STATE OF WEST VIRGINIA

Department of Health and Human Resources

Utilization Management and Prior Authorization Services

Request for Proposal
CRFP 0511 BMS1500000007

Technical Proposal
ORIGINAL

Proposal Submitted: 11/4/2015

11/04/15 10:23:25
WV Purchasing Division

APS Healthcare

KEPRO
INTELLIGENT VALUE

RFP Subject	State of West Virginia Department of Health and Human Resources Utilization Management and Prior Authorization Services
RFP Number	CRFP 0511 BMS1500000007
Vendor Name	APS Healthcare Quality Review, Inc. d/b/a KEPRO
Vendor Address	777 East Park Drive Harrisburg, PA 17111
Vendor Telephone Number	1-800-222-0771
Authorized Contact **Person who will receive all official notices concerning this RFP.**	Joseph Dougher, President and CEO, KEPRO **777 East Park Drive** Harrisburg, PA 17111 (Tel) 800-222-0771 (Fax) 717-564-3862 (Email) jdougher@kepro.com
Local Contact Person for information concerning this RFP.	Jennifer Britton, Vice President, APS Healthcare 100 Capitol Street Suite 600 Charleston, WV 25301 (Tel) 800-461-0655 ext 4405 (Email) jwbritton@apshealthcare.com

Joseph A. Dougher
President & CEO

11/4/15
Date

APS Healthcare

November 4, 2015

Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

RE: CRFP 0511 BMS 1500000007

Dear Sir or Ms:

We are pleased to submit the above-referenced proposal to the Department of Administration for the Department of Health and Human Resources (DHHR) and its Bureaus. We submit the proposal as APS Healthcare Quality Review, Inc., d.b.a. KEPRO and a QIO-like Organization designated by the Centers for Medicare and Medicaid Services (CMS). We acknowledge the addenda to the CRFP and accept its terms and conditions.

This submission represents both a commitment to continue our 15-year record of achievement for DHHR and a new beginning for APS Healthcare West Virginia (APS-WV). Our incumbent status brings a fully staffed management team and operational systems based conveniently to the Department on Capitol Street in Charleston, WV. It also brings the recognition and support of West Virginia's provider community and acknowledgement from members and providers alike of our unstinting commitment to quality, service necessity, and community tenure.

We are prepared to implement the new contract period and expanded scope of work seamlessly in alliance with KEPRO's exceptional capabilities as a premier Quality Improvement Organization (QIO), representing almost 60% of Medicare beneficiaries nationwide, including West Virginia. As West Virginia's Beneficiary and Family-centered QIO, KEPRO is responsible to promote quality of care, exemplary medical care, and consumer safety with a conflict-free commitment to our beneficiaries. APS-WV and KEPRO share this important characteristic, enabling us to provide informed, transparent, and objective reviews, assessments, and reports the Department can use to measure, manage, and improve quality and efficiency across the spectrum of settings and care.

Thank you for this opportunity to present our proposed approach as an organization with a long-standing local presence, national scope, and single focus on continuing our record of performance for the Department. If further information is needed, please do not hesitate to contact Karen Eaton, Vice President, Growth & Development at keaton@kepro.com or 717-265-7010. We look forward to hearing from the Department of Administration regarding next steps.

Sincerely,

Joseph A. Dougher,
President & Chief Executive Officer

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1500000007

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.

APS Healthcare Quality Review, Inc. dba KEPRO
Company

Authorized Signature

November 3, 2015
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: APS Healthcare Quality Review, Inc. dba KEPRO

Authorized Signature: _____ Date: October 30, 2015

State of West Virginia

County of Kanawha, to-wit:

Taken, subscribed, and sworn to before me this 30 day of October, 2015.

My Commission expires May 20, 2016.

AFFIX SEAL HERE

NOTARY PUBLIC _____

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Mary Jane Light, Notary Public
Lower Paxton Twp., Dauphin County
My Commission Expires May 20, 2016
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

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

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

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

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

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

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

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.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 incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

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

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

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

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

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

4. **Addendum Administration.**

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

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

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED: West Virginia Department of Health and Human Resources, Bureau for Medical Services

Name of Agency:_____

Signature:_____

Title:_____

Date:_____

Name of Associate:_____

Signature:_____

Title: President & CEO

Date: 11/4/15

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY Of November 20 15
Patrick Morrisey
Attorney General
BY _____

Appendix A

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

Name of Associate: APS Healthcare Quality Review, Inc. d/b/a KEPRO

Name of Agency: West Virginia Department of Health and Human Resources
Bureau for Medical Services

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

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

Application and eligibility correspondence and notification
Referral to service providers
Member demographic information
Member medical information
Transfer/Discharge documentation
Member assessments
Service/Treatment Plans
Clinical documentation of services rendered
Service Authorization requests
Service Authorization outcomes

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Attachment A: Vendor Response Sheet

Section Four, Subsection 3.1: Organization & Experience

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

a. Organizational Chart

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

Vendor Response

We submit this proposal as APS Healthcare Quality Review, Inc. d/b/a KEPRO, a QIO-like entity designated by the Centers for Medicare and Medicaid Services (APS-WV). In this section, we describe and illustrate the exceptional project organization of APS-WV. Our proposed approach and methodology builds on that of our corporate parent, a long-standing and now the largest Quality Improvement Organization (QIO), KEPRO. The Beneficiary and Family-Centered Care (BFCC-QIO) for 34 states including West Virginia, KEPRO brings 35 years of federal and state medical review and quality improvement experience, uniquely complementing APS-WV's strong background in behavioral health, intellectual/developmental disabilities and other waiver program management, and West Virginia's Medicaid and state-funded programs.

APS West Virginia

As APS enters its sixteenth year in West Virginia, it is prepared to meet the needs of the Bureaus within the Department of Health and Human Resources with a comprehensive and integrated structure for unparalleled performance and accountability. With an experienced and local operational team, APS has the infrastructure *in place* to continue existing work seamlessly, transparently implement new components, and be ready to develop and implement the Optional Services when directed.

Corporate Organization

Figure 1 presents the corporate organization of KEPRO, based in Harrisburg, Pennsylvania, and regionally located to support APS-WV efficiently. Figure 2 presents the APS West Virginia project team with all named and other staff positions.

Figure 1 KEPRO Corporate Organizational Chart

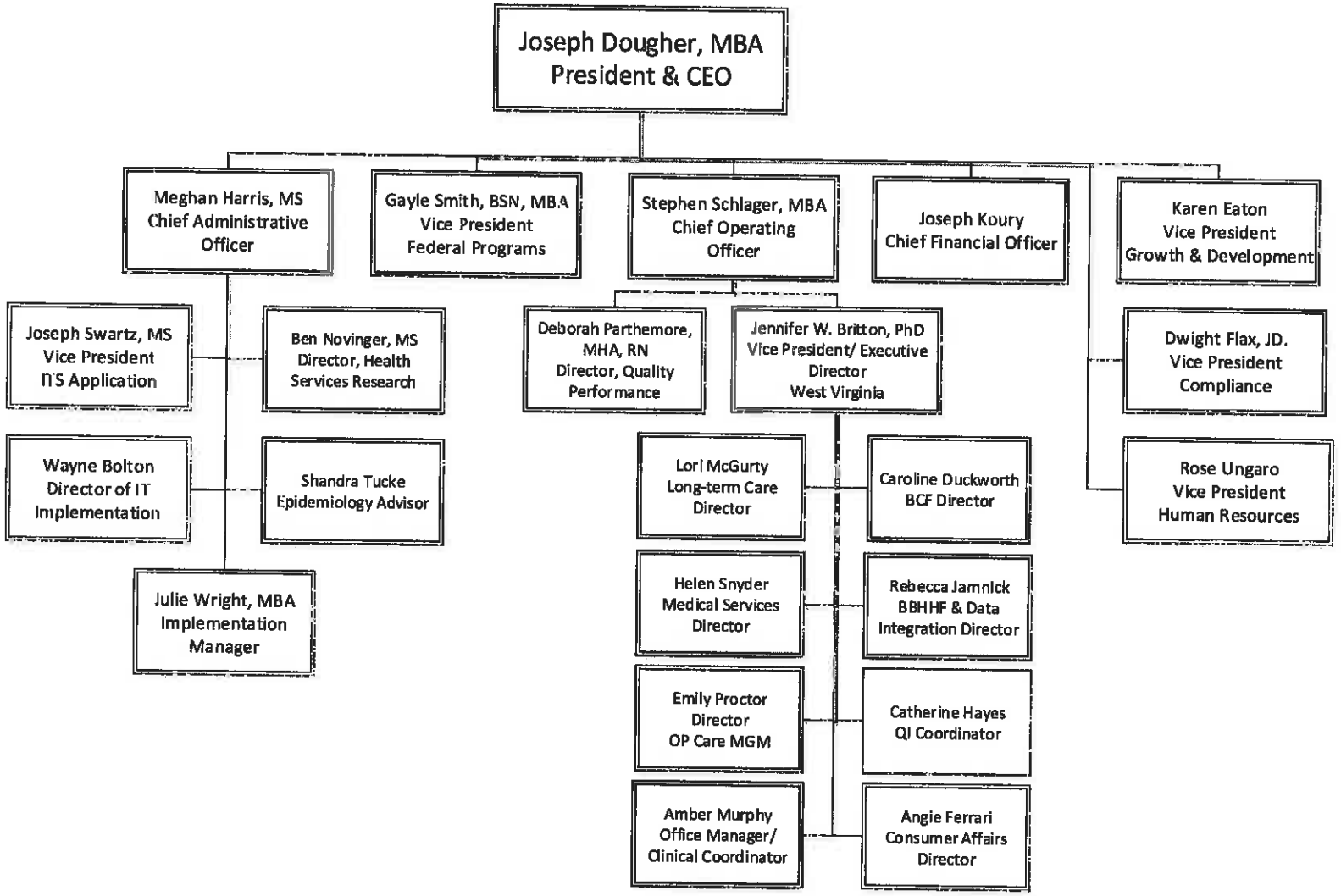
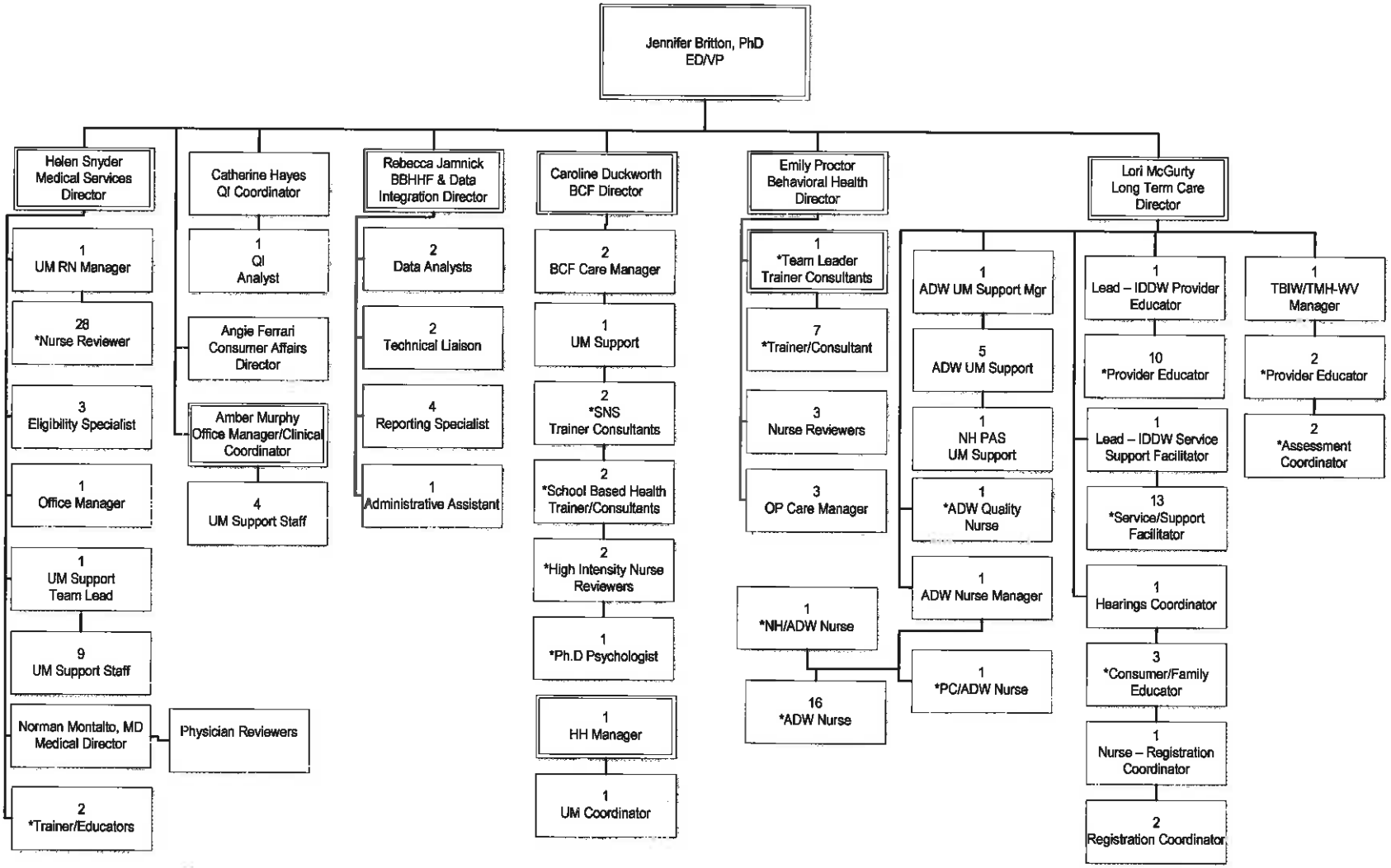


Figure 2 APS-WV Project Organizational Chart



* Indicates individuals who are field staff all others are office based.

Table 1 shows the placement of each position staffed for this contract; some positions may have multiple staff members as indicated by the level of effort needed to meet contract requirements.

Table 1 APS-WV Positions and Location

Position	Location	Position	Location
Administrative Assistant	Office	Medical UM Support Staff	Office
Administrative Assistant (SNS)	Office	Long-Term Care Director	Office
ADW Nurse	Field	Nurse Reviewer	Office
ADW Nurse Manager	Office	Office Manager	Office
ADW UM Support Manager	Office	IDD Provider Educator	Field
PC/ADW Nurse	Field	Provider Technical Assistant	Office
NH/ADW Nurse	Field	TBI Provider Educator	Field
ADW UM Support Staff	Office	Quality Improvement Coordinator	Office
ADW Quality Nurse	Office	IDD Registration Coordinator	Office
TBI Assessment Coordinator	Field	IDD RN Registration Coordinator	Office
Medical Services Director	Office	RN Care Manager (BMS)	Office
BBHHF Director	Office	Service Support Facilitator	Field
Care Manager (BHHF)	Office	IDD Service Support Facilitator	Field
Care Manager (BH)	Office	SNS Care Manager	Office
Behavioral Health Director	Office	SNS Director	Office
Consumer/Family Director	Office	Senior Administrative Assistant	Office
IDD Consumer/Family Educator	Office	Health Homes UM Coordinator	Office
Data Analyst	Office	T/C Team Leader/Psychologist	Field
Director of Health Homes	Office	TBI Manager	Office
Eligibility Specialist	Office	TBI UM Support Staff	Office
Vice President	Office	Technical Liaison	Office
Nurse Reviewer (BMS)	Field	Technical Liaison (FQHC)	Office
IDD UM Support Staff	Office	Trainer/Consultant (BH)	Field
IDD Lead Provider Educator	Office	Trainer/Consultant (BCF)	Field
IDD Lead Service Support Facilitator	Office	Trainer/Consultant (BBHHF)	Field
Medical Director/Physician Reviewer	Office	Trainer/Consultant (FQHC)	Office
Medical UM RN Coordinator	Office	UM Nurse Reviewer	Office
I/DD Hearings Coordinator	Office	QI Analyst	Office

b. Position Roles & Responsibilities

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

Vendor Response

We include the relevant Job Descriptions in Exhibit 1, and refer to these job descriptions for the roles, responsibilities, and skills associated with each position, as these documents provide the full description of qualifications and requirements.

c. Job Descriptions

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

Vendor Response

APS-WV's in-house Call Center exemplifies our unique approach to meeting the needs of provider and individual stakeholders. APS-WV staff members based in the Charleston Call Center share responsibilities for answering calls to ensure we can resolve any questions, issues, or concerns on a first call basis. We answer calls during business hours with a live Receptionist with nine (9) years of experience with APS-WV, Marsha Perry. Ms. Perry efficiently handles all calls and with her extensive experience with APS-WV, quickly locates the correct resource for callers. Additionally, APS-WV has two dedicated Technical Liaisons to assist providers with technical support with any issues they may be experiencing.

We include Job Descriptions in Exhibit 1 for relevant positions, including Case Reviewer, Physician Reviewer/Medical Director, and management staff, which demonstrate that individuals filling these positions meet – and exceed – the requirements of this RFP.

d. Key Positions

Key staff positions, such as, but not limited to, Project Manager(s), Assistant Manager (s), Provider Relations Manager(s), Outreach and Communications Manager(s) and other management staff, identified with named individuals and resumes demonstrating at least 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 Utilization/Prior Authorization Services (UMPA) experience in addition to the two years already specified. Resumes should be limited to three (3) single-sided pages.

Vendor Response

APS-WV includes the full Management Team as Key Positions for this project. The benefit of this approach is that individuals who meet the requirements currently hold these positions, and are available for immediate implementation of the project.

Table 2 lists key positions and key named staff.

Table 2 Key Positions

Position	Named Staff Member
Vice President	Jennifer W. Britton, PhD
Medical Services Director	Helen Snyder, MA, LPC, LCSW
BBHHF & Data Integration Director	Rebecca Jamnick, MSW
Bureau for Children & Families Director	Caroline Duckworth, MSW, LCSW
Behavioral Health Director	Emily Proctor, MA, LPC, AADC
Long-Term Care Director	Lori McGurty, MS, LSW
Consumer Affairs Director	Angie Ferrari
Quality Improvement Coordinator	Catherine Hayes, MA, LPC

We reference staff resumes in our response to 3.1.e below.

c. Resumes for Named Staff

Vendor Response

We include as resumes for individuals named in Table 2 as Exhibit 2 to the proposal. Exhibit 3 includes copies of Key Staff licenses, and Exhibit 4 includes licenses for remaining named staff.

d. Assurances for Offsite or Subcontracted Work

Vendor Response

As the Project Organizational Chart in Figure 2 illustrates, APS-WV designates experienced management team members for each component of the Scope of Work, with staffing for all contract requirements and deliverables reporting to these managers and their supervisors. Local staff members are responsible for operational responsibilities for the project, with support (such as finance and human resources) at the corporate level. This efficient approach enables us to assure the Department continuation of appropriate oversight of field-based and other offsite work.

APS-WV does not propose to subcontract work on this project to another organization.

e. Approach to Staff Retention & Continuity

Vendor Response

APS-WV has a comprehensive hiring/selection process to help ensure the hiring managers select the most qualified/skilled applicant for the position. With such an intensive and communicative method, the applicant has a more comprehensive understanding of the company, management style, expectations, and position in order to make a decision to on-board if offered. Additionally APS-WV cross-trains all staff, where appropriate and relevant, so that there is continuity of service to meet contract deliverables and exceed the Department's expectations for quality and service. All staff is knowledgeable of the various DHHR programs managed by APS in order to provide coordination across Bureaus. With this

comprehensive hiring and training program, staff has the confidence to perform well and the opportunity to work in other areas if so desired.

Actual staff retention metrics demonstrate the effectiveness of this approach. The average tenure for the APS-WV management team *is 13.9 years* – with APS and with the West Virginia program. Table 3 shows the average tenure for the management team as well as overall. As this table illustrates, APS-WV ensures continuity of project performance through an experienced project team – on average, APS-WV staff have almost six years of tenure with APS-WV. The average tenure of employees on a national level continues to decrease according to the Bureau of Labor Statistics—4.6 years as of January 2014.[1] The average tenure of APS-WV's management team is more than *triple this average*, demonstrating their commitment to the Department of Health and Human Resources and the valuable goals of this contract. Most recently, integration of all contract responsibilities within APS-WV increased staffing by 48 staff members, who have less than one year of tenure. We look forward to using our successful approach to retention to ensure the new staff members have the same positive experience as our longest-term employees, to increase their tenure year-to-year through the life of the contract and contribute to the continued success of the program.

Table 3 Average Tenure

Type of Position	Average Tenure
Management	13.9
All Staff Members (>1 Year)	5.9

h. Approach to Personnel Management

Vendor Response

The APS-WV approach to personnel management is an open communication environment with a strong emphasis on training. The training and communication ensure that our clients, members, and providers receive quality services from us. The expectations are high to provide excellent customer service and exceed all deliverables. Staff receives the training and support to meet the demands of their particular job. Team support is critical in this environment and we encourage it at every level. Staff members learn that APS-WV needs and supports every position to achieve program goals and objectives, and they are justly proud of their accomplishments.

Just as important is that every staff member has "line of sight" to the member and provider. We know why the Department created the programs we support and we understand the value they create: equitable access to publicly funded services through expert administration, independence, community tenure, and the ability to hold valued roles in society. These programs achieve vital goals that ensure the integrity and necessity of services for the West Virginians who deliver them and use them. This aspect of our approach creates a cohesive team that collaborates with the Department to meet the challenges and issues on a daily basis and ensure continued project performance.

[1] Bureau of Labor Statistics. (2014). *Employee Tenure in 2014.* Available: www.bls.gov/news.release/pdf/tenure.pdf

Section 4, Subsection 3.2: Related Experience

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

Vendor Response

APS-WV brings both a national and local perspective of the various programs we manage for the WV Department of Health and Human Resources (DHHR). Our designation as a QIO-like Entity by the Centers for Medicare and Medicaid Services (CMS) acknowledges our capacity on a national basis. A copy of the CMS letter is in Exhibit 5. APS-WV is the incumbent vendor and well known to DHHR as a collaborator and partner for over 15 years. We are committed to assisting DHHR to meet current and future challenges with continued flexible, efficient, and customized programs. APS-WV has a long-standing record of achievement serving the Department. We began providing Behavioral Heath Utilization Management through an Administrative Services Organization (ASO) for the Bureau of Medical Services (BMS) in 2000; the Bureau for Behavioral Health and Health Facilities (BBHHF) data in 2002; and the Bureau for Children and Families (BCF) Socially Necessary services in 2003.

We implemented the Intellectual/Developmental Disabilities (IDD) Waiver (ADW) program in 2006, followed by BBHHF Charity Care in 2010 and the Traumatic Brain Injury (TBI) Waiver in 2011. With the current contract period, we implemented Medical Fee for Service (FFS) and the Aged & Disabled Waiver in 2009. Most recently, we completed the Health Homes design/implementation/ASO in 2012 and brought previously subcontracted services in-house in 2015. In addition, all programs had a quality management component including working with the CMS Quality Measures for each of the three Waivers.

APS also developed and managed the IDD Waiver Statistical Budget Model based on Dr. Ed Campbell's national model and statistical protocols. APS-WV conducts in-home assessments in the TBI, ADW, and I/DD Waivers by our professionally trained staff. This extensive scope of work goes beyond the traditional UM/PA model to meet the comprehensive needs of the department. Figure 3 displays the scope of work history and demonstrates the length of our experience with all components. APS-WV and our corporate parent, KEPRO, are among the most experienced and capable organizations in the public sector. The chart in Figure 4 shows our extensive collaboration with the Department.

