contracted with brokers to arrange transportation for all MCO members requiring wheelchair vans and transportation using less acute modes for trips more than 30 miles.	89
Oklahoma	Single	Broker	One statewide broker arranged transportation.	100
Washington	Single	Broker	Six regional brokers arranged transportation for beneficiaries in specified geographic areas.	100
Wisconsin	Single	Broker	One statewide broker arranged transportation.	100

Source: GAO analysis of state NEMT documentation and interviews with state officials. | GAO-22-105447

^aBeneficiaries in FFS Medicaid. In addition to the 11 percent of beneficiaries in FFS Medicaid, some MCO members may also receive NEMT through counties.

Officials in the selected states provided examples of how this flexibility helped them tailor their administration of NEMT to meet the differing circumstances across their states:

- Colorado officials noted that the state's combination approach, which includes a broker approach in urban counties and an in-house approach in rural counties, has allowed them to respond to specific regional needs. In particular, these officials said the state's in-house approach in rural counties has allowed beneficiaries in more remote areas of the state to maintain existing provider-beneficiary relationships.
- Ohio officials said the state's combination approach, which relies largely on individual counties and MCOs to administer NEMT, has allowed them to account for differences in transportation resources across the state. For example, urban counties generally have more transportation options—such as public transportation—than rural counties, and MCOs have used transportation network companies to provide NEMT to beneficiaries.
- Washington officials said the state's use of regional brokers has allowed them to ensure continuity of services to beneficiaries, particularly in instances of inclement weather. Specifically, the officials

noted that the brokers were familiar with environmental and seasonal conditions that can affect road conditions in their respective regions. This enabled the brokers to schedule trips to account for road closures that may occur due to events such as fires or local weather conditions.

- Wisconsin officials said the state's use of a single, statewide broker who manages and administers NEMT in a uniform manner across the state has improved the consistency of beneficiaries' NEMT experiences.

Investigations and Program Audits Identified Instances of Fraud or Non-Compliance with Nonemergency Medical Transportation Requirements

Transportation Fraud Investigations Resulted in Criminal Convictions, and Civil Settlements and Judgments in 25 States

From fiscal years 2015 through 2020, state MFCU fraud-related investigations of NEMT providers resulted in 132 criminal convictions, and 57 civil settlements and judgments in 25 states. These cases represented about 2 percent (189 of the total 11,276) of all Medicaid provider fraud-related MFCU investigations with these outcomes during this time period.²¹ The majority (71 percent) of these NEMT cases were concentrated in five states—Indiana, Louisiana, Minnesota, New York, and Ohio. (See table 2 for information on the distribution of MFCU investigations among the 25 states, and app. I for more information on these states.)

²¹Subsequent to the completion of our analysis, the HHS-OIG issued MFCU data for fiscal year 2021, which were consistent with data from the previous years we analyzed. Specifically, in fiscal year 2021, NEMT represented about 2 percent (24 of the total 1,483) of all fraud-related investigations that resulted in criminal convictions, or civil settlements and judgments. Fraud-related investigations related to personal care services were the most common.

Table 2: Distribution of Medicaid Fraud Control Unit (MFCU) Investigations of Nonemergency Medical Transportation (NEMT) Providers Resulting in Criminal Convictions or Civil Settlements and Judgements, Fiscal Years 2015 through 2020

Distribution of investigations	Number of MFCUs	Number of NEMT investigations	NEMT investigations as a share of all MFCU investigations (percentage)
11+ investigations	5	135	71
1 to 10 investigations	20	54	29
0 investigations	28	0	0
Total	53	189	100

Source: GAO analysis of data from the Department of Health and Human Services' Office of the Inspector General (HHS-OIG). | GAO-22-105447

Note: Our analysis included fraud-related investigations of NEMT providers that resulted in criminal convictions, or civil settlements and judgments among 53 MFCUs (the 50 U.S. states, District of Columbia, Puerto Rico, and U.S. Virgin Islands). No MFCU operated in Puerto Rico and the U.S. Virgin Islands from 2015 through 2018 or in North Dakota from 2015 through 2019.

Because of how MFCUs initiate investigations, the distribution of fraud cases cannot be used to assess the extent to which fraud occurs in NEMT. In general, MFCUs initiate investigations based on (1) referrals from external sources, such as the public or other federal and state agencies; or (2) a process of screening and analyzing data called data mining. Thus, the lack of findings from the other 28 MFCUs does not necessarily reflect the absence of fraud, but rather the absence of identified allegations in those states through referrals or data mining.

MFCU officials in three selected states provided additional information about the nature of NEMT fraud-related allegations that resulted in criminal convictions, or civil settlements and judgments in their states. For example, allegations included instances in which NEMT providers did the following:

- Billed Medicaid for services not provided, such as billing for trips to facilities that were closed or on days when the beneficiary did not have a medical appointment.
- Billed Medicaid for ineligible beneficiaries, such as beneficiaries who were hospitalized or deceased.
- Overbilled for services to receive excess payment, such as overcharging for tolls or billing a single trip with multiple beneficiaries as several individual trips.