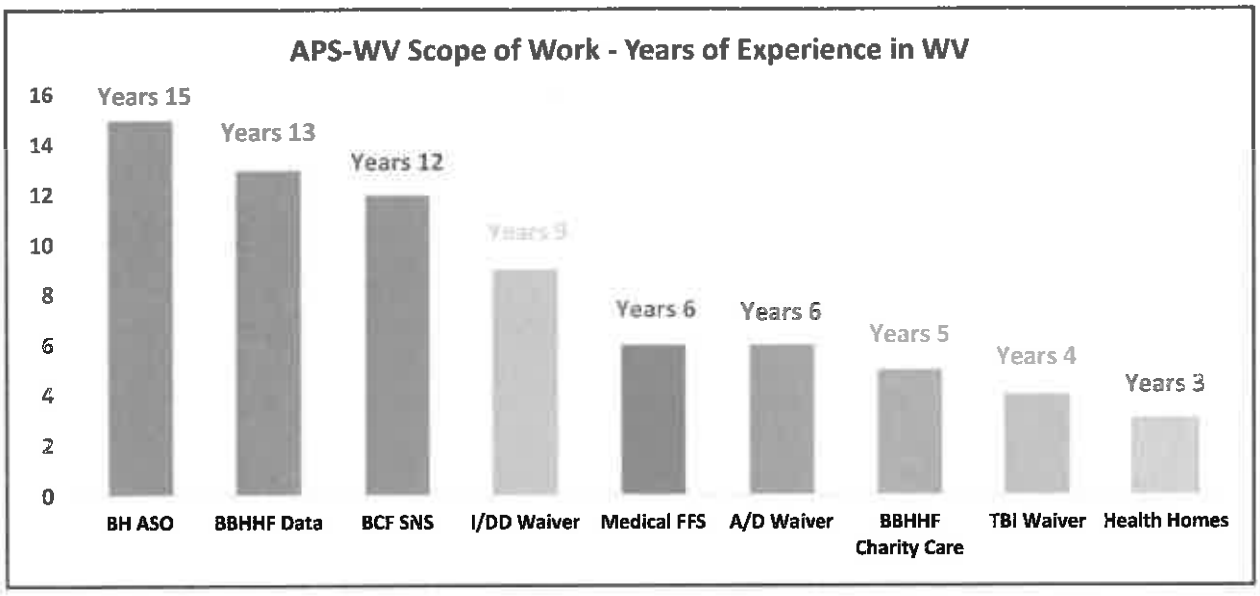


Figure 3 Number of Years by Program

Contract Cycle I	Change Order #1	Contract Cycle II	Change Order #2	Ext 1 - 3	Contract Cycle III
8/1/2000 - 7/31/2003	8/1/2002 - 7/31/2005	8/1/2003 - 7/31/2007	8/2006 - 7/2007	8/1/2008 - 11/30/2009	12/1/2009 - 11/30/2015
Behavioral Health Outpatient Svcs	Behavioral Health Outpatient Svcs	Behavioral Health Outpatient Svcs	Behavioral Health Outpatient Svcs	Behavioral Health Outpatient Svcs	Behavioral Health Outpatient Svcs
Prior Authorization	Prior Authorization	Prior Authorization	Prior Authorization	Prior Authorization	Prior Authorization
Retrospective Review	Retrospective Review	Retrospective Review	Retrospective Review	Retrospective Review	Retrospective Review
Training and Consultation	Training and Consultation	Training and Consultation	Training and Consultation	Training and Consultation	Training and Consultation
Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement
Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral
	Data Simplifications for BHHF	Data Simplifications for BHHF	Data Simplifications for BHHF	Data Simplifications for BHHF	Data Simplifications for BHHF
	Services & Policy Development for BCF	Services & Policy Development for BCF	Services & Policy Development for BCF	Services & Policy Development for BCF	Services & Policy Development for BCF
		Socially Necessary Service Implementation for BCF	Socially Necessary Service for BCF	Socially Necessary Service for BCF	Socially Necessary Service for BCF
		Prior Authorization	Prior Authorization	Prior Authorization	Prior Authorization
		Retrospective Review	Retrospective Review	Retrospective Review	Retrospective Review
		Training and Consultation	Training and Consultation	Training and Consultation	Training and Consultation
		Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement
		Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral
		Private Practice Provider Implementation	Private Practice Providers	Private Practice Providers	Private Practice Providers
		Prior Authorization	Prior Authorization	Prior Authorization	Prior Authorization
		Retrospective Review	Retrospective Review	Retrospective Review	Retrospective Review
		Training and Consultation	Training and Consultation	Training and Consultation	Training and Consultation
		Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement
		2004 MR/DD Waiver Implementation	MR/DD Waiver	MR/DD Waiver	MR/DD Waiver
		Conduct Assessments for Individualized Budgets	Conduct Assessments for Individualized Budgets	Conduct Assessments for Individualized Budgets	Conduct Assessments for Individualized Budgets
		Prior Authorization	Prior Authorization	Prior Authorization	Prior Authorization
		Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	Data Analysis, Reporting and Quality Improvement	The Scope of Work
					Overall Eligibility Verification
					Inpatient and long term BH
					Prior Authorization
					I/DD Waiver
					Member Eligibility
					Complaint Investigation
		Consumer Education and Referral	Consumer Education and Referral	Consumer Education and Referral	Provider CMS Quality Reviews
			Implement BCF Services	BCF Services	Wait list & Appeals
			New Socially Necessary Services added requiring Prior Authorization	New Socially Necessary Services added requiring Prior Authorization	Medical
			Retrospective Review	Retrospective Review	UR for all Medical Services (FFS)
			Built Electronic Referral File Interface with FACTS	Built Electronic Referral File Interface with FACTS	Aged and Disabled Waiver
					Assessments
					Eligibility determination
					Prior Authorization
					Wait list & Appeals
					BHHF
					Eligibility Gatekeeping
					Service Level Prior Auth
					Training and Consultation
					Data Analysis, Reporting and Quality Improvement
					Retrospective Review
					IMD Project
					Specific Data Set Collection
					PCMH/PMH
					See BH Outpatient Services above for a list of ASD services provided
					Health Homes
					Eligibility Gatekeeping
					Service Level Prior Auth
					Training and Consultation
					Retrospective Review
					Data Analysis, Reporting and Quality Improvement

WV TBI Program
Contract Cycle I
11/1/2011 - 11/30/2015
Traumatic Brain Injury Waiver
Assessments
Eligibility determination
Prior Authorization
Data Analysis, Reporting and Quality Improvement
Consumer Education and Referral

Figure 4 Timeline of Contracts and Contract Modifications

As a long-standing Quality Improvement Organization, KEPRO began as a Peer Review Organization (PRO), specializing in prior authorization, concurrent review, and retrospective review for Medicare inpatient and outpatient medical care and inpatient psychiatric, rehabilitation, and other specialty hospital admissions. As KEPRO expanded its capabilities to all aspects of medical review for Medicare and Medicaid programs, APS Healthcare began as a behavioral health organization and expanded to encompass all aspects of specialty and healthcare and community-based services and supports. Together, KEPRO and APS-WV form an organization with the experience, capabilities, and systems to support the Department in the future with the same high quality, customer-service oriented, value the Department required over the past fifteen years.

References

APS-WV provides contact information for the projects profiled in this section. As our *four references alone demonstrate*, APS-WV and our parent KEPRO together are the most qualified organization to continue to deliver Utilization Management and Prior Authorization Services. With experience in every component of the scope of work and more—from medical care to behavioral health to socially necessary services and block grant reporting—APS-WV has the experience, capabilities, and skills to meet the Department's needs today, in the future contract period, and beyond.

Utilization Management and Service Authorization

Department of Medical Assistance Services, Commonwealth of Virginia

Commonwealth of Virginia/DMAS Cheryl Roberts	600 East Broad Street, Suite 1300 Richmond, VA 23219 Cheryl.Roberts@dmas.virginia.gov Phone: (804) 786-6147

KEPRO began providing Utilization Management and Service Authorization services to the Commonwealth of Virginia's Department of Medical Assistance Services in 2006. KEPRO performs Medicaid medical necessity and quality reviews for the fee-for-service population and for Managed Care Organizations (MCO) carved-out services such as Home and Community Based Services (HCBS) waivers and Community Behavioral health. We work with stakeholders and providers in Virginia to ensure delivery of the right care at right time through contract activities. These activities include precertification and retrospective reviews, reconsiderations, and fair hearings for inpatient medical/surgical hospital care, inpatient psychiatric, inpatient rehabilitation, home health, outpatient, imaging, Durable Medical Equipment (DME), prosthetics, transplants, behavioral health Residential Treatment Centers (RTC) / group home, community behavioral health, specialized care/long-stay hospital, HCBS waivers, and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The annual review volume exceeds 350,000 authorizations for nearly 900,000 Medicaid and SCHIP fee-for-service members and, for MCO carve-out services (such as HCBS waivers and community behavioral health), Medicaid, and SCHIP MCO members.

Administrative Services Organization

Department of Health and Human Services, State of Maine

Department of Health and Human Services Julie Tosswill, Manager, Authorization Review	11 State House Station Augusta, ME 04333 207-287-1773

APS began providing mental health and substance abuse administrative services to State of Maine Medicaid members in 2007. These services include utilization management and prior authorization for approximately 290,000 adults and children enrolled in MaineCare. We are a strategic partner with the Maine provider community, facilitating a Provider Advisory Council and delivering robust provider training. The Department of Health and Human Services modified the contract six times to add inpatient and outpatient behavioral health services to the scope of UM. APS conducts prior authorization and retrospective review and coordinates a statewide Quality Improvement Council in collaboration with the State, providers, and stakeholders. APS uses MCG Care Guidelines and State-specific criteria in this contract, and completes manual and auto-authorizations. Since contract initiation, our role helped to achieve increased access to services and decreased lengths of residential and inpatient stay in the Maine Behavioral Health community. Child readmission rates to psychiatric hospitals continue to decrease. Through Maine's efforts, which our services support, 71% of children discharged from Child Psychiatric Hospital services were living in their own home upon discharge and 20% were discharged to residential settings. Since contract start, we closely monitor behavioral health inpatient services, reducing avoidable behavioral health inpatient days, and achieving $48 million in savings over two years by working closely with the state to ensure the most appropriate use of residential care.

Southwestern Pennsylvania Healthcare Quality Unit

Office of Developmental Programs, Commonwealth of Pennsylvania

Westmoreland County, Pennsylvania Austin J. Breegle, Administrator Behavioral Health/Developmental Services Program	Courthouse Square Extension 40 N. Pennsylvania Avenue Greensburg, PA 15601 breegla@westmoreland.swstx.com 724-830-3629

APS' Southwestern Pennsylvania Healthcare Quality Unit (HCQU) supports county Administrative Entity programs for physical/behavioral health of individuals receiving services in Pennsylvania's Allegheny, Bedford/Somerset, Cambria, Fayette, Greene, Washington, and Westmoreland counties. CMS and the Commonwealth of Pennsylvania Office of Developmental Programs (ODP) share an interest in promoting quality services for individuals with intellectual and developmental disabilities. As a result, the ODP established Healthcare Quality Units in 2002 to assist Administrative Entities with building capacity and competency to address the physical and behavioral healthcare needs of the individuals served by those programs. APS operates the second largest HCQU in Pennsylvania. As the HCQU, APS works with the ODP and Administrative Entities within the southwest region to enhance the quality of life of individuals with intellectual and developmental disabilities (ID/DD) by leading initiatives that facilitate improvements in the delivery of and access to healthcare and services to this population. The HCQU also collects data to focus activities on improving the quality of care for individuals with I/DD.

One of the primary functions of the HCQU is to provide physical and behavioral health related training to caregivers so that they can better assist persons with developmental disabilities. These trainings are conducted based on data from a standardized needs assessment and by special request. Each quarter, the HCQU develops a training syllabus comprised of the most requested trainings available on a county-by-county basis. APS then holds the caregiver trainings at various locations in the HCQU region to provide maximum accessibility for participants.

In addition to quarterly caregiver trainings, the APS HCQU provides person-centered technical assistance to facilitate team discussions and planning; assist with information analyses; and educate providers, consumer/family members, support staff, and county staff regarding I/DD best practices. We provide over 800 technical assistance/training sessions per year for 12,000 participants, covering 200 different healthcare and behavioral topics. In addition, the HCQU offers 45 Web-based trainings that are competency-based. Approximately 3,000 service providers have access to our online trainings modules.

Prior Service Authorization

Agency for Persons with Disabilities, State of Florida

Florida Agency for Persons with Disabilities Lorena Fulcher, Senior Management Analyst Supervisor	4030 Esplanade Way Tallahassee, FL, 32399 Lorena.Fulcher@apdcares.org (850) 488-5998

APS offered a broad set of solutions to the State of Florida for improving health outcomes, while reducing costs for the State's most vulnerable population. Our program included prior service authorization review for individuals enrolled in Florida's ID/DD HCBS, Consumer Directed Care Plus, and Tier Medicaid Waivers. This program applied a local service center model to improve community engagement and collaboration. Our prior authorization review services ensured authorization of Medicaid ID/DD Waiver services at the appropriate intensity, frequency, and duration. We also provided personalized education and training to facilitate systemic improvements in care delivery. Program accomplishments included saving over $136 million in program costs for the Agency for Persons with Disabilities over a period of four years; consistently providing efficient responses to requests/inquires – the average turnaround time for prior service authorization decisions was just two days and our response to customer inquiries was less than 24 hours; and 100% state contract compliance. APS also offered an extensive training program with area/district office staff and daily technical assistance on issues related to prior service authorizations for persons with developmental disabilities. APS provided extensive technical assistance via telephone to case managers in the field as well as district agency staff.

Section Four, Subsection 3.3: Experience Operating QIO/QIO-Like UM/PA

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

a. State Medicaid and/or other governmental utilization/prior authorization programs;

b. Providing Utilization/Prior Authorization Services;

c. Hiring Providers to perform Utilization/Prior Authorization review services;

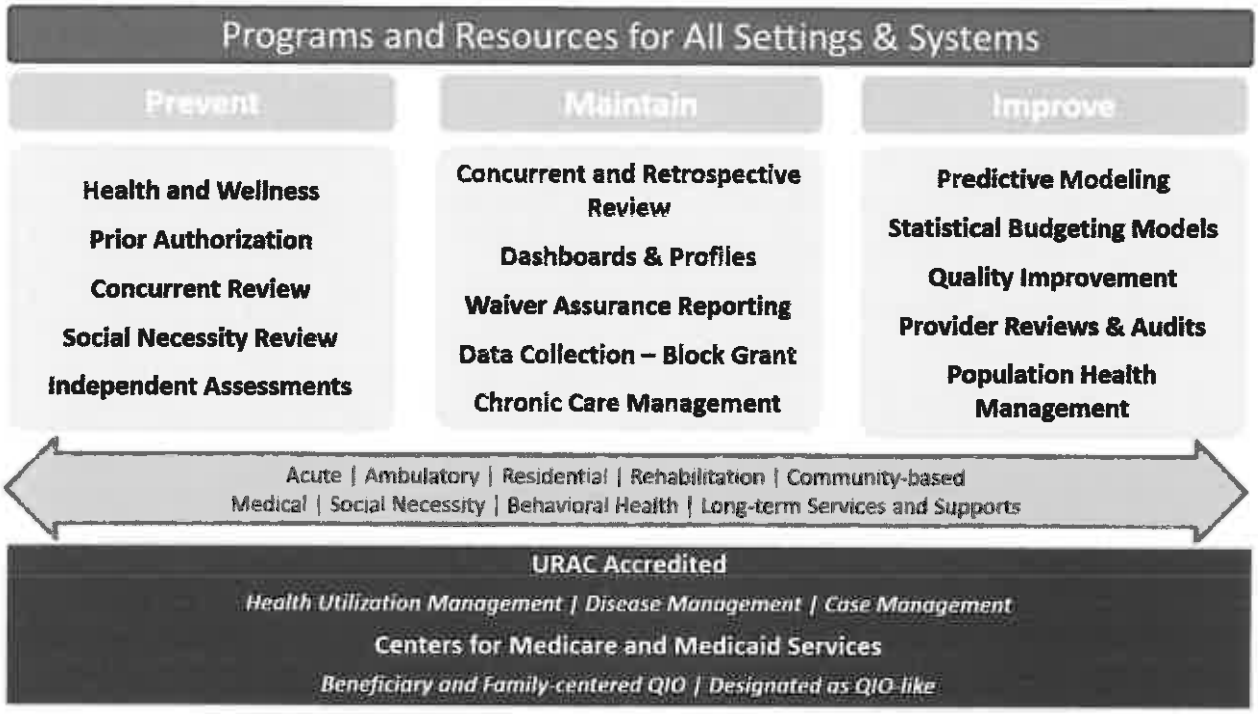
d. Staffing a Utilization/Prior Authorization Services customer service in-house call center

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

Vendor Response

The combination of KEPRO and APS Healthcare in 2015 created an organization with unequaled experience with utilization management and prior authorization across the spectrum of health and human services and settings of care. As Figure 5 illustrates, our program offerings encompass services and supports for all settings and systems of care – from prior authorization for acute medical services to socially necessary review to data collection for block grant funds to reporting for Quality Assurances.

Figure 5 KEPRO/APS-WV Program Offerings are Comprehensive



KEPRO – A Premier Quality Improvement Organization

KEPRO's most recent URAC accreditation review indicated 100 percent compliance with the highest standards established by this prestigious organization.

For the past 35 years, KEPRO has provided Utilization Management solutions to public and commercial clients. KEPRO represents 52 government and commercial clients nationwide. Serving broad geographical and client market segments enables us to offer the Department best practices from other states and national efforts to healthcare issues and challenges.

We began providing services to Medicaid agencies in 1992. Today, KEPRO is a leading quality improvement and care management organization offering outcomes-focused solutions to reduce avoidable utilization of healthcare resources and optimize quality of care for public and other clients. Our experience in performing utilization management in federal, state, local and other programs include the following:

- Utilization Review (UR) for numerous state Medicaid agencies.
- Experience in approving, tracking, and providing technical assistance to hospitals annual Utilization Review (UR) plans.
- URAC Accreditation for Health Utilization, Case, and Disease Management. URAC accreditation demonstrates our adherence to nationally recognized standards for process management and control.

KEPRO's knowledge of Medicaid includes:

- Healthcare management solutions for more than 19 million members since 1985. We are a trusted partner to nine state Medicaid agencies since 1992.
- The Beneficiary and Family Care Centered QIO contracted by the Centers for Medicare & Medicaid Services (CMS) Medicare Quality Improvement Organization for 34 states and almost 60% of Medicare beneficiaries, including West Virginia Medicare and Dual Eligible beneficiaries.
- Comprehensive Utilization Management for TRICARE, the Department of Defense's (DoD's) health program for military dependents; and for other federal government agencies.
- The Expert Medical Review Contractor for the Health Resources and Services Administration (HRSA).

As an experience and respected Utilization Management organization, KEPRO reviews over 800,000 medical records on an annual basis, using standard procedures to ensure reliability, accuracy, and timeliness. We summarize KEPRO experience with Utilization Management in Table 4.

Table 4. KEPRO Experience with Utilization Management of Medicaid Services

Contracts	# of Years	# of Medicaid Clients	Annual Review Volume
Florida Medicaid	10	3,703,388	450,000
Virginia Medicaid	9	1,027,075	375,000

Contracts	# of Years	# of Medicaid Clients	Annual Review Volume
Colorado	5	600,000	200,000
Maryland Medicaid	4	975,437	175,000
Commercial Accounts	9	387,661	80,000
South Carolina Medicaid	3	922,560	74,000
Wyoming Medicaid	3	87,433	60,000
Hillsborough County, FL	9	11,309	40,000
New Hampshire Medicaid	2	167,560	20,000
TennCare	8	1,509,354	18,000
Minnesota Medicaid	3	936,488	15,000
Total			**1,307,000**

APS Healthcare Quality Review – A National Specialty Healthcare Organization

With the organizational experience and expertise to deliver comprehensive Utilization Management and Prior Authorization services in accordance with the Department requirements, APS-WV is uniquely prepared to continue contracting with the Department. URAC accredited for Health Utilization Management, APS as an organization has over 15 years of experience performing utilization management and utilization review (UM/UR) services in West Virginia alone, determining medical necessity and appropriateness of care for Medicaid populations. This experience also includes UM/UR services through the Home and Community-Based Waiver programs for individuals with special needs. Populations include those who have intellectual or developmental disabilities, traumatic brain injury, or those who are aged and/or have physical disabilities. Our experience spans the spectrum of utilization management, from prior authorization to intensive case management of high-risk clients. Formed as a managed behavioral health organization, utilization management of behavioral healthcare remains a foundational capability of APS, informing our understanding of the medical needs of clients with behavioral health needs as well as barriers and issues that interfere with appropriate coordination of their care.

From this experience, APS-WV gains expertise in all aspects of the Scope of Work. UR services include Prior Authorization, concurrent review, and post-payment review (retrospective review) for inpatient, ambulatory care, Durable Medical Equipment, and other services such as imaging. APS has URAC accreditation for Health Utilization Management.

APS emphasizes technical assistance to, and collaboration with, the provider community and other entities. This approach greatly facilitates healthcare quality improvement and reduction of avoidable costs, advancing the goals and objectives of state programs and initiatives. We have more than 20 years of experience with collaboration on contracts with care coordination, disease management, or case management components for Medicaid memberships. Our comprehensive experience across the array of utilization management informs our approach to program design and provider relations, and presents a significant opportunity to work in partnership with the Department and Health Homes. We have proven experience as a contractor to Medicaid agencies, improving utilization through special programming for high risk, high-cost Medicaid enrollees.

Over the past five years, APS experience includes administration of public sector utilization management programs for 36 states, streamlining UM practices, working in collaboration with stakeholders, providers, and agencies, and improving access to, and the quality of, healthcare for more than 10 million people. We discuss our utilization/management experience in response to items (a) through (e).

Response to RFP Items

a. State Medicaid/Other Government Experience

In this section, we present the combined experience of APS Healthcare and KEPRO, including current and past contracts for the most recent five years *only*. This experience substantiates our capabilities for the Scope of Work in the current RFP and goes beyond those requirements to include state and national responsibilities for utilization and quality management for Medicaid, state-funded, and other government-funded services. Our average contract term is over 10 years, demonstrating our ability to maintain long-term and positive relationships with clients and stakeholders. This background translates into stability, continuity, and consistent improvement of systems and methods to meet the needs of our clients with flexible, responsive, and efficient services. This experience is in Table 5.

Table 5 Overview of State Medicaid / Other Government Experience

Client /Contract	Nature of Contract	Medicaid (M) Other (O)	Years of Experience
West Virginia Department of Health and Human Resources Multiple Expansions include Waiver – since 2006 Medical – since 2009	Behavioral health, including PA/UM, training, member and provider education; call center, technical assistance	M, O	15
*Maine Department of Health and Human Services/Maine Behavioral Health ASO	Contract covers both behavioral health and substance abuse services for adults and children; vocational and mental health services for special populations	M, O	8
*Virginia Department of Medical Assistance Services	Utilization Management, prior authorization, call center, member quality assurance	M	9
*Pennsylvania Department of Public Welfare/Southwest PA Health Care Quality Unit	Development and delivery of over 9.000 hours of training on healthcare for people with I/DD.	O	10
*Florida Department for Children and Families / Florida Prior Services Authorization	Evaluation and review of care plans for Florida's I/DD Waiver enrollees to ensure necessity of service and alignment with assessed need	O	4

Client /Contract	Nature of Contract	Medicaid (M) Other (O)	Years of Experience
Florida Agency for Health Care Administration/Preadmission Screening & Resident Review	Monitoring of Level I screenings and Level II evaluations, provider training, reporting	M	8
Oklahoma Health Care Authority (Medicaid) (OHCA)/Oklahoma Medicaid QIO	Medical and BH utilization and case management, peer review, and quality assurance services for inpatient and outpatient	M	5
Wyoming Office of Healthcare Financing (Medicaid)/Wyoming Medicaid Utilization Management	Utilization review, behavioral health case management, and quality assurance	M	6
State of Maryland Mental Hygiene Administration/ MAPS-MD	Prior authorization, case management, network and quality management, member and provider education and training and services	M, O	5
Georgia Department of Behavioral Health and Developmental Disabilities/Georgia External Review	UM services including prior authorization and concurrent reviews, on-site provider audits and technical assistance.	M, O	16
California Department of Mental Health/California EQRO for Medicaid Mental Health Plans	External Quality Review of 56 prepaid county mental health plans, including performance improvement projects, and performance measures.	M, O	10
Massachusetts Office of Medicaid (MassHealth)/ Massachusetts (EQRO)	EQR of Medicaid plans including validation of performance measures and performance and improvement projects.	M	10
Puerto Rico Health Insurance Administration MBHO	Services include utilization, disease, case, and pharmacy management as well as direct behavioral health services for over 1 million beneficiaries.	M	15
Hawaii Department of Human Services / Hawaii Community Care Services	Behavioral health administrative services and community-based case management for 2,000 highest risk Medicaid members.	M	7

Client /Contract	Nature of Contract	Medicaid (M) Other (O)	Years of Experience
Center for Medicare and Medicaid Services (CMS)	Quality Improvement Organization for Ohio; BFCC-QIO for Areas 2, 3, and 4 (34 states)	O	35
Tricare Management Authority / Tricare Quality Monitoring Contractor	National contract to provide utilization management, quality improvement, facility certification, Emerging Technologies review	O	6
		Average Length of Service	10.6

*Indicates contracts cited as references

In response to the next set of items, Table 6 highlights the extensive experience with all aspects of utilization management/prior authorization review that KEPRO and APS bring to the important requirements of the scope of work in this contract. This experience incorporates processes to ensure reliability and independence of peer review, facilitation of access to staff for providers, members, and others, and managing a comprehensive, longitudinal data set for reports and profiles. We then draw on these experience examples in our discussion of items (b) through (e).

Table 6 Contract Experience with UM Related Requirements for APS and KEPRO

Program Capabilities	WV	VA	TN	FL	SC	MD	MN	WY	NH	ME	CO	OK	GA	AR	NY
Analyze & Recommend Policy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
New Program Design & Development	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicaid Program Expansion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Utilization Management	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Data & Statistical Analysis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Identify & Manage Over-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 6 Contract Experience with UM Related Requirements for APS and KEPRO															
and Under-Utilization															
Electronic PA Submission	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
"Smart Review" Automated Authorization		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Recons & Appeal Support	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Develop Evidence-based Criteria	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
InterQual and/or MCG Milliman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
QI & QA programs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Call Centers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Provider Training	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reporting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Program Focus	WV	VA	TN	FL	SC	MD	MN	WY	NH	ME	CO	OK	GA	AR	NY
Medical Care	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓
Behavioral Health/PASRR	✓			✓		✓		✓		✓		✓	✓	✓	✓
Medicaid Waiver Support	✓			✓		✓		✓		✓	✓	✓	✓		
State Funded Program Support	✓					✓				✓		✓	✓	✓	

b. Utilization/Prior Authorization Services

Utilization and Prior Authorization review are functions developed decades ago to manage access to medical and other services. In their current form, they universally draw their methodology and approach from the procedures the Centers for Medicare and Medicaid Services[2] (CMS) established for review beginning with the Peer Review Organization program in 1984. KEPRO's experience with utilization management and prior authorization extends back to these beginnings, a depth of experience that

[2] Then the Health Care Financing Administration (HCFA).

ensures the Department our approach to meeting RFP requirements aligns with CMS expectations. Our combined organizations have 35 years of experience with review – almost 20 years of experience with behavioral health utilization review, and almost a decade of support for waiver programs.

c. Hiring Peer Reviewers

Peer review provides the assurance that denials or modifications of service or utilization requests only occur after expert evaluation. In each of our utilization management programs, APS and KEPRO recruit Board-certified Physician Reviewers with unrestricted licenses and experienced in the same specialty as the provider requesting the services. The process of recruiting, credentialing, and training is continuous. APS-WV can rely on the corporate resources of KEPRO for the network management functions to assure appropriate credentials for Peer Reviewers; further, APS-WV has access to over 1,000 Board-certified Specialists through KEPRO contracting with national Peer Review providers.

An important aspect of our approach to Peer Review draws on our capacity as the Beneficiary and Family-centered QIO for West Virginia and 33 other states. CMS made the landmark decision in 2014 to separate the functions of QIOs to eliminate the potential for conflicts of interest between alignment with the provider community for quality improvement and the need for independence to represent the interests of beneficiaries and their families. KEPRO and APS-WV have affiliations with providers only for the purpose of expert review and are therefore without conflict of interest.

d. Staffing the Customer Service Call Center

APS-WV staffs the Call Center with administrative and clinical staff members to ensure a "one call" response and resolution for every call. The expertise of our national Call Center in Maryland illustrates our capacity and performance, with volume by type of call in Table 7.

Table 7 Call Volume – KEPRO National Call Center - 2014

Metric	Calls Received
Call Volume	218,464
Call Volume by Type	
Crisis	9,634
Routine	200,576
Information and/or Other	8,254

With hundreds of thousands of calls on an annual basis, the KEPRO Call Center operates twenty-four hours a day, seven days a week – exceeding operational requirements of our clients, as Table 8 shows.

Table 8 Performance Metrics for National Call Center - 2014

Metric	Actual Performance	Contract Requirement
Speed of answer for crisis or emergency line	00:14	00:15
Percent of crisis calls answered within 15 seconds	91.3%	80% w/in 15 seconds
% Crisis line calls abandoned	1.2%	<5%

Speed of answer for access and referral line	00:15	00:30
Percent of access calls answered within 30 seconds	92.6%	80% w/in 30 seconds
% Access line calls abandoned	1.8%	<5%

This operational expertise informs our staffing approach to ensure that we have sufficient staffing to meet contract requirements and exceed our customers' expectations for customer service. In West Virginia, providers represent the majority of calls. APS-WV maintains toll-free numbers for specific programs to facilitate the ability of providers to reach program staff efficiently. Additionally, we staff the WV Call Center with an effective combination of administrative, technical, and clinical staff, all of whom have training on use of the Call Center system to answer, transfer, and manage call volume with exemplary customer service. Our staffing volumes and credentials enable us to respond to provider questions and concerns on a timely basis. Additionally, administrative and waiver staff are available for member calls to ensure a prompt, culturally and linguistically appropriate response to calls.

e. Developing & Managing a UM/PA Database

As the contracts illustrate in Table 5 Overview of State Medicaid / Other Government Experience, APS and KEPRO maintain a robust system environment. APS-WV uses the proprietary APS System to meet the needs of the current contract and will continue development to ensure optimal system configuration for West Virginia. Between West Virginia and Maine alone, APS stores data for over 700,000 authorizations annually, assuring secure storage, accurate reporting, and data exchange with the MMIS vendor.

Section Four, Subsection 3.4

3.4 The Vendor should describe their experience demonstrating at least three (3) years management experience and knowledge of the State and Federal Medicaid rules and regulations pertaining to the Intellectual/Developmental Disabilities (UDD) Waiver Services Program, Aged and Disabled (ADW) Waiver Services Program, and Traumatic Brain Injury (TBI) Waiver Services.

Vendor Response

APS has been the Administrative Service Organization (ASO) for the Intellectual/Developmental Disability Waiver program in West Virginia (WV) since 2010; this project was an expansion of previous work performed, which began in 2006. APS-WV almost 10 years direct experience with the WV I/DD Waiver program; six years of direct experience with the WV Aged and Disabled Waiver program, and 4 years direct experience with the Traumatic Brain Injury Waiver Program. APS developed and implemented approved procedures to advance quality improvement internally and externally.

For all WV Waiver programs, APS was partly or fully responsible for and an integral part of collecting, maintaining, and reporting for the Centers for Medicare and Medicaid Services Quality measures. For the IDD Waiver, APS participated in the CMS Waiver application and policy renewal for both the 2010 and 2015 Waiver renewal periods. In 2015, we participated in these same actions for the Aged and Disabled and TBI Waiver renewals. We have designed our information systems, provider quality reviews and other processes specifically to capture many of the data elements required for federal reporting including requirements for: Administrative authority, level of care, qualified providers, service planning, health and welfare and financial accountability. APS designed the template currently in use for this report, and the Bureau was so pleased with the design, it recommended the template for use by another vendor.

APS worked side-by-side with the Bureau and provided research and recommendations related to previous, current and upcoming I/DD, Aged and Disabled and TBI Waiver policy. APS has significant knowledge of the policy and an equal amount of experience implementing it, training and providing technical assistance related to it. APS is pleased to continue these efforts.

Section Four, Subsection 4.1

4.1 Vendor should describe their approach and methodology to administering program utilization through prior authorization and intensive case management of medical and dental authorizations to assure that those BMS, BCF, and BBHHF services are provided sufficiently in extent, duration, and scope, that the provision of those services are appropriately documented in provider and recipient files, and that the services rendered are authorized within the Medicaid, Child Welfare and Behavioral Health Program coverage and benefit limitations in effect as of the date of service. The Vendor should include an Implementation Work Plan and timeline showing how they propose to meet project deliverables, including what they propose as the Operational Start Date, The Vendor's approach should address the following:

1. Appendix 1, Operational Specifications, including all deliverables and proposal components described therein.
2. Appendix 2, Implementation Specifications, including all deliverables and proposal components described therein.
3. Appendix 3, Agency Specific Reporting Requirements, including all deliverables and proposal components described therein.
4. Appendix 5, Implementation Deliverables, Milestones, and Start-Up Cost Payments, including all deliverables and proposal components described therein.

We embed responses to Appendix 1, Operations Specifications, in Attachment A to facilitate cross-reference of related elements, since the operational specifications are relevant to Sections 4.1 through 4.39. We include Appendix 2, 3, and 5 as separate appendices following Attachment A.

Appendix 1 – Operational Specifications

I. Utilization/Prior Authorization Service Request Processing

Vendor Response

In this section, we describe our approach and methodology to meet the requirements of the scope of work and achieve the Department of Health and Human Resources' goals for programs the Bureaus for Medical Services (BMS), Children and Families (BCF), and Behavioral Health and Health Facilities (BBHHF) administer. The experience of APS Healthcare West Virginia (APS-WV) over the past 15 years enables us to base our proposal on proven solutions, experienced staff, and a veteran management team.

In West Virginia and on a national basis, APS Healthcare and our corporate parent, KEPRO, deliver services that assure the medical necessity of services covered by state Benefit Plans, authorize those services for the most effective extent, duration, and scope, and delivered in the most appropriate, least restrictive settings of care. Our proposal provides a detailed response that describes all aspects of our solution and its multiple benefits to the Department. Table 9 shows the applicability of the contents of this section to specific programs. We discuss the processes and systems applicable to other programs in relevant sections in Appendix 1.

Table 9 Requirements by Bureau and Program

	BMS Medical Services	BMS Behavioral Health Services	BMS Aged & Disabled Waiver	BMS I/DD Waiver	BMS TBI Waiver	BMS Health Homes	BMS PAS for Nursing Home	BMS Personal Care	BCF Socially Necessary Services	BBHHF Indigent Care O/P Behavioral Health
Verify member eligibility & MCO coverage.	X	X	X	X	X			X		X
Verify BBHHF eligibility.		X								X
Verify referral for socially necessary services by BCF workers.									X	
Verify provider and facility enrollment.	X	X	X	X	X	X	X	X	X	X
Verify and communicate to Agency if there are other payer sources involved with the services being requested	X	X	X	X	X	X		X		X
Verify that the Benefit Plan covers the service requested.	X	X	X	X	X	X		X		X
Verify which Medicaid plan the member is enrolled.	X	X	X	X	X	X		X		X
Verify service limits, if there are any limitations, attached to the coverage.	X	X	X	X	X	X		X	X	X
Verify that the appropriate CPT, CDT, HCPCS, and ICD-10 diagnosis codes and/or applicable modifiers for the service requested. ** DSM-V approved for use by BMS*	X	X*	X	X	X	X		X		X*
Provide professionals able to review for behavioral and medical necessity, social necessity, appropriateness, cost efficiency and approve services based on Medicaid coverage, socially necessary coverage, and behavioral health coverage guidelines, limitations, and eligibility.	X	X	X	X	X	X	X	X	X	X
Accommodate the use of the National Provider Identifier (NPI).	X	X	X	X	X		X	X		X
Verify if the performance of an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) screening identified the service.	X	X						X	X	X

We go beyond smart systems to create learning systems—customized, proprietary systems that we innovate to meet the evolving requirements of our contracts and create increasing productivity that drives value for our clients, the triple aim of service: accuracy, reliability, and satisfaction. From this efficient basis, we collaborate with the Bureaus, providers, members, and other stakeholders to improve the quality of care, the efficiency of service, and West Virginians' experience of care.

System Functionality and Performance

APS-WV developed a system to provide eligibility verification, screening, review, and authorization of services customized to West Virginia requirements and applicable state and federal guidelines. The APS system modules provide timely and efficient Utilization Management/Prior authorization of BMS medical, behavioral health and other services in all review areas outlined in the contract. The system has three major components: eligibility and other verifications, service authorization and Medical care management (CM) and follow-up for designated services. In the Medical UM module, the eligibility and service verification and other validation components are robust. The Behavioral Health module integrates eligibility and service authorizations that become the foundation for provider reviews. In contrast, the Health Homes program requires assessment and management so these components are highly developed in this module. For the BCF Socially Necessary services model, the APS System integrates the referral from the BCF worker and the authorization component is the most critical component. For ADW Waiver, the member's program eligibility is determined on entry to the program and the scheduling, assessment and annual member assessment form the backbone of the program. With the I/DD Waiver system, we manage program eligibility, enrollment, receive and review requests for authorization and manage provider and service delivery model. A general overview of available features in the APS medical System is outlined in Exhibit 6. This overview does not include the numerous customized features in the various applications designed to meet the specific requirements of West Virginia policy and the specific needs of each program within the purview of the scope of work. The specific features of each application are addressed in each program section in the RFP. The APS System integrates data from the claims payer and enrollment vendor to validate required functions and support review processes:

- Provider and Facility Enrollment: APS-WV receives a daily provider enrollment file from Molina. APS-WV verifies active Medicaid enrollment for the referring and servicing provider before reviewing and/or authorizing the service. Per Medicaid policy, only enrolled WV Medicaid physicians may order services and only WV Medicaid enrolled providers may deliver services. Out of network (OON) providers may receive authorizations to deliver services if no in-network provider is available.

- Medicaid Member Eligibility and Managed Care Organization (MCO) Coverage: the system displays member eligibility (including MCO coverage) when the provider searches for the member in the APS System, prior to creating the request for service authorization. Thus, if the provider does not locate non-MCO coverage for the individual, they do not continue with the entry of clinical information. This approach eliminates unnecessary work on the part of the provider if APS-WV should not conduct the prior authorization review due to lack of payer coverage.

- BBHHF Person-Level Indigent Care Eligibility: Based upon criteria established by BBHHF, APS-West Virginia will review each designated consumer's Bureau for Behavioral Health and Health Facilities (BBHHF) indigent care eligibility by way of evaluating newly Comprehensive Behavioral Health

Provider-submitted APS System records. The submitting provider will have timely access to the results of their BBHHF Person-level Indigent Care eligibility determinations, which will include the reason(s) for ineligibility. Furthermore, BBHHF will receive needed information regarding eligible individuals. Persons found to have existing Medicaid eligibility for behavioral health services will not receive BBHHF Indigent Care eligibility.

- BBHHF Indigent Care: APS-West Virginia verifies each member's payer eligibility before the provider is required to enter additional information via the web portal relative to a request for prior authorization of service(s). When an individual does not have another payer for the service, such as Medicaid, and a Comprehensive Behavioral Health Providers submits a BBHHF Indigent Care number when requesting authorization, which covers the requested start date and service, the request will then process for medical necessity determination and authorization. On the other hand, when a person has another third party payer for the behavioral health service, the request will not process for an authorization with BBHHF indigent care as the payer. Medicaid and other third party payers is the payer of choice over BBHHF Indigent Care as it is the payer of last resort.

- Referral for socially necessary services not applicable for medical services: SNS providers are verified in three ways. 1) The DHHR staff in charge of credentialing sends a report when any new SNS providers are enrolled in their system. 2) APS-WV's technical liaison requests a copy of the providers approval letter from BCF's Director of Child and Adult Services be sent by the provider before issuing user id's and passwords. 3) An exception occurs in the processing of the referral file when the agency's provider number does not match one of the approved provider list established in item one. Referrals cannot be accepted by APS-WV if the provider has not been approved by BCF. All out of state residential providers are verified by completion of the APS-WV Agency Self-Assessment, which is sent with the residential providers DHHR Provider Agreement by the Office of Grants and Contracts.

- Communication to the Agency if there are other payer sources involved with the services being requested (i.e., Rehabilitation, Workers' Compensation, Third Party insurance or other payer): The Medicaid applications contain fields for providers to report other payers and TPL. APS-WV notes other providers listed in the Molina system to ensure appropriate review of the request or administrative closure if another payer is responsible for the specific service. APS-WV will consider all available eligibility information to ensure other potential payer sources are identified and inform the requesting provider. APS-WV understands that WV Medicaid is the payer of last resort in most situations and will diligently identify and communicate other coverage options.

- The Benefit Plan actually covers the service requested: The APS System contains covered services and services requiring prior authorizations. One of the most significant benefits of using the APS System is that Benefit Plans that pertain to different eligibility groups are embedded in the application. This information includes limits to the number of service units and other coverage limits, for example, to the types of services available under the specific Plan. This information is available to APS-WV staff members as they document and respond to review requests and is available to providers who use the web interface to create prior authorization requests. Providers are therefore able to identify inconsistencies in the review request quickly that, if not corrected, could cause delays in the authorization process for the member. An important additional benefit

is the reduction in data entry errors for HCPCS and CPT codes and specification of service units and durations.

- Member enrollment in a specific Medicaid plan: the eligibility file obtained from Molina also delineates the type of Medicaid coverage for each member. The APS System displays this information when the service is requested.
- Service limits, if there are any limitations, attached to the coverage: The APS System manages coverage limits, restrictions and combination edits through a series of rules and specific programming within the application. These validations and edits are based on the Medicaid Policy Manual and the specific chapter(s) relevant to the program.
- Identification of appropriate coding for the service requested[3]: The APS System requires compliant, current CPT; CDT and HCPCS codes; and current ICD-10 diagnostic coding in accordance with the requirements set by DHHR for the specific program and in compliance with federal requirements and common coding procedures.
- With coverage definitions, service limits, and code sets embedded in the APS-WV application, we are able to build valid value tables for required fields, conduct data validation prior to processing a request, identify service limitations for requested services, and discuss alternatives to services that have been exhausted or are not available in a specific Plan. This resource makes the review process far more efficient and significant increases data quality. For this reason, APS-WV will emphasize the availability of the web system for provider requests and promote provider adoption of web-enabled requests.
- Provide professional staff (such as Physician Advisor, Nurse Reviewer, Dentist, Social Worker) to review for behavioral and medical necessity, social necessity, appropriateness, cost efficiency and approve services based on Medicaid coverage, socially necessary coverage, and behavioral health coverage guidelines, limitations, and eligibility. The medical and behavioral health programs utilize appropriately credentialed review staff to authorize services within the scope of their practice and licensure. All other programs; socially necessary services, waiver programs, Health Homes, Personal Care and NH PAS review; utilize appropriately credentialed staff to perform the required activities for these programs.
- Accommodate the use of the National Provider Identifier (NPI): APS-WV will accommodate the use of the National Provider Number (NPI) by all medical and behavioral health providers and will continue to use the FACTS Provider Number for identification of socially necessary service providers.
- Identification of service during the performance of an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) screening: In the APS System, providers are able to identify requests as EPSDT to trigger application of EPSDT criteria. APS-WV may also review and authorize non-covered services through this process if coverage is appropriate and within guidelines for the EPSDT program.

[3] Current Procedural Terminology (CPT); Current Dental Terminology (CDT); Healthcare Common Procedure Coding System (HCPCS) service codes; and International Classification of Diseases ICD-9/ICD10 diagnosis codes and/or applicable modifiers

A. Technical Requirements

1. General Prior Authorization Requirements

The purpose of *prior* authorization is to evaluate the necessity of services and appropriateness of setting before delivery. This conventional approach is a long-standing solution in public programs and uses a standard set of staffing and activities to accomplish review and authorization of services. Concepts and standards that are customary provide protections for both members and payers to which the review organization must adhere to ensure determinations are sound and timely, including notifications to providers and members as required and submission of accurate results to claims processors.

APS-WV assures those key elements essential to transparent processes for responsible review determinations that promote equitable access to high quality care:

- Experienced and expert review staff
  - Staff members supporting review activities have an average of 5.4 years of experience.
  - Management members supervising review activities have an average of 13.9 years.
  - APS-WV positions require a specific number of years of experience in a relevant field with appropriate credentials (depending on the position) and on average, the APS-WV review team exceeds these requirements for both experience and expertise.
- Customized and reliable information systems
  - The APS System platforms have been in place for West Virginia since 2000 with continued modification to meet new programs and requirements.
  - The APS System features "smart form" review screens, field-specific edits, embedded rules, and the ability to auto-adjudicate review requests. In fact, the APS System model is in place with over 40 applications for Medicare and Medicaid review, offering the efficiency of auto-adjudication to our clients.
- Evidence-based criteria
  - APS-WV uses both InterQual™ and MCG Care Guidelines™ for medical and behavioral health review, and custom criteria for waiver authorizations and Social Necessity Review, based on best practices and peer-reviewed literature.
  - For ease of provider use, the InterQual criteria will be utilized in both medical and behavioral health programs beginning January 2016.
- Availability of peers
  - APS-WV has a robust network of physicians and other peer reviewers, credentialed and licensed in the State of West Virginia.
  - Supplementing this network and assuring independent review services is the KEPRO contracted, national network of physicians and allied health professionals.

We show the standard prior authorization review process in Figure 6, displaying the process points for key activities and determinations. In Figure 7, we display the reconsideration process applicable in the event of adverse determinations such as denials or modifications. In the discussion of items (a) through (cc), we describe our approach, and indicate where specific program requirements differ from this standard.

Figure 6 General Prior Authorization Processes

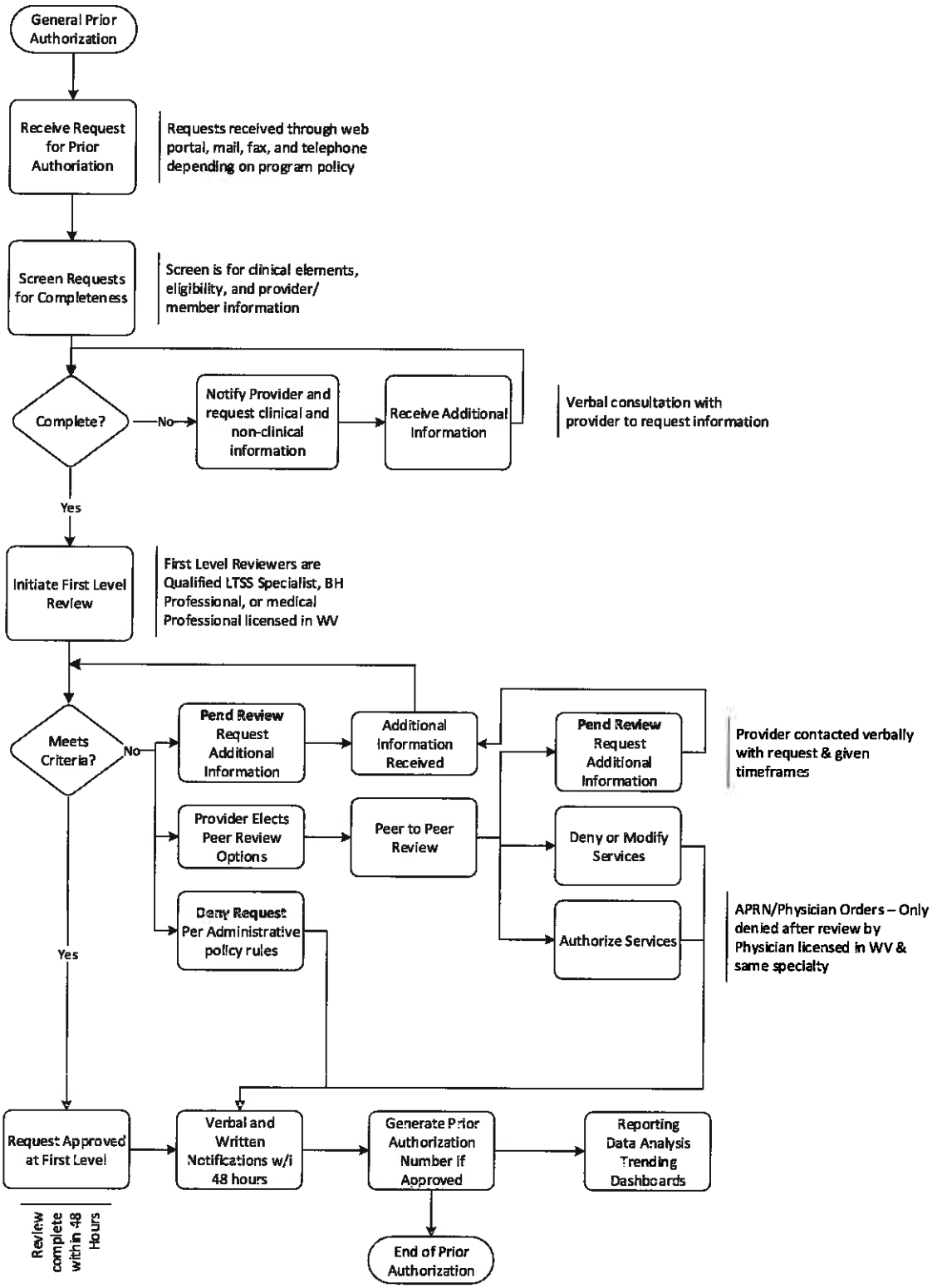
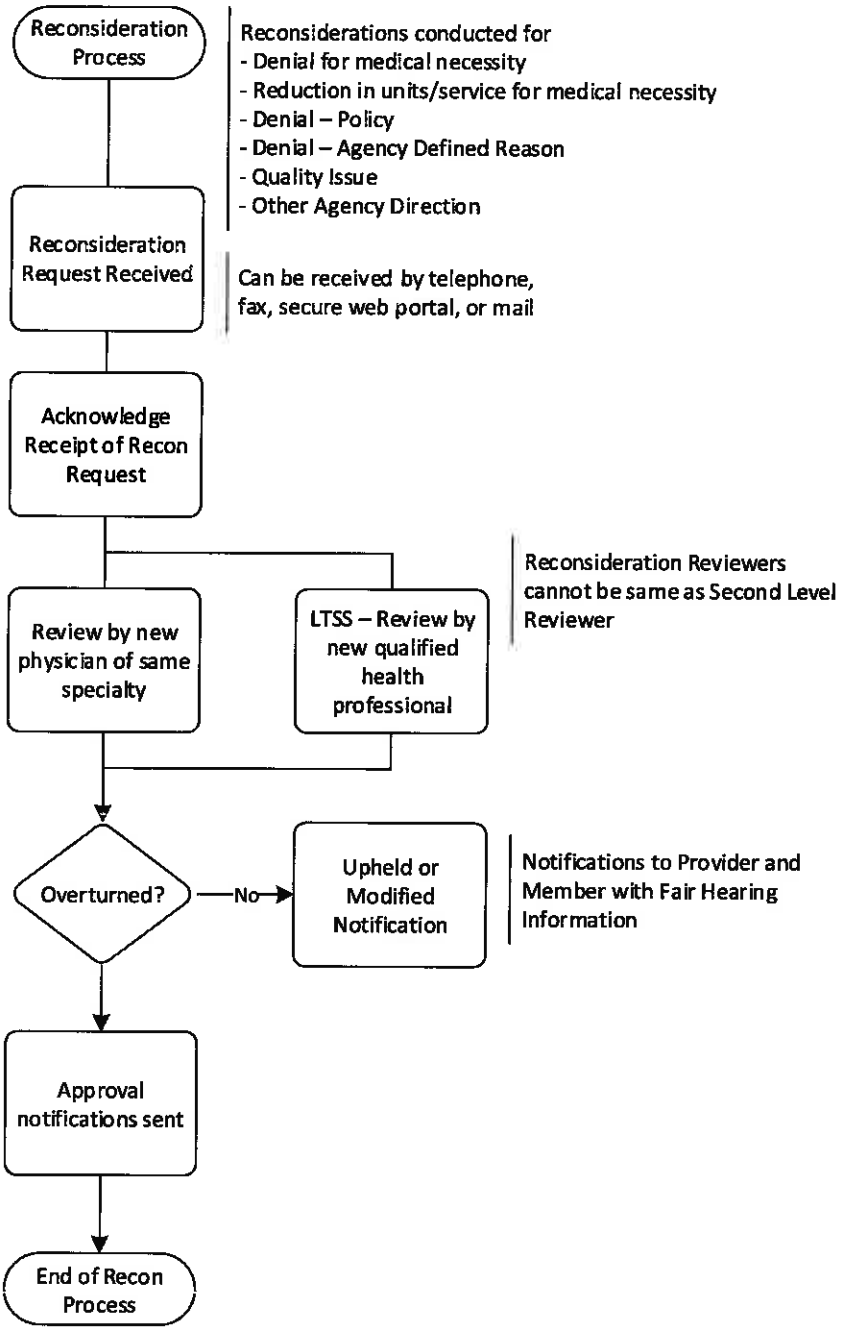