-
- Used unauthorized drivers or vehicles, such as drivers with suspended licenses or vehicles that were not appropriately certified or inspected.
 - Falsified supporting documentation for services, such as asking individuals to sign for trips that were not provided.

Program Audits Identified Non-Compliance with Certain Transportation Benefit Requirements in 10 States

HHS-OIG and state audit organizations have also assessed states' administration of Medicaid NEMT through program audits, and we reviewed such audits issued between 2017 and 2021. These audits identified non-compliance with certain federal and state NEMT requirements in 10 states.²² Specifically, seven HHS-OIG program audits found that, depending on the state, between 15 and 86 percent of claims were not compliant with benefit requirements, resulting in about \$20 million of improperly paid federal funds. Non-compliance issues included instances in which there was a lack of documentation to support the following:

- A service was provided. For example, one state's documentation did not include trip information, such as the date of service, or pick up and drop off locations. Another state's NEMT providers did not maintain copies of service records after they changed locations or no longer participated in Medicaid.
- Properly credentialed drivers and vehicles. For example, one state could not provide documentation of driver qualifications, such as driver's licenses. Another state could not provide documentation of vehicle inspections, registration, or timely maintenance records.

The HHS-OIG and state program audits recommended states improve their oversight and monitoring of NEMT; for example, by ensuring that NEMT providers maintain proper documentation of services provided, as well as of driver and vehicle credentialing. HHS-OIG also recommended the return of improperly paid federal funds. Although non-compliance is not necessarily indicative of fraud, addressing these recommendations could help reduce the potential for NEMT fraud and improve program integrity.

²²The 10 states were Colorado, Connecticut, Indiana, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, and Oklahoma. At least seven of these 10 states had MFCU investigations that resulted in NEMT fraud-related criminal convictions or civil settlements and judgments in fiscal years 2015 through 2020.

Selected States Cited Oversight Strategies in Four Areas to Address Fraud in Nonemergency Medical Transportation

In all eight selected states, state officials or their contractors provided information about various strategies to address NEMT fraud and often cited the importance of data and technology in improving such efforts. The strategies identified by the state officials and contractors generally fell within four areas:

- **NEMT provider and vehicle screening.** All selected states had initial enrollment and ongoing screening efforts they or their contractors conducted to ensure NEMT providers and vehicles met program requirements, according to officials we interviewed. Strategies included documenting that provider and vehicle credentials met state requirements and inspecting vehicles to ensure they are safe to transport beneficiaries. Officials in four states noted that the state had categorized NEMT providers as a high-risk provider type, meaning the states conducted a site visit and a fingerprint-based criminal background check of each provider prior to enrollment.²³ In addition, when asked about challenges to provider screening, state officials or contractors in four states cited NEMT provider turnover or the lack of standardization of provider credentials.
- **Pre-trip approval.** In all selected states, state officials or their contractors shared processes they had in place to verify beneficiary eligibility, ensure that the purpose of the trip was covered, and determine the appropriate mode of transportation prior to authorizing or scheduling a trip. For certain trips—such as long distance trips, or trips requiring a wheelchair van or support from an attendant—states or their contractors verified the necessity of the trip or mode of transportation with a health care provider, obtained through fax, phone, or an online portal. Contractors in two states cited challenges they faced obtaining necessary information and approvals from health care providers. Another contractor noted it had dedicated resources to educate health care providers about their role in arranging NEMT services.
- **Post-trip validation.** All selected states had strategies that state officials or their contractors said they used to validate that (1) the trip was for a Medicaid-covered service—for instance, by matching the

²³States are required to verify all providers' licenses and their eligibility to participate in Medicaid. 42 C.F.R. §§ 455.410, .412 (2021). Additionally, states must assign a categorical risk level for all providers, including those providing NEMT, and conduct designated screening activities based on that risk level. 42 C.F.R. § 455.450 (2021). For providers deemed to be high-risk, states must conduct additional efforts, such as site visits and fingerprint-based criminal background checks. 42 C.F.R. § 455.450(c) (2021).

date of an NEMT trip to a medical claim; that (2) trips occurred as authorized—for instance, by reviewing trip logs; or (3) both. In six selected states, states or their contractors used GPS tracking applications to compare trip logs with time-stamped GPS data. According to two contractors, GPS data are more reliable than self-reported trip logs and could be used to improve trip validation efforts by automating the validation of trips.²⁴

- **Contractor requirements.** Officials from the seven selected states that contracted the administration of NEMT to other entities said they used their contracts with these entities to improve oversight and to address any fraud related to NEMT. According to these officials, their states included provisions in the contracts to specify oversight requirements and responsibilities, which in some cases were linked to performance standards with incentives or penalties. In four states, officials noted that they recently updated the contracts to improve oversight by adding new data or reporting requirements. For example, Ohio officials said that they added quarterly reporting requirements on NEMT to its MCO contracts, and officials in Louisiana and New York said they mandated the use of GPS tracking for all trips.