Figure 7 General Reconsideration Process



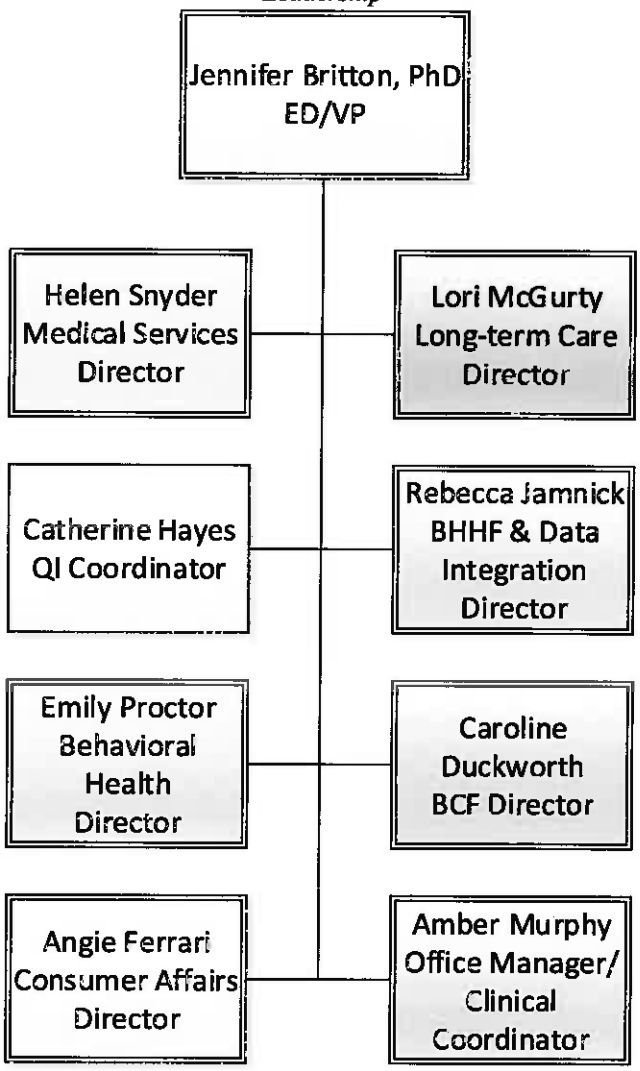
a. Administrative & Clinical Leadership

a. Demonstrate administrative and clinical leadership in UM services. The requirements in this section are applicable to all review functions.

Vendor Response

The APS-WV management team is in place and provides the clinical and administrative leadership for the program – and brings an average of 13.9 years of experience to these important roles. Figure 8 shows the APS-WV management team.

Figure 8 APS-WV Clinical and Administrative Leadership



This effective and well-coordinated team provides transparency and efficiency, and brings a record of achievement extending back to the very beginning of the contract. Through multiple project expansions, development of leading-edge programs such as social necessity and West Virginia's waiver management, APS-WV is a collaborative partner for the Department as a whole as well as its individual Bureaus. Together we designed and implemented the Department's innovative vision for West Virginia public programs.

We demonstrate leadership through acknowledgement as well as continuity. APS-WV provides credible and transparent prior authorization and other review decisions that encompass the full scope of the Department's programs. Our historically low denial, reconsideration, and hearing rates illustrate the validity and reliability of our review determinations and our willingness to discuss service duration, scope, and setting with providers to achieve optimal delivery for the West Virginia citizens who use them.

Just as we customize our systems, policies, and procedures for complete alignment with contract responsibilities, the management team and the staff they supervise align with contract responsibilities to ensure we meet the requirements of the scope of work and exceed the Bureaus' expectations for responsive, responsible, and flexible performance. We apply these principles to all review functions,

demonstrating our clinical and administrative leadership in all components of the scope of work now and for the future contract.

b. Develop, Implement & Maintain a UM Program

b. Develop, implement, and maintain a UM program that includes prior authorization and eligibility review, within forty-eight (48) hours of the request, in accordance with current federal and state policy guidelines and/or applicable court orders, and make any necessary referrals to outside agencies. This includes any changes by way of Current Procedural Terminology (CPT) changes, Current Dental Terminology (CDT) changes, International Classification of Diseases (ICD) revisions, National Correct Coding Initiative (NCCI) edits, Healthcare Common Procedure Coding System (HCPCS) changes, CMS directives, and/or changes developed by the Agency or its Fiscal Agent.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

BMS Medical and Behavioral Health

APS-WV provides an established operating system that accomplishes eligibility determination and prior authorization review for WV Medicaid providers offering medical and behavioral health services within 48 hours of the request. All determinations will adhere to federal and state policy guidelines, applicable court orders and make necessary referrals to outside agencies. We begin discussing the utilization management system in place for both of these programs.

The medical and behavioral health UM programs were developed and implemented to accommodate all of the services contained in the related Medicaid Manuals that require prior authorization either at the initial service or beyond service limits. It includes customized programming that alerts the provider to age restrictions, diagnostic restrictions, service limits or other limitations on a service that requires prior authorization. This information is communicated to the provider through a series of messages and prompts that appear on the request.

There are also certain policy limitations that will not allow the provider to submit a request (e.g. age restricted services for children cannot be requested for an adult). The date of birth regulates the service request being allowed or prohibited. Policy exceptions granted by BMS can be entered by APS staff. Our UM program is amenable to use with EPSDT and Out of Network Requests. Any requests for non-covered services (e.g., EPSDT requested) are addressed through approved workflows to ensure medical necessity. There is more information about these special workflows in the sections related to these services.

We maintain the APS system on an ongoing basis for consistency with coding and regulatory updates. These areas include, for example, Current Procedural Terminology (CPT) changes, Current Dental Terminology (CDT) changes, Diagnosis and Statistical Manual of Mental Disorders (DSM), International Classification of diseases (ICD) revisions, and Healthcare Common Procedure Coding System (HCPCS) changes. We also update the system to reflect National Correct Coding Initiative (NCCI) edits, CMS directives, and/or changes developed by the Agency or its Fiscal Agent (including but not limited to, code

additions, changes in coverage, rate changes, or policy changes). Maintenance is at a minimum quarterly but is performed as needed based on the necessary timelines to implement a change.

BCF Bureau for Children and Families

APS has developed, implemented, and maintained a UM program for Socially Necessary Services that includes prior authorization and eligibility review, within forty-eight (48) hours of the request. The system only permits access to referrals assigned to the specific provider by the referring DHHR workers. For behavioral health services paid for by BCF the corresponding Medicaid policy and procedures will be used including the prior authorization and eligibility reviews within 48 hours of the request.

c. Screen Requests for Completeness

c. Screen requests for completeness and request clinical and non-clinical information as appropriate for prior authorization and eligibility review, regardless of the mode of receipt.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Requests for prior authorizations are screened for completeness in several ways:

- All requests will be subject to eligibility verification to ensure coverage is appropriate for the service requested. A lack of coverage or identification of another payer source will result in notification to the provider. APS-WV's eligibility process is central to inform the provider at the time of submission whether eligibility issues are present.
- If a request is faxed, is it screened to be sure all mandatory fields are complete on the form, all critical clinical information is included on the faxed form or in attachments, and for legibility. If any information is missing or incomplete or if the form cannot be keyed into an APS System record for any reason, the form is faxed back to the provider with a fax cover indicating all information required for the request to be keyed into the APS System by an APS staff.
- If a request is Direct Data Entered (DDE), then all required attached and mandatory fields must be complete before the provider is able to submit the request. The provider is prompted as to the missing information or incomplete request fields when they attempt to submit the request. The provider may go back as many times as necessary to complete information and receives a message when the request is successfully submitted;
- If a request is in the clinical queue for review and there is specific information missing required for a case to meet criteria, the health professional will place the request in documentation requested status. We also a) place a note on the record indicating the information the provider needs to send to complete the request, and b) contact the provider by telephonic means, if necessary, to prompt regarding the needed information.

BCF Bureau for Children and Families

The APS System program utilized for the Socially Necessary Services program validates the submission items as they are entered, and will not permit a request to be sent without complete information. Medical services paid for by BCF follow the same specification as regular Medicaid requests.

d. Conduct Prior Authorization & Eligibility Review

d. Conduct prior authorization and eligibility review processes that include two (2) levels of review. The first level of medical review is to be conducted by a qualified long-term care support specialist or a qualified health professional licensed in the State of West Virginia with clinical knowledge and experience in utilization review. The first level of long-term care support services review is to be conducted by a qualified professional with clinical knowledge and experience in long-term care support services and utilization review. Requests not approved at the first level for not meeting criteria should be referred for a second level review by an appropriate healthcare professional (physician, dentist, orthodontist, etc.).

Vendor Response

Medical and Behavioral Health

APS-WV utilizes qualified health professionals licensed in the State of West Virginia with clinical knowledge and experience in utilization review. Registered nurses perform the first level review of medical requests, in addition to acute inpatient psychiatric services, partial hospitalization and psychiatric residential treatment facility services. Outpatient behavioral health services level one reviews are performed by Master's level licensed social workers and counselors for Medicaid and BBHHF Indigent Care behavioral health services that each cover.

In the medical system, the eligibility review is completed when a request has triggered an exception in the automated eligibility check (based on BMS' verification requirements). If the exception precludes APS review of the case then the case is administratively closed and the provider receives a message containing the current MCO active enrollment and contact number. For example, a Medicaid member is in a MCO on the date of service but the provider overrode the message and submitted the request but the eligibility check verifies that there has been no change in the member's status and they are in a MCO, the request would be administratively closed. Conversely, a case where the manual verification of eligibility in the Molina system confirms a change in the member's status that is not yet reflected in the daily eligibility file then the request is placed in the clinical queue for review.

The clinical queue is managed on a "first in, first out" basis. Each request is date and time stamped upon submission. Emergency/Urgent requests are managed first. The initial review is performed by an RN or consultant (e.g. speech therapist, audiologist, and chiropractor) based on approved clinical criteria. If the first level reviewer cannot approve the case based on criteria, the clinician makes notes regarding their findings and assigns the case to a physician (MD, DO, Specialty match) and is either authorized or denied. The physician level reviewer notes the reason(s) for the approval or denial in a note. If denied the member and referring physician and service provider are notified of the denial. The denial letter contains the specific policy and/or clinical reasons for the denial, reconsideration timelines and policy and notification of appeal rights to the member. The specific requirements for initial review for each medical review area

are discussed in more detail in Section B. Bureau for Medical Services (BMS) Prior Authorization Requirements under each listed medical service. This discussion includes a flow chart for review areas.

As in the medical system, behavioral health requests are subject to an initial eligibility review at the time of submission. The web based submission site will indicate to the provider if there are potential eligibility concerns based upon the start date of service requested. Our Eligibility Specialists will address those requests that do not automatically authorize due to an eligibility issue. Those requests in which eligibility can be determined will be moved along into the clinical queue for timely review. Those requests will be "pended" for further clinical staff review. Any request without Medicaid eligibility for the date of service will be closed and conveyed to the provider. This provider notification also includes identification of any other payer source.

While APS has the capability to receive prior authorization requests by any mode of receipt, we strongly encourage the use of our web-based application. This data-driven application provides real-time validation to ensure completeness of information submitted for clinical review. Clinical and business rules are embedded into the application to improve the accuracy of data entered and to ensure medical necessity is indicated for the requested service.

Clinical review of pended requests may result in the following outcomes: authorization, review status, closure, or denial. We will issue an authorization following clinical staff review, including any subsequent documentation received from the provider. Review status indicates providers need to submit further information, including those requiring physician reviews. Closures of requests typically involve a change to the APS System information (i.e., an incorrect service code is selected by the provider). A denial status is utilized only when a physician has reviewed the clinical information, including any subsequent documentation sent by the provider, and deems the request does not meet medical necessity. These Level II reviews are all completed by WV licensed psychiatrists. Denial notices are sent to providers, members, and guardians along with information on accessing further appeal options. Further information regarding specific behavioral health services is included in Section B. Bureau for Medical Services (BMS) Prior Authorization Requirements.

BCF Bureau for Children and Families

BCF does not fund long-term care support services at this time. However, if the BCF coverage status for these services does change it would match the existing Medicaid request policy and procedures. For the Socially Necessary Services program master's level social workers, counselors, and/or psychologist licensed at the master's level will be utilized for service request reviews at both levels of review.

BMS Long-Term Care

APS-WV will use WV licensed and experienced registered nurses, to perform first level medical approvals of Nursing Facility requests. In the event a request does not meet medical necessity upon first review, the RN will request additional or follow-up information from the submitting provider. If, upon receipt (or no receipt) of additional information, the request cannot be medically approved, the RN will refer the case to the RN Manager or another RN for consideration prior to determining the request not medically eligible.

Waiver and Personal Care services reviews are program-specific and are detailed in their respective sections.

e. First Level Determinations

e. Complete a first level determination with one of the following:

1. Certification of services by the first level reviewer;
2. Certification through the automated rules system, when appropriate;
3. Referral to second level review;
4. Pending of the review based on a request for additional information from the provider; or
5. Denial of the request due to administrative policy rules, as defined by the Agency.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

In the medical system, the initial request for prior authorization is reviewed with several possible outcomes:

1. Certification of services by the first level reviewer: this result occurs when medical necessity criteria are met and the first level reviewer is able to authorize the request. Upon authorization, a unique authorization number is automatically generated and is exported to the claims payer. The authorization is also available to the provider in several locations.
2. Certification through the automated rules system: requests can auto adjudicate in PT/OT if the request is for the initial 20 visits in the calendar year that do not require clinical review for authorization or for the initial 60 visits in the calendar year for Home Health requests. Additional areas slated for auto-adjudication are oxygen supplies and incontinence supplies in DME. These algorithms are developed and pending BMS approval. If the request cannot be authorized based on the algorithm it is sent to an initial level reviewer for review;

   Behavioral health service requests for eligible members are processed through an automated clinical rules system. Service authorization is dependent upon the service selection; select high-intensity services are not eligible for automatic authorization. When auto authorization is not possible, or clinical rules are not met, requests are reviewed by designated first level reviewers.
3. Referral to second level reviewer: If the first level reviewer cannot approve the case based on criteria, the clinician makes notes regarding their findings and assigns the case to a physician (MD, DO, Specialty match) and is either authorized or denied. The physician level reviewer notes the reason(s) for the approval or denial in a note.
4. If additional information is required to complete the clinical review: If additional information is required for the review to proceed, the review timeline is suspended for up to three (3) business days and the provider is notified of the information needed to complete the review. If the information is provided within the specified period, the review resumes and the APS timeline for reviewing the request resumes. If the information is not provided the request is administratively closed. In this instance the provider may copy the request for a new submission, update with the necessary information and the request is reviewed;

5. Denial of the request due to administrative policy rules, as defined by the Agency: An administrative denial is based on non-clinical reasons for denying a request for prior authorization. These include, but are not limited to, submitting a request out of timelines for prior authorization approved by BMS and not meeting BMS conditions for retrospective review, submission of a request for a service that is non-covered; submission of a service that is age restricted and the member does not meet policy guidelines, etc. In these cases, an administrative policy denial notification is generated that delineates the policy reason for decision.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. For Socially Necessary services, requests are first processed through a set of program based rules and auto authorized if the data matches the required criteria. If the request does not meet auto authorization standards a care manager will review, and can authorize, services. At this point, the care manager may also refer to a second level internal reviewer for further review, request further information from the provider or close for administrative reasons.

f. Second Level Determinations

f. Complete a second level determination with one of the following:

1. Certification of services by the second level reviewer;
2. Denial (or modification) of services by the second level reviewer;
3. Pending the review based on a request for additional information from the provider; or
4. Denial of the request due to administrative policy rules, as defined by the Agency.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

In the UM system, in instances where a second level reviewer is involved in determination several possible outcomes can occur:

1. Certification of services by the second level reviewer: this result occurs when a second level reviewer determines medical necessity criteria are met and the request can be authorized. Upon authorization, a unique authorization number is automatically generated and is exported to the claims payer, Molina. The authorization is also available to the provider in several locations.
2. Denial or modification of the services by the second level reviewer: If the physician (specialty match) denies a request, the reasons for denial are documented and included in the denial letter to the provider and member. All letters contain the service denied, the reason for denial (criteria that were not met), and BMS policy relevant to the denial. Both the physician and member letters indicate that the physician may request reconsideration. The member letter contains information informing the member of their appeal rights. All denials reference specific policy and/or criteria that were not met to assist the member and provider in appealing the adverse decision.

The second level physician reviewer may also approve a request with modifications. This is generally the result of discussion with the referring provider and an agreement to reduce units and/or duration of the authorization, request a lower level of service, or to provide a less costly but efficacious service. The modification is reflected in the APS System record along with the initial request from the provider.

3. Pending the review based on a request for additional information from the provider: The physician reviewer may also request additional information in an effort to make a determination of medical necessity. In this instance, the review timeline is suspended for up to three (3) business days. The provider is given notification of this action on the request- including the reviewer requesting the information and the specific information requested. If the information is provided within the specified period, the review resumes. If the information is not provided within the designated time, the second level reviewer either authorizes or denies the request based only on the available information.
4. Denial of the request due to administrative policy rules, as defined by the Agency: an administrative policy denial does not occur at the second reviewer level since they are performed by the level one reviewer. If a request does not comply with BMS policy, it is not clinically reviewed unless a specific policy exception has been made by BMS. In this instance, the result of the second level review, when indicated would be outcomes 1-3 above.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. For Socially Necessary Services the secondary reviewer may authorize a service, deny a service, request more information, or refer it to the DHHR Review Committee following the SOP for Denials updated in December 2014.

g. Denials by Physician Reviewer

g. Ensure that member's Advance Practice Nurse and/or physician orders may only be denied by a physician reviewer licensed in the State of West Virginia and of the same specialty as a result of the second level review.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

APS-WV can access a panel of physicians and consultants with expertise and experience in all review areas requiring prior authorization. Specialties represented on the review panel include, but are not limited to, the following areas of practice:

- Cardiologist
- Chiropractor
- Dentist
- Ear, Nose, and Throat
- Obstetrics & Gynecology
- Oncologist
- Orthodontist
- Orthopedist

- General Surgeon
- General, Family and/or Internal Medicine
- Geneticist
- Nephrologist
- Neurologist
- Neurosurgeon
- Psychiatrist
- Pathologist
- Pediatrician
- Podiatrist
- Radiologist
- Spinal Cord Injury Specialist
- Thoracic Surgeon

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program does not utilize physicians.

h. Pending Review Requests

h. Pend any services review request if the provider submits a request for certification with incomplete, inadequate, or ambiguous information; seek clarification or request that the provider submit all required information, including additional supporting clinical information, as necessary; initiate a process of placing a request on hold (pending) until additional information has been received.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Requests for which additional information is needed the request can be placed in a status of pending-documentation requested. This status suspends the review timeline for up to three (3) business days. The provider is given notification of this action on the request- including the reviewer requesting the information and the specific information requested. If the information is provided within the specified period the review and the APS timeline for reviewing the request resumes. If the information is not provided the request is administratively closed. In this instance the provider may copy the request for a new submission, update with the necessary information and the request is reviewed. If information is requested at the physician review level and not provided within the three (3) business day period the request is reviewed with the information provided and authorized or denied, as appropriate. In most instances, the result is a denial because the physician required the information to determine if medical necessity criteria were met. In these cases, the referring physician may request a reconsideration—Peer-to-Peer (Level I Reconsideration) or Reconsideration (Level II). The additional information will be provided at that time to the physician conducting the reconsideration review.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program care managers may place requests in a pending status while awaiting extra information that has been requested from the provider or DHHR worker.

i. Issue Verbal & Written Notifications

i. Issue verbal and written notification to the requesting provider of a pended review and for informing the provider of the information needed along with a time frame for submission.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Medical and behavioral health requests are held in the system when further documentation is requested from providers. The requests are placed in a pending-documentation and review status, respectively. This status suspends the review timeline for up to three (3) business days. The provider is notified using the same mode of submission as the request, the documentation requested and the timeline for receipt.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. For the SNS program, the APS System displays the reasons each request was placed in a pending status. Care Managers will call providers if the pend cannot be resolved without extra documentation.

j. Issue Denials for Services

j. Issue a denial for services when the case does not meet the Agency policy or supporting documentation is insufficient for approval of service.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

A denial for services when the case does not meet the Agency policy is considered an administrative denial. The decision is based on non-clinical reasons, which can include submission of a request for a service that is non-covered, submission of a service that is age restricted and submission of a request where the member does not meet policy guidelines. In these cases, we send administrative policy denial letters to providers delineating policy reasons for the decision and providing notification of appeal options.

During an initial RN/physician review, the reviewer may determine the current supporting documentation is insufficient to provide desired clinical information. In those instances, the provider is notified and has three (3) days to submit requested information to the reviewer. If receipt of the information is not received within timelines, the physician may deny the service based upon insufficient clinical information or if there is not enough clinical information to conduct a review the RN reviewer will administratively close the request. All letters contain the service denied, the reason for denial (criteria that were not met),

and BMS policy relevant to the denial. Both the physician and member letters indicate that the physician may request reconsideration. The member letter contains information informing the member of their appeal rights. All denials reference specific policy and/or criteria that were not met to assist the member and provider in appealing the adverse decision. We include the workflow for denials as Exhibit 7.These requests are not clinically reviewed except on Agency request for a policy exception or for EPSDT requests.

Upon physician review, we will either issue an authorization or proceed with the denial process. The provider will be notified when the physician does not issue an authorization; the requesting physician (ordering, referring, prescribing ORP) has the option to elect to speak with the APS physician regarding the review. Following that discussion, the APS physician can either modify the earlier decision and issue an authorization or uphold the earlier denial decision. The provider is notified of either outcome.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

k. Generate Authorization Number

k. Generate an authorization number when a case meets all policy and medical criteria necessary for certification of the services requested.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

When requests meet all policy and medically necessary criteria necessary for authorization, a unique authorization number is generated in conformance with the specifications of the claims payer Molina. The authorization is exported to Molina in a daily file and is available to the provider in several locations (i.e., within the web request, in a reports view, and within response files). The reports view can be converted to an Excel spreadsheet that can be manipulated by the provider to interface with their billing system, if desired. Authorization numbers may be issued in two ways: first, by auto adjudication through APS System application and, secondly, following clinical review by APS staff.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will also generate authorization numbers for requests that meet all policy and criteria.

l. Notify Medicaid Members

l. Notify Medicaid members of the denied requests in writing via U.S. Mail, and ensure that the member notice contains the basis for the denial and notice of the member's right to a fair hearing, except as otherwise noted.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

APS-WV notifies WV Medicaid members via U.S. Mail of denied requests. The denial letter contains the specific clinical and/or policy reasons (including specific BMS Provider Manual citations) for the denial. The letter also explains provider and member appeal options, including members' rights to fair hearings. If a member does not have a right to appeal the decision, e.g., service is not covered or OON service is denied because an in-network provider of the service is available, it is noted in the denial letter.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

m. Provide Written Notices

m. Provide written notices to providers online and/or via facsimile notifications, but also allow verbal notification of pended reviews to providers unable to receive written facsimile notification.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

APS-WV provides both verbal and written notification of pended cases. Notifications occur via the APS System modules through automated pend reasons, sent messages, and notes included from the initial reviewers. For those providers unable to utilize the system because of internet connectivity or other issues, specific arrangements are made to communicate with the provider via telephonic, fax or USPS means, based on provider preference.

APS-WV will provide written notices to providers online, through the APS System, regarding reasons for a pended case review. When a case does not meet full medical necessity criteria, it pends for clinical review. In addition to providers accessing pend reasons, cases moved from pend to review have a note section which is visible to providers and includes information from the care manager to the provider as to the reason the case is being held in review status.

The care manager may request specific documentation be faxed or emailed (e.g. perhaps an MCM-1 has not yet been received from a facility or a diagnostic report is not attached). Clinical staff communicates regularly with providers to ensure accurate, timely, and medically necessary services are available to the member. In the event a denial is issued, providers will be emailed via secure network the denial letter including appeal options. Providers who do not have online or facsimile access will receive verbal notification of pended reviews and any documentation requests.

Providers are notified of denials via letters that are attached to the APS System record within one (1) business day of the denial. The provider is also sent a message in the APS System to notify them that a denial has been issued for a specific case. Many providers have multiple staff members who are notified of denials to expedite the process of responding to the denial notification. This process is linked to the reconsideration process- as soon as the denial status is employed by the physician reviewer in the APS System- the provider has the Peer-to-Peer (Level I Reconsideration) and Reconsideration actions available in their action menu. They may exercise this option for up to 60 days following the denial. The denial letter includes the specific clinical and/or policy reasons (including specific BMS Provider Manual citations) for the denial. The letter also contains information about the reconsideration process.

1. While use of the secure online DDE system is encouraged, providers registered with APS (required for any provider requiring a prior authorization for medical services) that are unable to access the online system receive denial notices by fax and/or mail, depending on their preferences for notification.
2. With respect to other provider notifications (pending for documentation, administratively closed, authorizations, etc.) these are indicated in the APS System record and the provider uses their secure access to track the prior authorization requests they submit. For those providers unable to utilize the system because of internet connectivity or other issues, specific arrangements are made to communicate with the provider via telephonic, fax or USPS means, based on provider preference.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

n. Requesting Reconsiderations

n. Include in the written notice of adverse actions (denials or reductions) a statement that a provider, attending/ordering/referring physician, or member/representative/responsible party who is dissatisfied with the review determination is entitled to a reconsideration of the determination. The written notice should also explain the method by which a provider, Attending/ordering/referring physician, or member/representative/responsible party can request a reconsideration of the review outcome.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Written notices of adverse actions are sent to the provider, attending/ordering/referring physician, or member/representative/responsible party. The notices contain specific information related to the process for providers to request a reconsideration of the adverse action. With respect to the members/representatives/responsible parties, the written denial notice informs them that their physician/provider may request a reconsideration and indicates they should contact the provider to determine if the provider will exercise this. Members cannot request clinical reconsideration for themselves; however, they can request a fair hearing in the event their physician/provider does not exercise the reconsideration option and/or if reconsideration results in a denial of service being upheld.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

o. Conducting Reconsiderations

o. Conduct reconsiderations and make determinations upholding, modifying, or reversing the denial of payment for requested services by taking into consideration all pertinent information, including any additional or new information that may be presented during the reconsideration in accordance with current federal and state policy guidelines.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

When a reconsideration is requested, all pertinent clinical information provided at the initial request and any additional information provided upon reconsideration request is evaluated to make a determination of medical necessity and reverse or uphold the initial denial. Review of additional documentation and/or a discussion between the attending/ordering/referring physician and the APS reviewing physician, may result in a reversal of the initial denial (generating an authorization) or an upholding of the initial decision.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

p. Reviews Subject to Reconsideration

p. Provide, at a minimum, a reconsideration process for all types of reviews in which the decision is:

1. Denial of all services/items based on medical necessity;
2. Reduction in services/items based on medical necessity;
3. Denial based on West Virginia Medicaid policy that excludes coverage;
4. Denial on certain issues as defined by the Agency;
5. A quality issue, or
6. Other adverse decisions as defined by the Agency.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

The reconsideration process is available for all review areas. The reconsideration process may result in several outcomes:

1. Denial of all services/items based on medical necessity: Providers, ordering/referring/prescribing physician, members and/or their responsible parties receive denial notifications. Providers and physicians are informed of their option for a reconsideration when allowable by policy through the denial notification. Members are informed of their appeal option once the provider/physician has exercised their reconsideration option that results in no change in the denial status.
2. Reduction in service/items based upon medical necessity: the process for reconsideration following an earlier decision to reduce service/items is similar to the description in #1. The reconsideration request will be reviewed by a physician different from the original reviewer although a specialty match will be maintained.
3. Denial of the services (denial upheld): If the physician (specialty match) denies a request, the reasons for denial being upheld are documented and included in the letter to the provider and member. All letters contain the service denied, the reason for the denial being upheld (criteria that were not met), and BMS policy relevant to the denial. Both the physician and member letters indicate that the reconsideration has resulted in the initial denial being upheld. The member letter contains information informing the member of their appeal rights. All reconsideration letters reference specific policy and/or criteria that were not met to assist the member in appealing the adverse decision.
4. The reconsideration may also result in an approval with modifications. This is generally the result of discussion with the referring provider and an agreement to reduce units, request a lower level of service, or to provide a less costly but efficacious service. In these instances, the reason for the approval appears as "reapproved with modifications". The modification is reflected in the APS System record along with the initial request from the provider. The reconsideration letter to the member and provider indicate the reduction in services/items as approved based on policy.
5. Reconsideration may be requested by BMS. Reasons for reconsideration include:
    a. A request that was denied for non-coverage but a policy exception is being made;

b. A denial has been rendered but BMS has identified an issue they wish to be reconsidered in the review;
c. A quality issue has been identified (e.g. error on the part of the ASO);
d. Any other reason the adverse decision is to be reviewed, as defined by the agency.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

q. Accepting Reconsideration Requests

q. Accept reconsideration requests by phone, facsimile, secure web based system, or mail, and have dedicated phone and facsimile numbers for reconsiderations.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

In the APS System, reconsideration requests are accepted by fax, USPS and the secure web based system. In the medical system, the Reconsideration Level I and Reconsideration Level II actions become immediately available in the System for the provider to request Peer-to-Peer review and/or reconsideration. Behavioral health providers directly notify APS staff rather than through the DDE system. The Peer-to-Peer (Level I Reconsideration) action must be requested before the Reconsideration (Level II) is requested, if the provider wishes to utilize the Peer-to-Peer review option. The Level II Reconsideration action must be utilized within 60 days of the denial, after this time the actions related to reconsideration are no longer available to the provider (per BMS policy). A reconsideration review may be approved at any time by BMS, based on an Administrative Appeal. In cases where more than 60 days have elapsed, the provider must fax the information to APS in order to complete the reconsideration review. If the provider faxes or mails the information to APS, the reconsideration action is selected by APS and the information is attached to initiate the reconsideration review process.

Peer-to-Peer discussions (Reconsideration Level I) are documented in the APS System record. This physician-to-physician discussion may result in an approval of the request. In this instance, the Reconsideration Level II action is not necessary. If the Peer-to-Peer discussion results in the denial being upheld, the Level II Reconsideration is still available to the provider.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

r. Acknowledge Reconsideration Request

r. Notify individuals requesting reconsiderations of receipt of the request and afford the individual the opportunity to provide additional information in accordance with current federal and state policy guidelines.

Vendor Response

We respond to this section with a focus on the BMS Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Providers receive notification of receipt of their reconsideration request. Notification occurs through phone, fax, and APS System features. Any additional information submitted at the time of reconsideration request will be presented for physician review.

This information is attached to the reconsideration to separate it from the initial information upon which the denial was based. Reconsideration reviews are performed by physicians on the APS-WV panel of the same specialty who did not complete the initial denial review. The physician completing the reconsideration review utilizes the information from the first review and any additional information sent at the time of the reconsideration request to render a decision regarding whether the initial denial should be upheld or overturned.

The appropriate letters are attached at this level of the record when the review is complete and the decision is rendered. Those providers that cannot utilize the online system are notified by fax when a faxed request for reconsideration is received or telephonically when a mailed request is received. Letters are sent in the same format that the reconsideration was requested.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

s. Reviewing Physician - Reconsiderations

s. Ensure that a second physician of the same specialty as the Attending/ordering/referring physician or a qualified long-term care support specialist not involved in the initial decision reviews the reconsideration request, the original information, and any additional information submitted with the reconsideration request and makes a determination.

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Attending/ordering/referring physicians may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. The initial review information, reconsideration request, and additional information are then forwarded to a different board certified MD/DO with specialty match or a qualified long-term care specialist, if appropriate for the review, for a final determination.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

t. Procedure for Discussing Cases

t. Establish and maintain a procedure for the attending/ordering/referring physician and/or applicable service provider to contact the Vendor's Medical Director, Dental Director, or program manager to discuss service cases that have been denied, modified, or considered for denial.

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

Following an initial denial the attending/ordering/referring may request a Peer-to-Peer discussion with the physician who rendered the initial denial. If the physician who rendered the denial reverses the decision following this discussion, an authorization is granted. If the decision is upheld, a reconsideration review by a second physician in the same specialty may be requested.

APS' Medical Director may be contacted at any time by an attending/ordering or referring physician to discuss any identified service issues related to physician reviews or to discuss cases that have been denied or modified. Due to the small volume of dental requests, APS does not have a specified Dental Director, but utilizes a lead reviewer in each of the dental specialty areas: general dentistry, orthodontia, and oral-maxillofacial surgery to discuss any identified service issues related to physician reviews or to discuss cases that have been denied or modified. Concerns that cannot be addressed at this level are referred to the Medical Director.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

u. Written Notification of Reconsideration

u. Provide written notification of reconsideration determinations in accordance with current federal and state policy guidelines for receipt of the request for a standard reconsideration.

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

APS provides written notification of reconsideration in accordance with current federal and state policy guidelines in formats approved by BMS and their legal counsel. Letters are modified at the request of BMS if there is a change required due to a change in federal or state policy or because of any court order.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

v. Request for Fair Hearings

v. Include a statement in the written notice explaining the member, representative, or responsible party has the right to request a fair hearing from the Agency if the reconsideration determination was upheld or any portion was not approved as requested.

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

The reconsideration notice for medical and behavioral health services mailed to the member contains a statement of the member's appeal rights. In addition, the Bureau's Fair Hearing Request Form is included with member denial notifications.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

w. Request Formats

w. Receive prior authorizations and eligibility review requests and supporting information via secure web-based submissions, facsimile, and mail from services providers through all of the following:

1. *Establishing and maintaining a dedicated telephone number, toll-free in West Virginia, for the receipt of prior authorization requests for services submitted by telephone.*
2. *Establishing and maintaining a facsimile number, toll-free in West Virginia, for the receipt of review requests for services submitted by facsimile.*
3. *Establishing and maintaining a physical mailing address in West Virginia for the receipt of review requests for services submitted by mail.*
4. *Establishing and maintaining a secure web-based system for receipt of review requests for services submitted electronically.*

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

The APS web-based system has a secure provider portal that permits registered providers and their designated users to request prior authorization for medical services. Although providers are encouraged to direct data enter requests for optimal timeliness of review, providers may also fax or mail requests to APS. A form has been developed for each review area, which contains all of the mandatory elements and prompts the provider to send all the necessary information for a record to be created in the system by an APS staff. Upon receipt of a mailed or faxed request, APS reviews the completeness of the request. Incomplete requests are returned by the same means it is received. Once a faxed or mailed request is keyed in the APS System, the review timelines begin. The following elements are present in the APS system to support these methods of submission:

1. APS maintains dedicated toll-free numbers for receipt of telephonic requests. APS-WV publishes these numbers to providers in contact materials we distribute.
2. APS maintains several general fax lines but also maintains dedicated fax lines for the receipt of faxed requests in the various review areas these numbers are in Table 10. APS-WV also publishes these numbers to providers in contact materials we distribute.

Table 10 Fax Numbers for Prior Authorization Requests

Fax Numbers	
Bariatric, Inpatient (Acute), Inpatient Rehab Under 21, Organ Transplants	Fax 844-633-8426
Outpatient Surgery	Fax 844-633-8427
Imaging/Radiology, Lab	Fax 844-633-8428
Cardiac & Pulmonary Rehab, DME, Orthotics & Prosthetics	Fax 844-633-8429
Home Health, Hospice, Private Duty Nursing	Fax 844-633-8430
Audiology/Speech, Chiropractic, Dental/Orthodontic, Podiatry, PT/OT, Vision	Fax 844-633-8431
Modification Requests, EPSDT, Out of Network	Fax 866-209-9632
Behavioral Health	Fax 866-473-2354

3. APS maintains a physical mailing address in West Virginia for the receipt of review requests and additional or supporting materials submitted by mail. APS-WV publicizes this address to providers in contact materials we distribute. This address is:

   APS Healthcare
   100 Capitol Street, Suite 600
   Charleston, WV 25301

4. APS maintains a secure web-based system- the APS WV System for receipt of medical and behavioral health prior authorization requests in all medical review areas and from all provider types. APS-WV publishes the URLs for this system to providers in contact materials we distribute. This application currently has the ability to perform "smart" or auto-adjudicated reviews and APS-WV will implement this capability in the next contract period.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

x. Automated Review Request System

x. *Develop, implement, and maintain a secure web-based, electronic review request system for prior authorization and eligibility review that allows for data input by the submitting providers with an automated criteria/rules-based certification system.*

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

The APS web-based system has a secure provider portal that permits registered providers and their designated users to request prior authorization for services. Organizations must register with APS in order to utilize the system. Each provider organization must be an enrolled West Virginia Medicaid provider to

be approved to utilize the system. Once registered the provider organization designates an organization manager (medical) or data contact/care manager contact (BH) who may authorize users to receive secure access to the system in order to create requests for the specific organization. Provider access to various review areas is governed by a provider grid. For recognition as a referring provider, the provider must be an active WV Medicaid enrolled physician or practitioner permitted to write an order for the specific service; to be a service provider, the provider must be actively enrolled permitted by WV policy to perform the specific service. The provider creating the record in the APS System is referred to as the requesting provider. Requesting providers have access to records they create; the service provider has access to the prior authorization and member information necessary to schedule and perform the service. Requesting providers log into the system using their user names and secure passwords and can then create requests, faxes, or mails a request to APS-WV for entry in the system. The Reviewer verifies member eligibility for the requested service as well as the member's Medicaid eligibility through data embedded in the review application. The system pre-fills member demographic and provider enrollment information based on the requesting provider's selections.

The APS-WV Medical application supports the specific policies and the approved medical necessity criteria for RFP review areas. Clinical information required is based on information necessary to conduct the medical necessity review. Specific fields are mandated and validated in the applications to ensure that the information needed to authorize the appropriate service, duration, amount and the most cost effective item, are contained in the request. Providers are alerted through error messages if they attempt to submit a request that does not contain all mandatory fields. Error messages to the submitting provider are designed to indicate unit limits and member benefit limitations. Programming in the application is designed to alert the APS reviewer to areas not meeting policy requirements and/or criteria checks. These exceptions are displayed as pend reasons that guide the reviewer to areas of policy that require special attention when the review criteria are applied to the authorization request. This approach provides consistency to the review with respect to service limits, areas of possible service duplication, possible service combination edits, and diagnostic or other restrictions applicable to specific services.

APS designed the application to comply with state and federal requirements for medically necessary services as well as Bureau specific policies. We update these resources as necessary to maintain compliance if requirements change.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program's existing system is a secure web-based, electronic review request system for prior authorization and eligibility review that allows for data input by the submitting providers with an automated criteria/rules-based certification system.

y. Manual Review

y. Manually review each prior authorization and eligibility review request received that is not certified by the Vendor's rules-based system, along with any required supporting documentation to support the need for services.

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

All service requests submitted through the APS System application are subject to eligibility verification, provider verification, service eligibility verification and are subject to a series of validation and accumulation rules. This rule checking delivers pend reasons for any area that requires reviewer attention. This checking also alerts the reviewer to possible service limit issues related to previous authorizations and to any clinical issues or possible duplications related to the request. This assists the Reviewer in evaluating any policy issues in addition to applying the approved medical necessity criteria to the service request. Any service not programmed for auto-adjudication or which does not meet auto-adjudication requirements receives manual review. This process includes the review of all supporting clinical documentation provided to support medical necessity.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program's care managers currently manually review each prior authorization and eligibility review request received that is not certified by our rules-based system, along with any required supporting documentation to support the need for services.

z. First Level Review

z. Provide a first level review conducted by a complement of qualified staff, which includes registered nurses, and/or other staff as deemed necessary by the Department to apply the Agency policy and the Agency approved medical necessity criteria based on certification policy and criteria or refer requests that cannot be approved to a second level review.

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

An RN, Consultant (e.g., speech therapist, audiologist, or chiropractor) or Master's level Social Worker/Counselor for behavioral health outpatient requests performs the initial review based on approved clinical criteria and BMS policy. If the first level reviewer cannot approve the case based on criteria, the clinician makes notes regarding their findings, and assigns the case to a physician (MD, DO, Specialty match) and makes a recommendation for approval or denial. The physician level reviewer notes

the reason(s) for the approval or denial in a note. If denied the member and referring physician and service provider receive notifications of the denial. The denial letter contains the specific policy and/or clinical reasons for the denial, reconsideration timelines and policy and notification of appeal rights to the member. We discuss the specific requirements for initial review of each medical area in more detail in Section B. Bureau for Medical Services (BMS) Prior Authorization Requirements. These responses reference workflows included as Exhibits to the proposal for each review area.

Medical and Behavioral Health

In the Medical and BH APS Systems, review of the initial request for prior authorization has several possible outcomes:

1. Authorization of services by the first level reviewer: this result occurs when documentation supports medical necessity criteria and the first level reviewer is able to authorize the request. Upon authorization, the system generates a unique authorization number automatically, which it exports to the claims payer, Molina. The authorization is also available to the provider in several locations in the request and in a reports view.
2. Authorization through the automated rules system: requests can auto adjudicate in PT/OT if the request is for the initial 20 visits in the calendar year that do not require clinical review for authorization or for the initial 60 visits in the calendar year for Home Health requests. Additional areas slated for auto-adjudication are oxygen supplies and incontinence supplies in DME. APS-WV completed development of these algorithms and they are pending BMS approval. If the system cannot authorize the request based on the algorithm an initial level reviewer, conducts review. The BH System is programmed to allow initial requests of various services to auto-authorize (e.g. assessment, initial individual and group therapy) if all clinical requirements in the algorithm are met.
3. Referral to second level reviewer: If the first level reviewer cannot approve the case based on criteria, the clinician makes notes regarding their findings and assigns the case to a physician (MD, DO, Specialty match) and is either authorized or denied. The physician level reviewer notes the reason(s) for the approval or denial in a note.
4. If additional information is required to complete the clinical review: If additional information is required for the review to proceed, the review timeline is suspended for up to three (3) business days and the status of the request is changed to pending-documentation requested. The provider receives written notification of this action on the request- including the reviewer requesting the information and the specific information requested. If we receive the information within the specified period, the review resumes and the APS-WV timeline for reviewing the request resumes. If we do not receive the information, we close the request administratively. In this instance, the provider may copy the request for a new submission, update with the necessary information and we then review the request.
5. Denial of the request due to administrative policy rules, as defined by the Agency: The reasons for an administrative denial are of a request for prior authorization non-clinical. These include submitting an untimely request for prior authorization approved by BMS and not meeting BMS conditions for retrospective review, submission of a request for a service that is non-covered; submission of a service that is age restricted and the member does not meet policy guidelines etc.). In these instances, APS-WV generates an administrative policy denial that delineates the policy reason for the administrative policy denial.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

aa. Second Level Review - Medical

aa. Provide a second level review, if the medical request is not approved at the first level, conducted by physicians to make review determinations on: 1)documentation that supports the medical necessity; 2) consideration of unique factors associated with each patient care episode; and 3) clinical experience, judgment, and generally accepted standards of healthcare. Second level review procedures should, at a minimum:

1. *Include a verbal consultation by the physician reviewer with the attending/ordering/referring physician to obtain additional information when the documentation submitted does not clearly support medical necessity.*
2. *Ensure that all cases (including reductions) not meeting medical necessity criteria are reviewed by a physician of the same specialty as the case under review.*

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

Medical and Behavioral Health

For medical and behavioral health requests second level medical review of an initial request is performed by a physician (specialty match) when the request cannot be approved by the RN Reviewer or Consultant (Speech & Audiology). The initial reviewer makes notes regarding the clinical presentation and medical necessity criteria not met. The physician conducts a review of the clinical information presented and the initial reviewer summary and makes a determination to authorize or deny the service. APS-WV bases the determination on 1) review of the documentation presented to support medical necessity; 2) review of the criteria not met with consideration of unique factors associated with the patient clinical presentation, and; 3) application of the reviewer's clinical experience, judgment, and application of generally accepted standards of care.

The second level reviewer may conduct a verbal consultation with the attending/ordering/referring to obtain additional information to clarify or support medical necessity. The physician reviewer must document the medical justification for the approval if the request did not meet criteria or document additional information obtained to meet criteria. If physician reviewers deny the request, they must document the denial reasons, criteria not met, and other factors evaluated in the denial determination.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

bb. Second Level Review – Long-term Care Support Services

bb. Provide a second level review if long term care support services request is not approved at the first (1) level, conducted by qualified health professional to make review determinations on: 1) documentation that supports the medical necessity; 2) consideration of unique factors associated with each patient care episode; and 3) clinical experience, judgment, and generally accepted standards of healthcare. Second level review procedures should, at a minimum:

1. *Establish procedures for verbal consultation by the qualified health professional reviewer with the referring long-term care provider to obtain additional information when the documentation submitted does not clearly support medical necessity.*
2. *Ensure that all cases (including reductions) not meeting medical necessity criteria are reviewed by a qualified long-term care support specialist or a licensed qualified health professional of the same specialty as the case under review.*

Vendor Response

This requirement applies differentially according to the program. For this reason, we respond by program and explain the process of second level review for the specific program. This discussion illustrates the technical capabilities of APS-WV as well as our ability to maintain and successfully administer highly varying program requirements.

Intellectual/Developmental Disability Waiver

To comply with existing policy and procedure, APS Registration Coordinators (RC) receives requests for I/DD Waiver services through the APS I/DD Waiver system. RCs are qualified in that they have at least two (2) years' experience with the intellectual/developmental disability population and a minimum of a Bachelor's Degree in a human service field. APS always assures a Registered Nurse fulfills at least one RC position (Bachelor's Degree preferred). Staff undergoes extensive training, shadowing, and supervision prior to being permitted to make decisions independently.

RCs receive requests and make determination based on the documentation submitted through The APS System, which includes demographic, medical, service plan or any other documentation available. Using their clinical judgment, they evaluate the possibility of the case being a unique situation or an outlier. In the event the RC is unable to authorize a request, they first move the status of the request to "doc requested." This initiates a notification for the Service Coordinator to submit information that would be necessary to authorize the request. Upon review of any new information submitted, the RC will make a decision related to the request. If unable to authorize, the RC offers to work with the Service Coordinator and recommend viable solutions and a service mix that APS-WV could authorize. If unsuccessful, the RC closes the request and makes a note to the provider offering they may submit a Second Level Negotiation form. Should the provider/member choose to pursue Second Level Negotiation, we will process the request and submit to the Bureau for Medical Services Program Manager. The Program Manager will make the decision to authorize or deny the request. We will then process the decision and make any necessary notices including Medicaid Fair Hearing rights for denials.