Table 3 provides examples of selected states’ strategies to address NEMT fraud across the four oversight areas.

Table 3: Oversight Areas and Examples of Selected States’ Strategies to Address Fraud in Medicaid Nonemergency Medical Transportation (NEMT)

Oversight area and strategies		Examples
NEMT provider and vehicle screening		
Document provider credentials	One broker verified provider documentation, like driver’s licenses, upon enrollment and randomly performs spot checks for at least 10 providers each week.	One state used an automated system to conduct continuous, real-time validation of providers’ driver’s licenses.
Inspect vehicles	One state did not conduct any vehicle inspections.	One broker conducted annual vehicle inspections and randomly inspected about 50 percent of its NEMT provider network throughout the year.
Pre-trip approval		
Check beneficiary eligibility	One broker manually determined beneficiary eligibility, because the state’s eligibility reports were not compatible with its trip management system.	One broker automatically identified ineligible beneficiaries using state data, which was integrated into its trip management system.

²⁴Contractors in three of these states noted that the majority of their NEMT providers had adopted GPS applications.

Oversight area and strategies	Examples	
Verify medical necessity	One broker required health care providers to submit a form by mail or fax to verify the need for specialized medical vehicle transportation.	One transportation manager used an online portal to enable health care providers to verify the level of transportation needed.
Post-trip validation		
Verify trip purpose	One broker contacted health care providers to confirm the beneficiary attended their medical appointment for a random sample of 10 percent of all NEMT trips.	One state did not pay a NEMT claim until it identified an associated medical claim.
Confirm trip occurred	One broker manually reviewed the trip logs from all NEMT providers to verify they included a patient signature prior to paying them.	One broker analyzed data to identify any variances between the scheduled pick-up and drop-off addresses and the GPS data gathered during the trip.
Contractor requirements		
Use standards and penalties	One state's managed care organization contract included general program integrity requirements, but none specific to NEMT.	One state's broker contract included specific performance standards for NEMT providers and associated penalties for each instance of noncompliance.
Ensure contractor compliance	One state's broker contract required an annual independent compliance audit, which assessed compliance with NEMT provider and eligibility requirements.	One state had on-site office space at the local broker office and shadowed broker activities on a regular basis.
Monitor trip data	One state compiled trip data submitted by all brokers, which it used to conduct regular monitoring and ad hoc reviews.	One state had direct access to the transportation managers' trip management systems and monitored trip data in real time.

Source: NEMT documentation and interviews with state officials and contractors in eight selected states. | GAO-22-105447

Agency Comments

We provided a draft of this report to HHS for comment. HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at yocomc@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be

found on the last page of this report. Other major contributors to this report are listed in appendix II.

A handwritten signature in black ink, appearing to read "Carolyn L. Yocom". The signature is fluid and cursive, with a long horizontal stroke at the end.

Carolyn L. Yocom
Director, Health Care

Appendix I: Information on Nonemergency Medical Transportation Fraud-Related Investigations, Fiscal Years 2015 - 2020

Table 4: Number of Medicaid Fraud Control Unit (MFCU) Investigations of Nonemergency Medical Transportation (NEMT) Providers Resulting in Criminal Convictions or Civil Settlements and Judgments, by State, Fiscal Years 2015–2020

State	Number of investigations of NEMT providers (n=189)	Cumulative total of investigations (percentage)
New York	56	29.6
Ohio	36	48.7
Indiana	18	58.2
Minnesota	14	65.6
Louisiana	11	71.4
Illinois	8	75.7
Kentucky	8	79.9
Massachusetts	7	83.6
Georgia	6	86.8
South Carolina	4	88.9
Arizona	3	90.5
California	3	92.1
Florida	2	93.1
Tennessee	2	94.2
Colorado	1	94.7
Delaware	1	95.2
Hawaii	1	95.8
Idaho	1	96.3
Maine	1	96.8
Michigan	1	97.4
Missouri	1	97.9
New Hampshire	1	98.4
Oklahoma	1	98.9
South Dakota	1	99.5
Virginia	1	100.0

Source: GAO analysis of data from the Department of Health and Human Services Office of the Inspector General (HHS-OIG). | GAO-22-105447

Note: Our analysis included fraud-related investigations of NEMT providers that resulted in criminal convictions or civil settlements and judgments among 53 MFCUs (the 50 U.S. states, District of Columbia, Puerto Rico, and U.S. Virgin Islands). No MFCU operated in Puerto Rico and the U.S. Virgin Islands from 2015 through 2018 or in North Dakota from 2015 through 2019.