Traumatic Brain Injury Waiver

The TBI Waiver Assessment Coordinator is responsible for determining medical necessity and appropriateness of TBI Waiver service requests as outlined in policy. Staff must have a minimum of a Bachelor's Degree (Master's Degree preferred), a license in Social Work, Registered Nursing, Counseling, and/or Rehabilitation Counseling, a minimum of one year of experience with the disability population and be a Certified Brain Injury Specialist.

Staff receives a request for TBI Waiver authorization. They review the information and any available information including assessments, service plan, demographic information, and any circumstances unique to the member. They will evaluate whether requested services are within policy, reflected on the service plan and within the maximum funding amount as determined by the Bureau for Medical Services. If unable to approve the request, staff will contact the Case Management agency and request additional information/documentation to substantiate the request. If, upon review of the additional information submitted, staff is unable to approve the request, the reviewer will request a second level case review by a different TBI Waiver Assessment Coordinator or the TBI Waiver Program Manager. The second level reviewer will make a final determination, and we will send the appropriate notice of decision letter including Medicaid Fair Hearing rights, if applicable.

Aged and Disabled Waiver

Consistent with existing policy, a Registered Nurse (RN) makes determination of medical necessity for the Aged and Disabled Waiver program through the Pre-Admission Screening assessment. In the event medical necessity is not determined based on criteria established in policy, we will issue a Potential Denial notice to the member/legal representative, provider (for reevaluations) and referring physician (for initial requests) with an opportunity to submit additional/supporting documentation within two weeks. We will outline what areas met deficit criteria as collected during the PAS. Upon receipt of new information, the RN reviews and submits to the APS System. We determine if information substantiates medical necessity for the program and issue a notice of decision including Medicaid Hearing Rights, if applicable.

Nursing Home

APS-WV receives requests for Nursing Home services via the APS-PAS system or via fax from the submitting provider. A Registered Nurse reviews the request including any unique factors and additional documentation for determination of medical necessity. If, after review, the RN cannot approve the request (it does not meet medical necessity), the RN will request additional documentation from the requesting provider. If providers wish to continue the request with additional information substantiating required deficits, they resubmit the request with new data elements (deficits) to substantiate medical necessity, as required by policy. If RNs cannot approve requests, they forward requests to another qualified Nursing Home RN for consideration and review. If the second reviewer cannot approve the request, we send the appropriate decision letter including Medicaid Fair Hearing rights, if applicable.

BCF Bureau for Children and Families

BCF and the Socially Necessary System do not cover long-term care support services. However, if this coverage changes it will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

cc. Notification of Review Determinations

cc. Notify providers and members or legal guardians/representatives of review determinations services requests.

1. *Issue verbal and written notification of approved certification results to the provider and/or attending/ordering/referring physician.*
2. *Issue verbal and written notification of denials (including modifications) to the provider, facility, attending/ordering/referring physician, and member or, the legal guardian/representative, if applicable.*
3. *Ensure timeframes for notification to providers and members of review outcomes for prior authorization and eligibility review of services comply with current federal and state policy guidelines utilizing the Agency approved criteria and policies.*

Vendor Response

On completion of first or second level review as applicable to the specific program and service, APS-WV prepares notifications for providers and members, including legal guardians/representatives as relevant. These stakeholders need accurate and timely information, presented in an accessible format, and supported by knowledgeable staff members in the Call Center who can answer questions and provide technical assistance as needed—especially for members who assistance with the reconsideration and/or Fair Hearing process. APS-WV has the systems and staffing to meet these requirements completely.

Verbal and Written Notifications of Approvals

The Review staff member will be responsible for verbal notification to the requesting provider on approval of authorization requests and will contact the requesting provider telephonically. APS-WV provides notification of request certification through secure electronic communications through The APS System.

Verbal and Written Notifications of Denials

The Review staff member is aiso responsible for verbal notifications of denied or modified services on completion of the second level of review, contacting members or their representatives/guardians as appropriate. APS-WV issues formal written notifications of denied and/or modified services to requesting providers, facilities, and members/guardians/representatives. These notices include a clear rationale for the adverse determination and specific instructions to request reconsiderations and/or Fair Hearings.

Ensuring Timeframes for Notifications

APS-WV ensures that we issue notices on a timely basis through formal mechanisms of process control. Policies and procedures detail the requirements and timeframes and align with our URAC accreditation in Health Utilization Management. Staff training provides the basis for knowledge and utilization of these policies and procedures, specific to the Bureau program and service requested. Tracking and reporting enable us to monitor adherence to these requirements, and through our quality assurance process, we identify and address any causes of non-adherence. This systematic approach to performance ensures we consistently meet timeframes for notifications and all other aspects of the requirements.

BCF Bureau for Children and Families

Medically necessary services funded through BCF will follow the same processes as Medicaid requests. The SNS program will follow the SOP for denials updated in December 2014.

B. Bureau for Medical Services (BMS) Prior Authorization Requirements

1. MEDICAL SERVICES TECHNICAL REQUIREMENTS

We describe the specified medical services provided in the UM program in detail in the subsequent sections. In general, APS-WV prior authorizes medical services for the Medicaid population not enrolled in Managed Care. This is primarily the Categorically Needy population who qualify for Medicaid under the enrollment categories that are not part of TANF and Medicaid Expansion (Alternative Benefit Plan) and SSI members. APS receives a daily eligibility file from Molina, which contains all Medicaid enrolled members. The system displays the current enrollment status for a member in the member search results. This capability is important for providers since many Medicaid members may change plans at re-enrollment junctures or if they qualify for another eligibility category based on disability, change of income status etc. If a member is MCO-enrolled, a search by the provider will indicate the member's assignment to the MCO. The provider may proceed to make a request for the member if they believe the MCO coverage is not current or the MCO does not cover the service. However, all such requests will require eligibility review by APS. If we determine that the request is within the purview of the MCO, the request is closed and the provider is informed that they must consult the MCO for the prior approval requirements and member coverage for the requested service.

a. Inpatient Medical/Surgical Services

a. Inpatient Medical/Surgical Services

Vendor Response

We respond to this section with a focus on the Medical and Behavioral Health and BCF programs. To enhance clarity and avoid duplication, individual program responses in future sections detail program-specific methodologies and capabilities.

The flow diagram included in Exhibit 8 illustrates the process for submission and review of Inpatient Medical/Surgical Requests. Inpatient Medical/ Surgical Requests are scheduled inpatient procedures or direct admissions for approved procedures normally performed in an inpatient setting. They may also be for surgical services normally performed in an outpatient surgical services that are not safe to perform in an outpatient setting due to the member's medical condition or concomitant medical issues that preclude patient safety in an outpatient setting (General and Acute Inpatient Hospital Admissions are discussed later in section v). Bariatric Surgery provided on an inpatient basis is included in this review area. The manual requirements for prior authorization are as follows:

Chapter 510 defines an inpatient admission as a "person who has been admitted to an inpatient facility for bed occupancy for purpose of receiving inpatient hospital facility services." Inpatient Hospital Services must be medically necessary to diagnose and treat an eligible member.

> "Inpatient and outpatient hospital services, including tests furnished by participating hospitals, are covered only when ordered by a licensed medical practitioner for the care and treatment indicated in the management of illness, injury, or maternity care, or for the purpose of determining existence of an illness or disease. All Medicaid covered items and services must be medically necessary. The physician's order and appropriate documentation of medical necessity

must be on file in the patient's record. The fact that a provider has prescribed, recommended, or approved medical care, goods, or a service, does not in itself make such care, goods or services medically necessary or a covered service."

The definition of medically necessary, per Chapter 200, Definitions is:" **Medically Necessary** – Services or supplies that are proper and needed to diagnose or treat a medical condition." Medically necessary services are not for the convenience of the member or the provider. Covered inpatient services include:

- General acute care admissions
- Critical access hospitalizations
- Medicare certified distinct part medical rehabilitation inpatient units (for members under 21) (these services are discussed in section ff)
- Medicare certified, distinct part Psychiatric Hospitals (children and adults) (these services are discussed in section a of the Behavioral Health Services Utilization Management Technical Requirements)

Prior authorization requirements include:

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

The inpatient facility obtains Prior Authorization or the attending physician makes the request on behalf of the facility. The prior authorization covers adjunct services provided by inpatient physicians (e.g., pathology, Emergency Room, anesthesia, radiology, and laboratory) unless a specific exception is noted. Inpatient authorizations are DRG driven. Per Chapter 510, covered services are inpatient admissions with prior authorizations from the Bureau's Utilization Management Contractor. Currently APS-WV authorizes these services. APS-WV uses the following procedure for inpatient medical/surgical review requests:

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility:* APS-WV receives requests for Inpatient Medical/Surgical services by Direct Data Entry (DDE), fax, mail, or telephone (if request is urgent) . APS-WV uses the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically. This system includes member eligibility information and provider enrollment information to ensure appropriate application of program-specific requirements for Medicaid eligibility, coverage, and eligibility for specific services. We discuss the process, with some variations depending on program, throughout the Technical Response.

b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and notify them that we cannot process the request until we establish their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS-WV to gain access to the APS System. A referring provider grid and a servicing provider grid determine provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area provide the basis for the grid, which also must meet the requirements of Molina provider contracts related to the provision of services authorized by APS-WV.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If we identify an alternative payer, APS-WV will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules that only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions in the system. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services meeting EPSDT requirements). The reviewer confirms that each request for service conforms to current Medicaid program coverage policy and benefit limitations. The system highlights any exceptions as pend reasons for the reviewer to evaluate. If APS-WV receives the service request by fax (and it is not EPSDT), and determines it is a non-covered benefit, we advise the requestor, do not enter the request, and discontinue the review process.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request. We do not extend inpatient requests beyond 30 days. Note that the Bureau identifies specific DRG's for which it will extend coverage based on any extenuating circumstances determined by the review.

2. *Determine if the request is complete:* If a request is incomplete (i.e. does not have all the required information), APS-WV will suspend the request and place it in a pending status documentation requested. The provider receives a System message and APS-WV contacts the provider within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we administratively close the request.

The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If nurse reviewers are still unable to approve the request with the additional information, they refer the review for physician review with all available information.

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson's Health Solutions' InterQual Criteria sets (InterQual Adult & Pediatric; interQual Procedures & Acute; InterQual Acute) as previously approved by the Bureau for Medical Services.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; the number is available in the System record and the reports tab for the referring and servicing provider. Providers who are unable to access the online system and notified APS of their inability to do so receive information by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system exports the authorization number to the claims payer in a daily file; it is available in the System record and the reports tab for the referring and servicing provider. Providers who are unable to access the online system and notified APS of their inability to do so receive information by fax or telephone.

6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in The APS System- this notification includes the policies and criteria that were not met and information about the reconsideration process. APS-WV sends the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward initial review information, reconsideration request, and any additional information to different board certified MD/DO with specialty match to conduct the reconsideration.

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

9. *Reconsiderations resulting in reversals:* If APS-WV reverses the initial decision we will send the approval decision to the MMIS. We illustrate the process for reconsideration in the workflow provided in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV will complete reviews within 48 hours. APS-WV will only accept retrospective requests in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

b. Organ Transplant Services

b. Organ Transplant Services

Vendor Response

The APS Team understands the cost of transplants can be a burden on the Medicaid budget. Therefore, it is necessary to provide careful oversight to the delivery of these services to ensure their medical necessity. Prior authorization with case management follow-up of these cases assists BMS in containing cost and delivering medically necessary transplants in the appropriate setting, in the most cost effective manner. Per BMS Manual Chapter 510: Organ Transplants:

- WV Medicaid covers certain types of organ transplants performed in a Medicare-approved transplant facility.
- Medicaid covers organ transplant services when generally considered safe, effective, and medically necessary when no alternative medical treatment as recognized by the medical community is available. The intended transplant must be to manage a disease consistent with recognized standards in the medical community. Investigational, research, or experimental procedures are not covered.
- Member selection criteria rely on critical medical need for transplantation and a maximum likelihood of successful clinical outcome. All other possible medical and surgical therapies expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:
    - Current medical therapy has failed and the member has failed to respond to appropriate therapeutic management;
    - The member is not in an irreversible terminal state;
    - The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living.

Prior authorization is required for all transplants. APS currently reviews requests for prior authorization, which covers the following types of transplants:

- Heart Transplant
- Bone Marrow Transplant
- Adult Liver Transplant
- Pancreas/Kidney Transplant
- Lung Transplant – single and double
- Heart/Lung Transplant

- Pediatric Liver Transplant
- Kidney Transplant
- Small Intestine Transplant
- Cornea

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

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

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

APS-WV will review medical necessity and appropriateness using InterQual criteria for those transplants covered by WV Medicaid for which McKesson has criteria sets. If a Medicaid covered transplant does not have an InterQual criteria set, Medicare guidelines or other Medicaid approved criteria are used. Due to the documentation requirements, labor intensity, and necessary clinical follow-up, medical case management follows these cases. A workflow for the organ transplant prior authorization process has been included in Exhibit 11.

Organ Transplant Prior Authorization Process

1. APS-WV will determine if the hospital is a Medicare certified transplant hospital and is in network.
2. We will determine if the Hospital Provider Manual lists coverage for the proposed transplant under Organ Transplant Services.
3. APS-WV will verify the name, address, age, and Medicaid identification number of the recipient.
4. If the request involves a child, the team will verify that inclusion of the legal guardian/custodian's name and address.
5. APS-WV will verify the
    a. Name and address of referring physician.
    b. Name and address of the physician and medical facility for the transplant surgery.
    c. Type of transplant, including detailed information on the plan of treatment and anticipated outcome.
    d. Diagnosis, prognosis, history, current physical condition, and indications for the transplant.
    e. Primary contact name and telephone number for additional information if needed.

6. APS-WV will receive requests for prior authorization of transplant by web-based, fax, or mail format.
7. We send any incomplete requests back to the provider and do not process them.
8. For requests that are complete upon receipt, APS-WV will verify the member eligibility through the MMIS.
9. If the member is in an MCO, we will refer the case to the appropriate MCO.
10. Administrative staff will enter the request into the database.
11. A case manager applying Medicaid approved criteria (InterQual/Medicare guidelines) will review the request for medical necessity and appropriateness. If approved, the system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for referring and servicing providers. Providers who are unable to access the online system and have notified APS of their inability to do so receive information by fax or telephone.
12. If case managers are unable to approve requests, they refer them to a physician reviewer for a determination. Due to the critical nature of organ transplant service, if the initial physician reviewer denies the request, APS-WV will expedite the reconsideration by sending the request and all information to a second physician reviewer for a determination. If the second reviewer disagrees with the initial review and approves the request, we will notify all parties of an approval.
12. APS-WV will only deny a request due to lack of medical necessity when two physician reviewers agree to a denial determination. APS-WV will attach denial notices to the provider and referring practitioner in The APS System—this notification includes the policies, criteria not met, and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
13. APS-WV will communicate the determination and applicable payer limits on requests for an organ transplant to the client or legal representative as well as to the requesting party within 48 hours of receipt of all necessary information.

c. Hospice Services

c. Hospice Services

Vendor Response

The WV Medicaid Hospice Services program is a comprehensive case management program for members who are terminally ill and in need of palliative care. APS-WV currently reviews and authorizes Hospice requests for Routine Home Care; Continuous Home Care; Inpatient Respite Care, and; General Inpatient Care. Additionally, for hospice members in Nursing Home facilities APS authorizes and prices the Billing and Reimbursement for Nursing Facility hospice. APS-WV understands that following a member through the continuum of services often needed in conjunction with a terminal diagnosis assists BMS in the management of utilization of services and addresses specific needs of members and their families. APS follows all state and federal requirements for the review and authorization of Hospice services. APS-WV issues an authorization at each election period and the system tracks member revocations and discharges to ensure service utilization is within policy guidelines. As the need for service coordination is particularly acute for members with a terminal diagnosis, the RN reviewer has access to other critical medical procedures requested and authorized for the Hospice member. This information serves members' best interests by ensuring that they receive all needed services and do not receive unnecessary procedures, and serves BMS' responsibility to control costs through utilization management to ensure that services are appropriate, unduplicated, and as non-intrusive as possible. In the event of a denial, nurses in our case management program will be able to provide referrals for other services that may be more appropriate and available to the member. APS-WV reviews Hospice requests as follows:

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility:* APS receives a request for a Hospice Service election period by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically. APS-WV uses standard verification processes discussed throughout this proposal.

    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them we cannot process the request before establishing their participation status in the program. Additionally, enrolled providers register with APS to gain access to The APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids. They must also meet the requirements of the Molina provider contracts related to the provision of services authorized

by APS-WV—only WV Medicaid Hospice providers may provide Hospice services for WV Medicaid members.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process, to establish whether an alternative payer may be responsible for the services requested. If we identify alternative payer(s), APS-WV will notify the provider through messaging on the request. APS reviews and authorizes Hospice services for dual eligible Medicare/ Medicaid members utilizing the agency approved criteria and policies.

d. *Coverage status of the service*: The APS System has validation rules that allow providers to request only covered services requiring prior authorization. Additionally, system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions in the system. APS-WV confirms for each request for service that it conforms to current Medicaid program coverage policy and benefit limitations. The system highlights any exceptions as pend reasons for the reviewer to evaluate. It also pends curative treatments for adult members who have elected hospice; the system does not flag these treatments for children who may elect the hospice benefit while continuing curative treatments without foregoing any of the services to which Medicaid entitles them. Finally, the system flags any request for Hospice for a member enrolled in a Home and Community Waiver program for evaluation of their status on the waiver.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request. For hospice members this verification includes checks to ensure the member did not exceed the allowable lifetime hospice revocations.

2. *Determine if the request is complete:* If a request is incomplete (i.e. does not have all the required information), APS-WV will suspend the request and place it in a pending status documentation requested. We message the provider in the system and contact them within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If nurse reviewers are still unable to approve the request with additional information provided, they will refer the request for physician review with all available information.

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service is medically necessary and appropriate. This process includes evaluating the qualifying diagnosis for hospice to be sure it is an allowable diagnosis per policy, and if the service should be approved or referred to physician review. Currently we use BMS/Medicaid criteria and Medicare criteria and policies to determine the appropriateness of Hospice services.

4. *If approved by the RN Reviewer*: The system exports the authorization number to the claims payer in a daily file; the number is available in the APS System record and the reports tab for the referring and servicing provider. Providers who are unable to access the online system and notified APS of their inability to do so receive information by fax or telephone.
5. *After referral from the nurse level for physician review*: APS-WV will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, APS_WV follows the same process described in step (4) above.
6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in The APS System- this notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. The initial review information, reconsideration request, and additional information are then forwarded to another board certified MD/DO with specialty match for a final determination.
8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via The APS System at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If the physician reviewer reverses the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow provided in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.

The workflows in Figure 9 and Figure 10 illustrate the process for authorizing Hospice Services for Community Services and Billing and Reimbursement for Nursing Facility Hospice.

Figure 9 Hospice Referral Workflow for Community-based Members

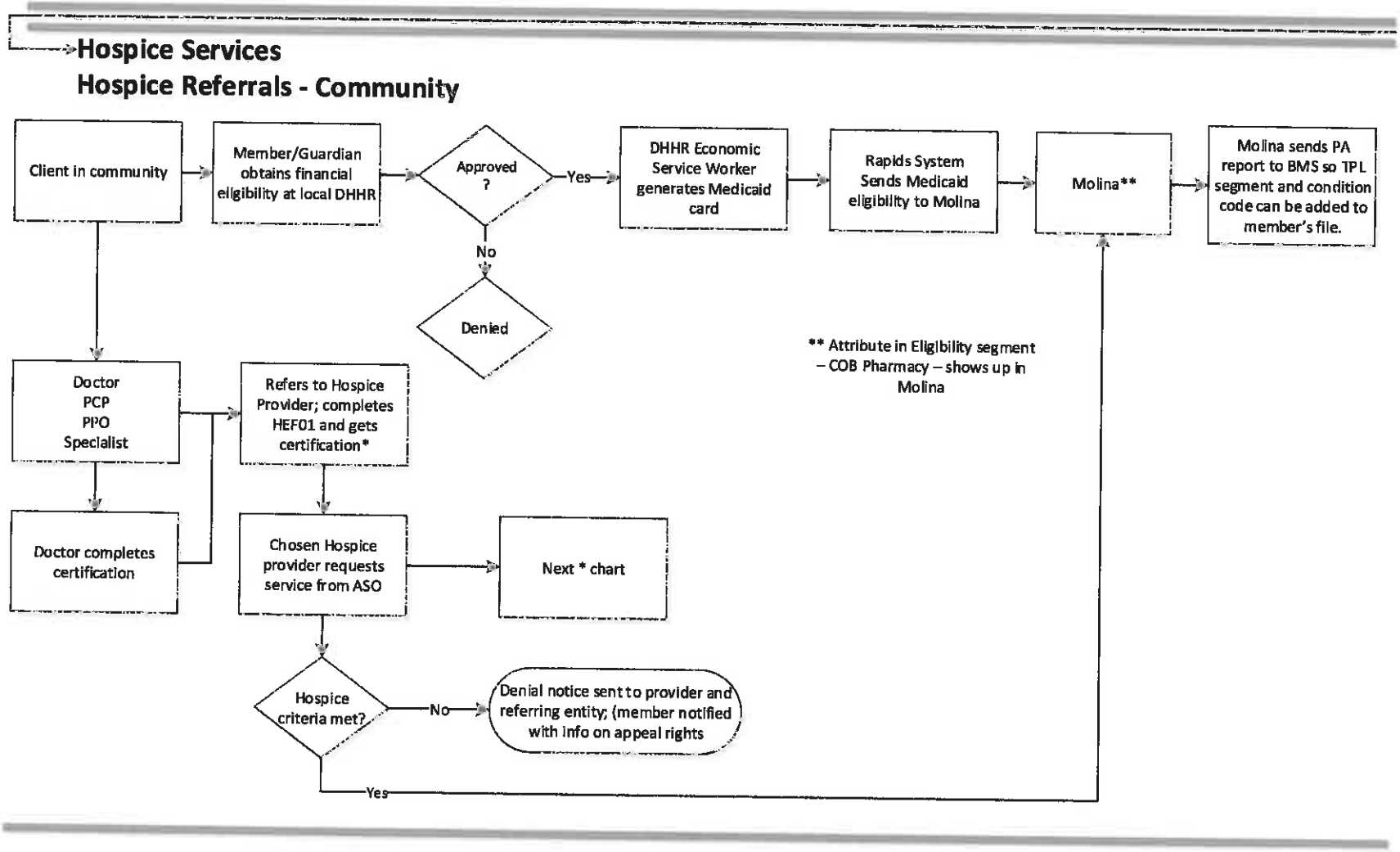
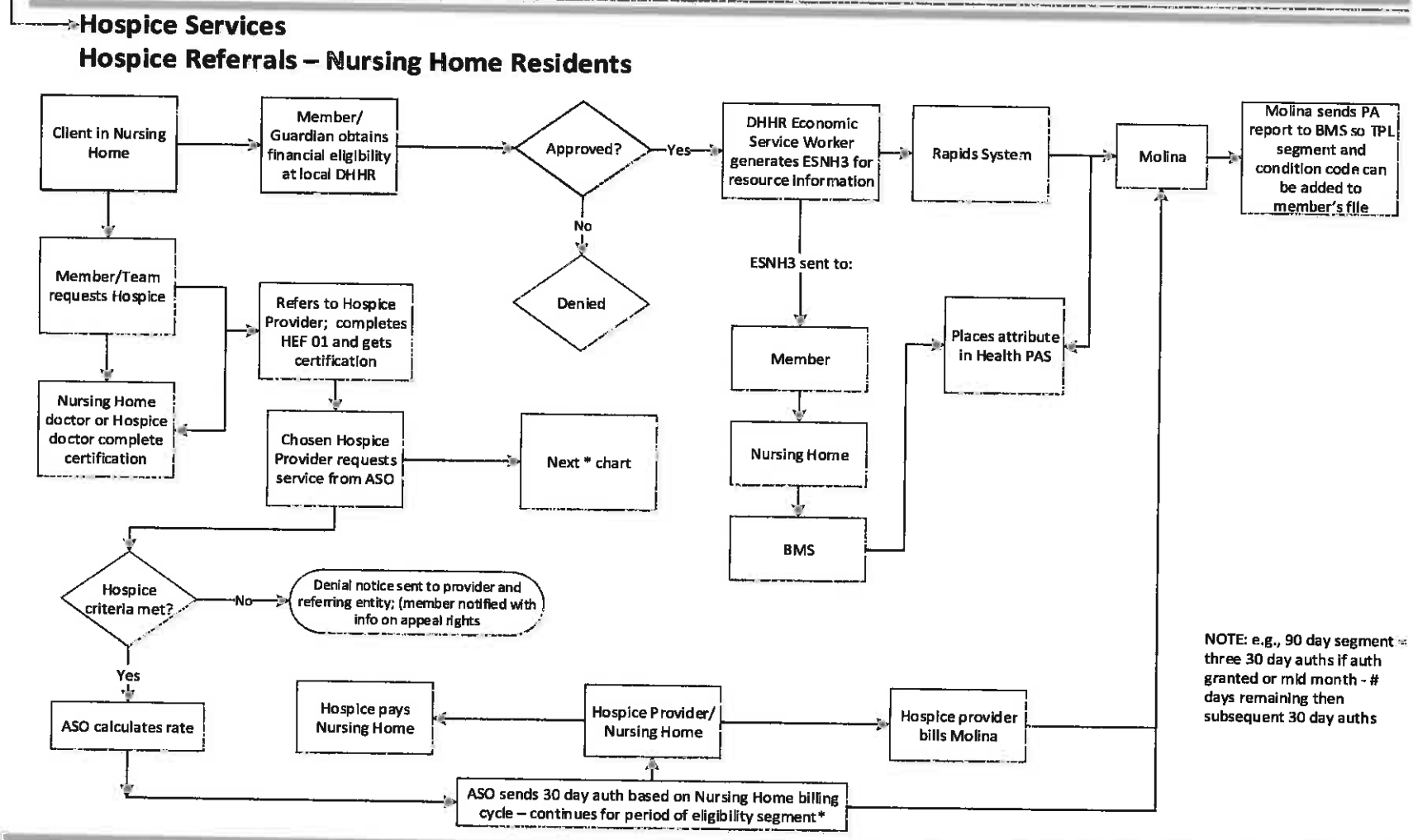


Figure 10 Hospice Referral Workflow for Community-based Members



APS-WV will develop educational trainings to Hospice providers regarding policy, available services, service delivery models, and any other topics requested by the Bureau for Medical Services. We provide technical assistance as requested by individual providers or to all Hospice providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will participate in and conduct training for members and other stakeholders as requested by the agency. APS will participate in conference calls at the request of the agency.

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

d. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Vendor Response

APS currently conducts prior authorization of durable medical equipment (DME), medical supplies, and orthotics and prosthetics for BMS. This area of review offers opportunity for cost savings through appropriate utilization of services and equipment. BMS' policy to provide the most cost effective equipment that meets the members' need coupled with InterQual screening criteria for medical necessity is successful in cost containment in the current UM contract. There are Local Medical policies approved for some services based on the requirements of Chapter 506. Additionally, APS proposes to auto-adjudicate oxygen supplies and incontinence supplies in line with the requirements of Chapter 506. With BMS approval of the proposed specifications, we will add this process to The APS System in the upcoming contract cycle. APS-WV clinical reviewers will continue to work with BMS in the new contract to refine DME criteria and ensure that this program continues to be cost effective and efficient. APS will continue to work with BMS to identify areas for additional cost savings.

We outline the process for prior authorization for DME, medical supplies, and orthotics & prosthetics (DMEPOS) below. We include the workflow in Exhibit 12 Durable Medical Equipment & Supplies, Exhibit 13 DMEPOS Pricing, and Exhibit 14 Orthotics and Prosthetics, to show the differences in the review process to meet the requirements of BMS Manual Chapter 506 (formerly Chapters 506 and 516).

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for a DMEPOS service(s) by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing

provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson Health Solutions InterQual DME criteria as the Bureau for Medical Services previously approved. There are local medical policies for some items and supplies. Additionally, if the request is for a wheelchair or other

mobility equipment, a DME consultant reviews the request for accuracy, coverage, units, appropriate coding and verifies that the item is the most cost effective for the member's needs.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone. If the item does not have a price, we do not release the authorization until the provider attaches an unaltered cost invoice to the record and enters the cost into the system for exporting in the prior authorization file. Cases awaiting pricing are in a status hold for pricing for 30 days. The system prompts the provider at multiple points to send the invoice. Vendors cannot place equipment without authorization.
5. *After referral from the nurse level for physician review*: APS-WV will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.
6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in The APS System- this notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board certified MD/DO with specialty match for a final determination.
8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.

e. Vision Services

e. Vision Services

Vendor Response

A number of outpatient procedures involving the eye are currently subject to prior authorization; for example, blepharoplasties, repairs for entropion and ectropion disorders, and lagopthalmos corrections. InterQual has criteria for a number of these surgical procedures and we use them to review these requests. However, some procedures do not have specific criteria. In these instances, we use the specifications of Chapter 525 and a board certified ophthalmologist reviews the request. We outline the process for the prior authorization of vision services below. An illustration of this process is in the workflow that in Exhibit 15.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for a vision service(s) by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

   d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT

requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson's Health Solutions' InterQual Criteria sets (InterQual Adult & Pediatric; InterQual Procedures & Acute) as previously approved by the Bureau for Medical Services. Services for which there are no InterQual criteria available go directly to physician review. APS will research clinically sound criteria for these services and submit them for BMS approval in the next contract cycle.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in The APS System. This notification includes the policies and criteria that were not met and information about the reconsideration process. We

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

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

f. Audiology Services

f. Audiology Services

Vendor Response

APS conducts prior authorization reviews of speech, language, and audiology services to include hearing aids, speech generating devices and cochlear implants for BMS under their current contract, and will continue to provide this service subject to BMS approval. APS has designed the APS System speech and audiology provider portals to reflect the current audiology services requiring prior authorization as outlined in the BMS Provider Manual-Chapter 530 Speech and Audiology Services. Included in the review process for this area are consultants: licensed speech therapists and audiologists who conduct reviews to ensure compliance with BMS policy for these services. We outline the process for audiology reviews in detail below. In addition, we show the process in a workflow in Exhibit 16.

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for audiology service(s) by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System,

which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

2. *Determine if the request is complete:* If a request is incomplete (i.e. does not have all the required information), APS-WV will suspend the request and place it in a pending status documentation requested. The provider receives a message in the system and contacted within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request

or by resubmitting the request by fax with the additional information. If the nurse reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service requested is medically necessary and appropriate, and if the service should be approved or referred to physician review. We use BMS/Medicaid criteria with consultant review; Speech Generating Device (SGD) InterQual Criteria; InterQual Hearing Aid criteria (with local edits); Cochlear implants BMS criteria and InterQual criteria . APS will research additional clinically sound criteria for these services and submit them for BMS approval in the next contract cycle.
4. *If approved by the audiology consultant reviewer*: : The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.
5. *After referral from the audiology consultant level for physician review*: APS-WV will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.
6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in The APS System. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board certified MD/DO with specialty match for a final determination.
8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

g. Physical, Occupational, and Speech Therapy

g. Physical, Occupational, and Speech Therapy

Vendor Response

APS currently provides review for occupational therapy and physical therapy services for BMS and will continue to provide this service subject to approval by BMS. Recent policy updates have separated Speech services from the 20 visit combination with PT/OT through the creation of Chapter 530-Speech and Audiology Services. The APS System reflects the new limits for both of these manuals to maintain compliance with Chapter 515 Occupational/Physical Therapy and Chapter 530 Speech and Audiology Services. For this reason, we discuss Physical and Occupational Therapy services and Speech Services separately in this section.

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

Physical and Occupational Therapy

We outline the process for physical and occupational therapy review in detail below and include the workflow in Exhibit 17.

1. *Verification of*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for PT/OT service(s) by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the

provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the request is an initial request:* If the request is an initial one, we authorize up to 20 visits without clinical review. The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing

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

4. *If the request is an established request determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson Health Solutions InterQual Criteria sets (InterQual Adult & Pediatric PT/OT), BMS criteria and Chapter 515 to determine medical necessity as approved by the Bureau for Medical Services.

5. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

6. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

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

10. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

12. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

Speech and Language Services

APS-WV authorizes Speech and language services in conformance with BMS Manual Chapter 530 Speech and Audiology Services. Speech therapy services require prior authorization from the initial service and are no longer subject to limits in conjunction with Occupational and Physical Therapy. Licensed speech therapists conduct reviews of Speech Therapy requests to ensure compliance with BMS policy for these services.

We outline the process for speech therapy reviews in detail below. In addition, the workflow for this process is in Exhibit 18.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for speech or language therapy service(s) by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic

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

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use BMS/Medicaid criteria with consultant review and Chapter 530 for the review of these services.

4. *If approved by the speech and language therapy consultant reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

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

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

7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration

request, and additional information to another board certified MD/DO with specialty match for a final determination.

8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

h. Physician and Non-Physician Practitioner Services

h. Physician and Non-Physician Practitioner Services

Vendor Response

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

We outline the process to conduct prior authorizations for elective surgery procedures below and include the workflow of this process in Exhibit 19.

1. *Verification of*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for an outpatient surgery service or bariatric procedure by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before

establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson's Health Solutions'

InterQual Criteria sets (InterQual Adult & Pediatric; InterQual Procedures & Acute) as previously approved by the Bureau for Medical Services. If APS-WV authorizes the bariatric procedure using BMS approved criteria, we also implement medical case management to monitor post-surgical outcomes for the member (refer to section z for a flow chart of the medical case management process).

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will develop educational trainings for physicians, physician assistants and advanced registered nurse practitioners regarding policy (particularly Chapter 519), available services, service delivery models, and any other topics requested by the Bureau for Medical Services. APS- WV provides technical assistance as requested by individual providers or to all providers when changes in policy or updates in the system occur. APS-WV will plan, advertise, and conduct, statewide training and webinars as requested by the agency, and communicate announcement of the training to providers. APS will participate in and conduct training for members and other stakeholders as requested by the agency. APS will participate in conference calls at the request of the agency.

i. Home Health Services

i. Home Health Services

Vendor Response

APS-WV understands that for BMS to manage the fiscal requirements of the Medicaid Program responsibly, it will be beneficial to have consistent monitoring of Home Health Service providers. APS-WV understands that as services are used, it may be necessary to change the requirements for prior authorization. In addition, APS-WV understands that BMS now requires a non-clinically reviewed prior authorization for the first 60 visits in a calendar year and clinical, medical necessity review and prior authorization after 60 home health visits per Chapter 508-updated June 1, 2015.

Below is the process for prior authorizations for Home Health services. APS modified the APS System workflow to accommodate the requirements of the current manual. We also provide this process as a workflow in Exhibit 20.

Home Health Prior Authorization Process

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for Home Health service by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing

provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request..

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

3. *Determine if the request is an initial request:* If the request is initial, APS-WV authorizes up to 60 visits without clinical review. The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

4. *If the request is an established request determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse

reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Chapter 508/BMS criteria and Medicare guidelines as approved by the Bureau for Medical Services. APS would like to recommend evaluation of the InterQual Home Care criteria for Home Health services with local edits as possible criteria for this service. APS will prepare recommendations for approval by BMS after the inception of this contract cycle.

5. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

6. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

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

10. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

12. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

j. Private Duty Nursing Services

j. Private Duty Nursing Services

Vendor Response

APS Medical staff will review and prior authorize all private duty nursing requests within guidelines established in the BMS Medicaid Manual Chapter 532-effective September 15, 2015. APS-WV completed all modifications to the system to accommodate changes in the manual and received BMS approval for these changes. The following describes the process to review and prior authorize private duty nursing requests. A workflow for this process is in Exhibit 21.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for Private Duty Nursing Services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

   d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered

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

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Chapter 532 (medical and psychosocial grid as well as policy requirements for the service) as approved by the Bureau for Medical Services. If the Private Duty Nursing service is authorized medical case management is implemented to monitor member service utilization, possible duplication of service and outcomes for the member (refer to section z for a flow chart of the medical case management process).

4. *If approved by the RN reviewer*: The authorization number is exported to the claims payer, Molina in a daily file and is available in the APS System record and the reports tab for the referring and servicing provider. Providers who are unable to access the online system and have notified APS of their inability to do so are informed by fax or telephonically.

5. *After referral from the nurse level for physician review*: APS-WV will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, the authorization number is exported to the claims payer, Molina in a daily file and is available in the APS System record and the reports tab for the referring and servicing provider. Providers who are unable to access the online system and have notified APS of their inability to do so are informed by fax or telephonically. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS System- this

notification includes the policies and criteria that were not met and information about the reconsideration process. The denial letter is sent to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

If the Private Duty Nursing service is authorized medical case management is implemented to monitor member service utilization, possible duplication of service and outcomes for the member (refer to section z for a flow chart of the medical case management process). If the service is denied medical case, management is initiated to make recommendations for alternative services to meet the member's needs.

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

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

8. *Reconsiderations resulting in reversals:* If the initial decision is reversed, APS-WV will send the approval decision to the MMIS. The process for reconsideration has been illustrated in the workflow provided in Exhibit 9.

9. *Obtaining an appeal:* Members may request an appeal of a denial of services that have not been provided. APS-WV will prepare documentation necessary to process the member's appeal.

10. *Retrospective requests follow the same review process:* Reviews will be completed within 48 hours. Retrospective requests will only be permitted in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will develop educational trainings for private duty nursing providers regarding policy (particularly Chapter 532), available services, service delivery models, and any other topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all Private Duty Nursing providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will participate in and conduct training for members and other stakeholders as requested by the agency. APS will participate in conference calls as requested.

k. Diagnostic Imaging/Radiology Services

k. Diagnostic Imaging/Radiology Services

Vendor Response

APS will provide prior authorization of elective outpatient high cost imaging studies such as computerized topographies (CT), positron emission tomography (PET), magnetic resonance imaging (MRI) and angiography (MRA) , as a method to control costs in the West Virginia Medicaid program and to ensure that these services are medically necessary and the most cost effective service for the member. We understand that these tests do not require prior authorization when provided in an emergency room, to avoid delaying emergency treatment for members.

When InterQual criteria are not available APS provides recommendations to the Bureau for medical services based on research of clinically sound and research-based criteria that have been endorsed by APS' Medical Director and physicians in the specialty of the criteria under review. It is possible to edit these criteria to create local medical policies (LMP's) that conform to BMS specific policies. BMS may also develop Local Medical policies for existing criteria, based on updated policy or clinical practices changes. The Bureau for Medical Services receives recommendations for approval, and once BMS approves, APS-WV implements the policies. We update providers regarding criteria changes and if the criteria are not proprietary, they are available to providers unless otherwise specified by BMS. Publishers do not release proprietary criteria, such as InterQual; however, McKesson developed "SmartSheets" for many review areas that providers can receive upon request.

APS will update the review criteria annually, and alert BMS to any changes in the criteria. Any recommended changes in criteria will be included in the annual report provided to the agency. Since InterQual criteria is utilized in a number of review areas it is not within the purview of APS or BMS to make major modifications to the proprietary criteria set- however, recommendations will be made to the agency for any additions or edits that may need to be approved to conform to BMS policies. For all other policies, we will present recommended changes to the agency for consideration. The Bureau may reject current or recommended criteria and specify use of different criteria. APS-WV will provide the agency with access to a complete set of materials associated with the criteria annually. APS-WV is responsible for the purchase of InterQual review materials and any other criteria adopted that are not public domain.

We describe the prior authorization process for diagnostic imaging and radiology services below and include the workflow for this process in Exhibit 22.

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for imaging procedures by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating

provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: the APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request..

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if

the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson Health Solutions InterQual DME criteria sets and local medical policies and BMS Manual Chapter 528.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.
5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.
6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS System. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board certified MD/DO with specialty match for a final determination.
8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS-WV will develop educational trainings for imaging stakeholders on topics requested by the Bureau for Medical Services. We provide technical assistance as requested by individual providers or to all Imaging providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcements of the training to providers. APS will provide the following services to the Bureau for Medical Services to ensure appropriate utilization management of imaging services:

- Participate in conference calls at the request of the agency;
- Develop a reference manual for providers;
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the APS website;
- Hold initial orientations to the APS System with key stakeholders, as requested by the Department;
- Provide support to the Department related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials;
- Provide a toll free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request;
- Make recommendations or develop forms upon request of the agency;
- Represent the agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.

APS will also coordinate with Molina, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. APS will also monitor over- and under-utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns

i. Ambulance Transportation

I. Ambulance Transportation

Vendor Response

APS will develop and maintain a utilization management program that conforms to the requirements of West Virginia Medicaid Manual Chapter 524 Transportation Services which was updated effective September 18, 2015. Specifically, the UM program will include:

- Prior authorization of non-emergency medical transportation provided in a ground ambulance (not currently included in the current NEMT vendor program);
- Retrospective authorization of emergency ground ambulance transportation;
- Retrospective review of emergency air ambulance transports.

The prior authorization process will incorporate the requirements in Chapter 524:

Non-Emergency Ambulance Transport:

- This may be provided to obtain treatment or diagnosis for a health condition if the use of any other transportation could endanger the ember's health or well-being;
- Non-emergency transportation must be prior authorized as medically necessary before the service is provided;
- Non-emergency transport will be evaluated based on the member's medical condition, the reason for the transport, the medical necessity of the transport for treatment and/or diagnosis, and the destination of the transport;
- In some cases, a physician may order ambulance transportation to a hospital or medical facility based on a member's medical condition; in these instances the order must be attached to the request and the medical necessity will be based on information provided by the ordering physician;
- Medical transport of bed confined individuals may be approved when all of the following are met:
    - The patient condition is such that any other means of transportation is contraindicated;
    - The patient is unable to get up from bed without assistance, is unable to ambulate, is unable to sit in a chair or wheelchair;
    - The patient's symptoms and physical or functional status require monitoring for safety.
- Transportation from one hospital facility to another may meet NEMT guidelines when medically necessary to obtain diagnostic or therapeutic services (e.g. MRI, CT scan, acute interventional cardiology) not available at the originating facility.-The provider of the specialized service must be the nearest facility to the originating facility that is capable of performing the required service. All of the following conditions must be met for approval:
    - The patient is a registered inpatient in an acute care hospital;
    - The required specialized services are considered medically necessary and are covered by Medicaid;
    - The required service is unavailable in the facility where the patient is registered.
- NEMT requests will be evaluated and authorized as either single trip requests or standing order trip requests;
- Non-emergency transport requests that do not meet requirements will be referred to the Agency's NEMT broker when it is determined the member does not require ambulance transport to be safely transported to the requested service. The denial letter sent to the member will include information regarding how to contact the NEMT vendor and arrange transportation.
- NEMT may be approved retrospectively in the following instances: the patient is pronounced dead while in route or upon arrival at the hospital or final destination, or, the patient was pronounced dead by a legally authorized individual (physician or medical examiner) after the ambulance call was made but prior to pick up. In all other instances prior authorization must be received for NEMT in an ambulance.

Emergency Ambulance Ground Transports:

- The retrospective request must meet medical necessity criteria for emergency ambulance transport as approved by the agency;
- The patient's condition must be such that any of form of transportation is medically contraindicated;
- The medical necessity criteria will be applied to the following ground transportation (ambulance) services: emergency room transports/return trip after emergency transport with appropriate order and Certificate of Medical Necessity (CMN); Hospital to Hospital Transports;
- The transport must meet one of the following classifications: Advanced Life Support; Basic Life Support-Emergency; Interfacility Transport requiring medical supplies and equipment; Paramedic Intercept;
- The member must be transported to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury;
- The criteria will be based on the Agency's Medical Necessity Chart for Ground Ambulance and Medicare criteria and will be approved by the Agency prior to implementation.

Emergency Air Transports:

- Air transportation (Fixed Wing(airplane) or Rotary Wing (helicopter)) will be retrospectively approved if the patient's medical condition at the time of transport indicated that immediate and rapid ambulance transportation was required (e.g. life-threatening injury that requires stabilization in a medical facility; pick-up location cannot be easily reached by ground transportation; long distances or other obstacles, like heavy traffic, will impede timely medical attention if ground ambulance is utilized);
- Medical necessity criteria are applied in instances of air transport and must be met.

Non-covered ambulance or medical transport services:

- When medical necessity guidelines are not met;
- If the patient is pronounced dead before the ambulance is called the service is not considered medically necessary;
- Ambulance transportation is primarily for the convenience of the member, their family or caregiver or their physician;
- Transportation for the purpose of receiving a non-emergent service (e.g. pick up pharmacy);
- Transportation to a service considered not medically necessary, even if the destination is an appropriate facility.

A toll-free number will be established for transportation requests. Additionally, the APS System application will be expanded to include transportation requests. The provider may select non-emergency transport or emergency transport. If emergency transport is selected then ground or air transport may be selected. Providers may direct data enter (DDE) requests or fax requests to be keyed by APS staff. Providers will register with APS and must be licensed as an Emergency Medical Services (EMS) agency by the West Virginia Office of EMS and be Medicare Part B certified.

Medical necessity criteria will be developed in conjunction with the Agency and a representative provider group within 90 days of program award. Criteria will be congruent with Chapter 524 Appendix A. Ground Ambulance Medical Necessity and will comply with all state and federal guidelines related to ambulance transportation. Subsequent to approval of criteria, providers training webinars will be conducted to include the following:

- Covered services, criteria, and guidelines for authorization;
- Registering with APS;
- Obtaining authorization;
- Timelines for obtaining prior authorization for NEMT ambulance transport and retrospective authorization for emergency transport;
- Other topics requested by the Agency

APS will implement the transportation program within 90 days of Agency sign-off on requirements and criteria. Provider training will be offered during this period to ensure providers are prepared for implementation of the process. Training and technical assistance will be provided on an ongoing basis following the implementation of the program.

The process for authorizing Transportation requests is outlined in Exhibit 23. An overview of the process is as follows:

1. The provider submits a request for NEMT or emergency ambulance or air transport;
2. Member Medicaid eligibility is verified for the date(s) of service;
3. Request is reviewed for completeness: physicians orders, CMN, plan of care, evaluations and other required documentation;
4. Complete NEMT requests are routed to a transportation specialist who applies approved NEMT criteria, if approved the authorization is recorded in C3. If denied, the request is routed to a RN and is screened for approval based on medical information provided. If approved the authorization is recorded in C3. If the request cannot be approved by the nurse, it is sent to a physician for final review, if approved the approval is recorded in C3, if denied the appropriate denial letter is attached in C3 for the provider and is mailed to the member. The letter will include the member's appeal rights and information for contacting the NEMT vendor;
5. NEMT requests are screened for appropriateness for medical case management based on member diagnosis and frequency of trips;
6. Complete emergency requests for ground or air ambulance are routed to a RN. Medical necessity criteria are applied based on medical information provided. If approved the authorization is recorded in C3. If the request cannot be approved by the nurse, it is sent to a physician for final review, if approved the approval is recorded in C3, if denied the appropriate denial letter is attached in C3 for the provider and is mailed to the member. The letter will include the member's appeal rights and reason for denial;
7. Emergency ground and air ambulance requests are screened for appropriateness for medical case management based on member diagnosis and utilization history.

m. Nursing Home Eligibility and PASRR

m. Nursing Home Eligibility and Pre-Admission Screening and Resident Review (PASRR) Eligibility

Vendor Response

BMS requires all individuals being placed in a nursing facility, or transferring between facilities, to have a medical necessity assessment completed, submitted, and reviewed in accordance with BMS policy. BMS utilizes the Pre-Admission Screening assessment instrument, PAS-2000, as the basis for conducting the medical necessity review. APS has managed the work to conduct NH/PASRR reviews for BMS since 2009. This effort has helped to ensure that individuals seeking placement in a nursing facility meet BMS' medical eligibility requirements for this level of care as well as whether an alternative placement is appropriate . The following is a detailed description of the nursing home review process that APS-WV will conduct. The workflow associated with this process is in Exhibit 24.

1. Hospitals and physician's offices submit the completed PAS-2000 to APS, by fax or through direct entry into the APS-PAS system. This approach allows providers to data enter demographics and information and submit requests electronically. It also allows providers to check the status of their referrals or reviews at any time 24 hours a day/7 days a week.
2. If the provider does not enter the data, we will enter it from the PAS-2000 and assign the case to a Registered Nurse reviewer. Using a computerized algorithm consistent with BMS policy/criteria for nursing facility services, we will evaluate the PAS-2000 data.
3. The nurse reviewer will also determine if a PASRR review is necessary, in accordance with BMS policy. We will use the APS-PAS system or a fax back form to relay the medical necessity determination and need for a PASRR Level II. This form is the same as page 6 of the PAS-2000 assessment instrument.
4. We will base the determination of the need for a PASRR on submitted information indicating the presence of intellectual disability, developmental disability and/or an associated condition, or major mental illness. Once we identify such a condition, the referring facility will be responsible for initiating the Level II PASRR process. [Note if the Bureau elects to implement optional performance of Level II, this aspect of the process will change, though minimally because the APS-PAS already tracks Level II information.]
5. APS-WV will process all reviews submitted, and issue a determination within 48 hours of receipt of the request.
6. If nurse reviewers require additional information, they will request it from the provider. Once they receive the additional information, they will issue a determination within 24 hours.
7. If they cannot make a decision at the nurse review level, they will make a referral to physician review within 24 hours of receipt of the original request.
8. The physician reviewer will make an approval/denial determination within 24 hours of the referral.
9. If physician reviewers require additional information, they will make the request within 24 hours.
10. APS-WV will transmit the physician review determination to the originating facility within 24 hours of receipt of the additional information.

11. All approvals consist of page 6. APS-WV will send a copy of the approval to the member and/or his/her legal representative.
12. For all denials, in addition to sending page 6, we will notify the individual and referring entity by mail and/or fax of the determination. The denial letter will include the criteria not met during the review process, as well as appeal rights. The denial packet will also include a Hearing Request form, with instructions for completion.
13. To receive approval for Nursing Facility benefits with WV Medicaid, the individual must have at least five deficits. The computerized algorithm ensures consistency and accuracy of the reviews consistent with BMS policy, within the scope of work, and across the long-term care continuum.

If a member requests a fair hearing as part of the appeal process, APS-WV will participate by requesting additional information. This includes, but is not be limited to, Minimum Data Set (MDS) section "G," Activities of Daily Living (ADL) sheets, care plan, and physician and nursing notes. We will request such information within five days of notice to APS-WV for the request and scheduling of a hearing. APS-WV will provide a nurse reviewer to attend and participate in fair hearings, either in person or by conference call. The nurse reviewer will support, review, and verify all information submitted in conjunction with current BMS policy/criteria for long-term care.

n. Traumatic Brain Injury (TBI) Waiver Program

n. Traumatic Brain Injury (TBI) Waiver Program

Vendor Response

APS-WV has served as the Operating Agency and Utilization Management Contractor for the Traumatic Brain Injury Waiver program in WV since its inception in November 2011. Since that time, APS has worked for the Bureau developing protocols, providing training, assessing for medical eligibility, conducting reviews, facilitating quality councils, and many other tasks. APS is prepared to continue our work with the TBI Waiver program.

Initial and Reevaluation Request for Medical Evaluation

APS proposes a process of medical eligibility determination that will be timely, equitable, person-centered, and include relevant stakeholders in the determination process. Through this process, we will document the member's initial and continuing medical eligibility for participation in the Waiver, and provide notification to relevant parties to ensure a thorough understanding of the process as well as the member's Fair Hearing rights and process. See Exhibit 25 for the TBI Waiver medical eligibility work flow.

We will receive daily referral requests for Waiver program assessment, including requests for either an initial or reevaluation. We will process applications on a first-in, first-out basis. We will conduct an initial screening of the application to ensure that it is complete, correct and includes all components necessary (such as within age requirements and has applicable diagnosis, etc.). We will notify the applicant in the event additional information is required. Once the application is complete, we will mail the applicant (with the Bureau's approved letter) and prompt them to obtain financial eligibility through their local DHHR. At this time, they may also select a Case Management Agency to assist them with this task.

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

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

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

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

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

Authorization

The member's Service Planning team using information from the assessments as well as information about the member's preferences will prepare the member service plan. This service plan will be documented in our information system when complete. APS will then review the plan to ensure assessed needs have been taken into account, the member has been involved in the decision-making, and other issues such as medical care, health, and safety have been addressed. APS will then review the service plan and provide authorizations to the fiscal system so that the provider can submit claims. APS will notify the member and provider when services have been authorized. A budget amount per member will be established based on the total cost of the services deemed necessary by assessment and the Service Plan team. No budget amount may exceed $35,000 per existing policy. See Exhibit 26 for the TBI Authorization workflow.

Managed Enrollment

When no slot is available, we will place those applicants determined medically eligible on the TBI Waiver Managed Enrollment List. When a funded slot becomes available, APS-WV will prepare correspondence to the eligible applicant/legal representative informing them we will contact them for an assessment and instructing them to obtain financial eligibility at their local DHHR (if it has expired from previously

acquiring). Only after the member is determined both medically and financially eligible will APS enroll the new program member.

TBI Waiver System

We will develop the TBI Waiver system to comply with all security requirements. The system will incorporate the ability for providers to request authorizations, generation of authorizations and TBI Waiver attribute information to be exported to the claims payer. The APS System will serve as a database from which we will produce data for state and federal reporting, including information required for the Hartley Court Monitor. The system will incorporate a Service Delivery Model module through which requests for self-directed services can be referred to the Fiscal/Employer Agent vendor.

Education, Training and Technical Assistance

During the course of our existing and previous contract, APS has been instrumental in developing training for the Bureau related to policy, available services, service delivery models, the choice between TBI Waiver and institutional care, and other relevant topics. We orient training toward multiple audiences, including members, families, agencies, advocacy groups, and others.

Training evaluations consistently document high degrees of satisfaction with training APS-WV staff conduct. Overall satisfaction ratings were 4.5 on a 5-point Likert Scale in 2013 and 4.6 out of 5 in 2014.

- APS will continue to plan, advertise, and produce statewide training and webinars at the request of the Bureau. APS will advertise electronically using an established email distribution list, which includes numerous stakeholders involved in the TBI Waiver program.
- APS will host a TBI Waiver Quarterly Provider Meeting up to 4 times per year at the request of the Bureau, which will include conference room rental and refreshments for attendees.
- APS has already developed an approved training on recognizing and reporting abuse, neglect and exploitation or other critical incidents. APS will continue to train on this topic and make the training available to providers (so they can train new staff) at the Bureau's request.
- APS will continue to collaborate with the TBI Fund Board and other stakeholder activities to remain current with issues related to the program and the population served in general.
- APS will continue to develop and make available the TBI Waiver Program Handbook and a reference guide of available providers/services that we will make available to members during their annual functional assessments.
- Using the established email distribution list, APS will continue to communicate program announcements to providers, members, and stakeholders on behalf of the Bureau.
- APS-WV will continue to participate in conference calls with providers, trainings, and webinars.
- APS-WV will continue to develop program forms and make recommendations to meet the needs of the program best.
- APS-WV will continue to conduct general community and specified outreach to grow program enrollment.

Review Criteria

As directed by current policy, APS-WV has administered the Pre-Admission Screening (PAS) and Rancho Los Amigos Scale since 2012 to determine program medical eligibility.

New APS-WV staff administering these assessments undergo a comprehensive orientation program where they are trained (classroom style), observe a seasoned staff for a minimum of two assessments, are observed/assisted by a seasoned staff for a minimum two assessments. Orientation of new staff lasts approximately 2 weeks, but can last up to a month, depending on the new staff's previous experience with the program, comfort level with conducting assessments and performance.

APS-WV has developed interpretive guidelines for all program eligibility assessments administered, and will submit to the Bureau upon request. APS-WV continually conducts inter-rater reliability activities with staff and updates interpretive guidelines as necessary. We will present any updates to the Bureau as recommendations for approval. We will based all services approved upon nationally accredited, research-based criteria with a clinically sound basis in the Agency-approved manual or automated review of each prior authorization request or eligibility review.

In 2015, APS-WV made recommendation for updated policy related to administering eligibility assessments necessary when adding children as a target population for the program. We researched available criteria, found a children's version of the Rancho Los Amigos and made recommendation for appropriate levels to consider for eligibility. We also made recommendation for incorporating age-appropriate milestones when capturing PAS functional abilities. The Bureau evaluated and approved all recommendations prior to implementation. APS-WV will continue to research and make recommendation about forms, policy, procedures and best practice as related to the program.

Quality Assurance Activities

APS-WV will continue to conduct quality assurance activities with members, families, agencies, stakeholders and the general community. Quality assurance and improvement is a core tenant of APS-WV Healthcare's philosophy and business practice. We tackle quality with a holistic approach and constantly seek out opportunities to improve quality within and outside the organization; ultimately with effort to improve the quality of services to members served. With this, we will continue to provide ongoing technical assistance at the request of the agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report. We will monitor our own performance and service quality.

Initial and Continued Certification Reviews

A strong community of well-credentialed and qualified providers is a key component of achieving the goals of the TBI Waiver. Just as important is a rigorous quality assurance and improvement process that identifies provider needs and responds with training and technical assistance programs. Our plan to certify prospective TBI Waiver providers builds on the criteria established in the Bureau's Waiver application as well as our experience with waiver management and provider reviews in West Virginia and other states.

The provider certification process begins with an interested provider requesting an application from APS-WV Healthcare. APS-WV will send a packet of information to prospective providers that include the Certification Application and Chapter 512 Manual Sections Provider Certification and Covered Services.

APS-WV must certify all provider agencies. Following the receipt of a completed Certification Application (Initial), APS-WV will conduct an onsite review if required, to verify that the prospective provider meets certification requirements. This requirement may be waived if the prospective provider is a current LBHC or is enrolled as an ADW, PC, or IDDW provider at the time of application.

APS-WV will notify BMS' fiscal agent upon satisfactory completion of the onsite review OR verification of LBHC, ADW, PC or IDDW status. BMS' fiscal agent will provide the provider applicant with an enrollment packet, which includes the TBIW Provider Agreement. BMS fiscal agent will send a letter to the Provider and the UMC, informing the certified provider agency it may begin providing and billing for TBIW services.

There are three possible determinations that may result from the review process:

- Full Certification - We will notify the provider, the Bureau, and the fiscal agent that the provider has been certified to deliver services as of a specific date. The provider will be added to the Agency Selection forms, which we will maintain per county.
- Provisional Certification - Provisionally certified providers will be requested to develop a Plan of Correction that addresses deficiencies identified during review. After the plan has been received and reviewed, we will schedule a follow-up review to identify the extent to which providers have implemented the plan of correction. If successful, providers will then be fully certified.
- Not certified - For providers that are not certified, we will provide notification in writing with an explanation of the rationale for our certification determination. Providers may then reapply after a period of time that we will establish in collaboration with the Bureau.

All providers with an enrolled member will be required to participate in an on-site certification validation and quality review annually. We will continue with notices, as approved by the Bureau, and will begin the on-site validation review with an entrance interview. We will tour the premises to evaluate compliance with ADA and HIPAA compliance complete with digital verification. We will review documentation (written policies and procedures, competency-based curriculum, personnel files, the quality management plan, the organization chart and the list of Board of Directors (if applicable).

Upon completion, we will conduct an exit interview to communicate preliminary findings of the review, allow providers to submit any additional documentation, and deliver technical assistance/training as necessary for any deficient areas. Within the Bureau's established timeline, we will finalize and submit completed reports.

On-site Quality Reviews

APS-WV began conducting TBI Waiver provider reviews in 2013. APS-WV used the reviews as an opportunity to educate all TBI Waiver providers about utilization management, proper documentation of a person-centered plan and services, and incorporation of assessment results into plans. The current on-site provider review tool (developed by APS-WV and approved by the Bureau) is easily adapted to capture new quality/performance measures, new services, and new policy.

APS-WV will conduct on-site quality reviews of TBI Waiver providers annually. We will provide the Bureau with the schedule of upcoming reviews a quarter in advance. During this review, APS-WV will verify compliance with current state and federal policy guidelines and appropriate utilization management and documentation of authorized services. APS-WV will continue with the imperative

technical assistance component of the review so that provider can continue to grow their knowledge and understanding of policy and requirements.

APS-WV will provide comprehensive draft reports within 10 days of the review to the Bureau and to the provider. These reports will include the Review and Disallowance Reports along with the Plan of Correction. The provider will have up to 30 days to respond to their draft reports. Upon receipt and reconciliation of the provider's response, APS-WV will prepare and send all components to the Bureau for final consideration. We will work with the provider until they have an approvable Plan of Correction. We will participate in Review Committee where the Bureau, the Office of Program Integrity, and APS-WV will discuss final disallowance amounts. APS-WV will prepare the final reports for the Bureau to disseminate to the provider.

APS-WV is eager to incorporate a follow-up review of providers who must submit a Plan of Correction after unsatisfactory findings during an on-site review. We believe this is imperative to improving the overall quality of services for our members. Depending on the severity of unsatisfactory findings, APS-WV will conduct either a desk or on-site visit of the provider to verify they did implement their Plan of Correction as agreed.

Quality Improvement Advisory Council

On-site provider review findings are an integral way of capturing statewide quality and performance management data as necessary for the CMS reports. APS-WV will share cumulative review findings with the Quality Improvement Council. APS-WV facilitates meetings of this council quarterly, the purpose of which is to advise the Bureau on program related matters and concerns. APS-WV will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they request reimbursement. To enhance program and disability-related knowledge, APS-WV will send a TBI Waiver staff to a national conference at the request of the Bureau.

Participant Experience Survey

APS-WV will continue to conduct the Participant Experience Survey with a representative sample of program members annually. We are familiar with the survey, as we have been conducting it with TBI Waiver members since 2012. We will compile, analyze, and present data from the survey to the Bureau to evaluate member experience and improve program quality.

Complaints

APS-WV will receive, review, track, trend, and/or investigate complaints submitted by providers, members or other stakeholders related to a program member's service(s) through a TBI Waiver provider. APS-WV follows a consistent procedure in responding to complaints and reporting to BMS on trends and outcomes. We tale each complaint seriously and use it as an opportunity for improvement and technical assistance.

APS-WV can receive complaints either verbally or in writing (email or fax). Upon receipt of a formal complaint, APS-WV will document the complaint and request any necessary information for follow-up. If the issue cannot be resolved over the phone through technical assistance and information and referral, APS-WV will investigate the complaint and/or make referrals to appropriate entities.

APS-WV will inform the complainant of procedures in following a chain of command at the provider agency. Every TBI Waiver provider is required to have a grievance/complaint procedure. It is required that each agency inform program members/legal representatives of this procedure. APS-WV will request information about steps taken thus far to resolve the complaint at the agency level. These steps may include notifying the Case Manager, Waiver Supervisor or accessing the agency's grievance/complaint procedure. It is not necessary for members to exhaust steps at the agency level; they may make direct complaint to APS-WV at any time.

- If we suspect that someone is abusing, neglecting, or exploiting the program member, APS-WV Healthcare will assist the member to make a referral to Adult or Child Protective Services (APS/ CPS). If the complainant cannot or will not make this referral, APS-WV will do so.
- If we suspect a provider agency is not following procedures consistent with certification, APS-WV will conduct an on-site or desk review to evaluate compliance.
- If we suspect a provider or agency is billing for and receiving payment for services inappropriately, APS-WV will refer to and/or work with the Medicaid Fraud Control Unit (MFCU) through a referral to the Office of Program Integrity (OPI) at BMS to investigate the issue.
- APS-WV may receive anonymous complaints. If the complaint contains enough information to follow-up, APS-WV will do so. If there is no way to follow up based on the information provided, APS-WV will log the complaint and indicate insufficient information for action. If complainants request anonymity, we will notify them it may not be possible to follow up on the complaint.
- If we suspect the topic of complaint is systemic, APS-WV may request additional information to determine the extent of the complaint.
- When APS-WV conducts an investigation, APS-WV will notify the provider agency of the complaint as long as doing so will not compromise the integrity of the investigation or put a program member at risk.
- When appropriate, APS-WV may utilize the provider agency's internal investigation system to acquire necessary information. In this event, APS-WV will request the agency forward specific information for APS-WV to conduct a desk review.
- When appropriate, APS-WV may conduct an on-site investigation at the provider agency after consultation with BMS.
- APS-WV Healthcare may investigate matters related to TBI Waiver policy manual compliance. For those matters in which the TBI Waiver policy manual overlaps with Adult Protective Services/Child Protective Services or OPI, APS-WV Healthcare will work with applicable parties or make referrals, as appropriate.

APS-WV Healthcare will initially respond either verbally or in writing to formal complaints within two business days. We will respond to complaints in a manner that is the least intrusive approach. Follow-up may require a request for information, interview with staff, the program member/legal representative or other applicable parties and/or an on-site visit.

Incident Management System

At the request of the Bureau, APS-WV has participated in development meetings related to the upcoming release of the Incident Management System. Once available, we will assist the Bureau with system testing until it is in production. Our vast experience with developing and testing our own systems will prove invaluable. Since program inception, APS-WV has been tracking incidents manually. Once the system is available, AS will provide daily monitoring, monthly reporting, and quarterly reporting, as necessary.

Fraud, Waste, Abuse Referral

In the event that we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

o. Intellectual/Developmental Disabilities Waiver Services

o. Intellectual/Developmental Disabilities (I/DD) Waiver Services

Vendor Response

APS-WV served as the Operating Agency and Utilization Management Contractor for the I/DD Waiver program since 2010. This was an expansion of previous work performed, which began in 2005. APS-WV has greater than 10 years' experience directly with the WV I/DD Waiver program. Since 2005, APS-WV participated in all aspects of program management, including

- Participated in development or developed policies and forms to support new policies and procedures.
- Participated in and facilitated Quality Improvement Advisory Councils.
- Participated in and facilitated Quarterly Provider Meetings.
- Assessed program members for the purpose of individualized budgets and/or medical eligibility.
- Reviewed requests for prior authorization; provided data/reports.
- Served as the primary resource for technical assistance/education.
- Conducted quality reviews of services.
- Represented the Department in hearings.

APS is prepared to continue our work with the I/DD Waiver program.

Initial Application Processing

The initial and reevaluation eligibility workflows can be found in Exhibit 27. APS will continue to manage and track initial applications for the I/DD Waiver program. Within 48 hours of receipt of an initial application, APS will key the request into the APS System and contact the applicant/legal representative to request they choose an Independent Psychologist (IP) to complete their Individual Psychological Evaluation (IPE) that will be used to determine initial medical eligibility. Upon receipt of their chosen IP, APS will refer the member's case to the IP through the APS System. The IP will then document their

attempt to contact the member for scheduling the IPE and document the appointment date and time within the system. This comprehensive system allows for seamless transition between the APS, Medical Eligibility Contract Agent (MECA), and IP functions.

Once the IPE is complete, the IP will upload the assessment into the system for review by the MECA who will determine whether the applicant is medically eligible for I/DD Waiver services. The MECA then tracks their decision within the APS System, which prompts APS to create an authorization (when applicable) and the appropriate Notice of Decision Letter, which we send to the applicant/legal representative.

Managed Enrollment

Those applicants determined medically eligible will be placed on the I/DD Waiver Managed Enrollment List which is currently maintained within the I/DD Waiver system. When a funded slot becomes available, APS will prepare correspondence to the eligible applicant/legal representative informing them APS will contact them for a functional assessment and instructing them to obtain financial eligibility at their local DHHR. Only after the member is determined both medically and financially eligible will APS enroll the new program member.

Annual Functional Assessment

APS will track attempted/successful contacts and appointments in the APS System. Experienced staff (Service Support Facilitators) will conduct the Annual Functional Assessment at least 30 calendar days prior to the member's Anchor Date. Data from the assessment will be input into the APS System, an individualized budget will be established, and MECA can use the data/assessments to determine continued medical eligibility for I/DD Waiver services.

The Annual Functional Assessment will incorporate a component of education, in that a Service Support Facilitator will educate potential program members/legal representatives and their chosen respondents about choices for the service delivery model (traditional or self-directed). Information will also address their choice of Service Coordination providers, available services, an option for Waiver services or for those provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). APS will review the program's approved Handbook during each assessment and answer questions and/or refer the member to an applicable resource contact. APS will use the standardized and other instruments, which may include Structured Interview, Inventory for Client and Agency Planning (ICAP) and the appropriate version of the Adaptive Behavior Assessment System for purposes of data necessary for the MECA to determine medical eligibility and for APS to develop an individualized budget.

APS will make every effort to complete assessments within timeline. When we cannot complete an assessment within the timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline.

Individualized Waiver Budgets

To make I/DD Waiver member services more person-centered and individualized, the Bureau sought in 2005 APS's assistance to develop and incorporate a fair and equitable means of determining funds available for Waiver services for each program member. Our unbiased independent assessments are the foundation to collecting necessary data elements for comparison to global claims and statistical evaluation for relevance in relation to those claims. We ultimately produce a needs-based individualized budget and make it available for each I/DD Waiver program member.

Upon receipt of to the total amount of I/DD Waiver program funds available for the program from the Bureau, APS will adjust the algorithm to produce future budgets that are within the total available program funds. In the event that a program member's needs change, APS can accommodate a new budget amount (upon request/approval from the Bureau), or authorizations for services in excess of the individual budget amount through the negotiation process. We will make the budget available to the Service Coordination Agency or the fiscal/employer agent for self-directing members through the APS System.

The APS System

APS proposes to continue use of our secure, web-based system for the I/DD Waiver program. This system allows multiple user types to interface with member records as their user role permits; displays each member's individualized budget; and provides a framework and a process for the prior authorization request of waiver services. It also provides a process to submit/receive authorization requests for services; assists with management of assessment completion through tracking of appointment contacts and outcomes; and provides a framework for oversight of the eligibility process. This comprehensive system tracks slot allocation and distribution through waitlist management; manages transfer of agency and/or service delivery model if the member wishes to self-direct their services; refers requests for self-directed services to the Fiscal/Employer Agent vendor, and provides a central location for document storage by allowing multiple users to attach documents onto a single member's record.

APS successfully managed program application and enrollment through this system allowing for better tracking for release of program slots throughout the year instead of just at a new fiscal year. The system prompts providers submitting a request for authorization to verify and update the member's demographic and medical information prior to submitting a request. The system includes validation rules to prevent submission of requests with missing information. In the event a program member's needs change, the system will accommodate modification (or special) requests for authorization review.

The system automatically transfers authorization and attribute information to the claims payer each night; though information is available in "real time." APS-WV specifically designed the system to capture data necessary for the Centers for Medicare and Medicaid Services (CMS) quality measures. APS will manage and produce the monthly Discovery and Remediation and other reports at the request of the Bureau.

Education, Training and Technical Assistance

During the course of our existing and previous contracts, APS was instrumental in developing training for the Bureau related to policy, available services, service delivery models, choices between Waiver and institutional care, and other relevant topics. We oriented training toward multiple audiences, such as members, families, agencies, advocacy groups, and local DHHR staff.

Training evaluations consistently report satisfaction with the training conducted by APS staff.

- APS will continue to plan, advertise, and produce statewide training and webinars at the request of the Bureau. For efficiency, APS will advertise electronically using an established email distribution list which includes numerous stakeholders involved in the I/DD Waiver program.
- APS will continue to host the I/DD Waiver Quarterly Provider Meeting up to 4 times per year at the request of the Bureau which will include conference room rental and refreshments for attendees.

- APS has already developed an approved training on recognizing and reporting abuse, neglect and exploitation or other critical incidents. APS will continue to train on this topic and make the training available to providers (so they can train new staff) at the Bureau's request.
- APS will continue to collaborate with the Developmental Disabilities Council, West Virginia Association of Positive Behavior Support (WVAPBS) Network and other stakeholder activities to remain abreast of current issues related to the program and disabilities in general.
- APS developed and received approval on the current Member Handbook. We will continue to develop and make available the Member Handbook and a reference guide of available providers/services to be made available to members during their annual functional assessments.
- Using the established email distribution list, APS will continue to communicate program announcements to providers, members, and stakeholders on behalf of the Bureau.
- An APS staff has historically attended the Annual Families Conference; we will continue to do so at the request of the Bureau.
- APS will continue to participate in necessary Policy Clarification and other conference calls and webinars.
- APS will continue to develop program forms and make recommendations to meet the needs of the program best.

Review Criteria

As directed by current policy, APS has been administering the Inventory for Client and Agency Planning since 2005 and the Adaptive Behavior Assessment System since 2011. These assessments, in conjunction with the Structured Interview and the Extraordinary Care Assessment (both developed by APS-WV) comprise the Annual Functional Assessment.

New APS staff administering these assessments undergo a comprehensive orientation program where they are trained (classroom style), observe a seasoned staff for a minimum of 1 week (usually 10-15 assessments), and are observed/assisted by a seasoned staff for a minimum of 1 week (usually 10-15 assessments). Orientation of new staff lasts approximately 1 month, but can last up to 2 months, depending on the new staff's previous experience with the program, comfort level with conducting assessments and performance.

APS developed interpretive guidelines for all assessments administered, and will submit to the Bureau upon request. APS continually conducts inter-rater reliability activities with staff and updates interpretive guidelines as necessary. Staff will present any updates to the Bureau as recommendations for approval.

During the Annual Functional Assessment, APS will also continue to provide the education component including choice of providers, choice of service delivery model, choice of Waiver or institutionalization. We will also present any changes or updates to the script or forms related to these tasks to the Bureau for recommended changes.

APS will conduct this education and assessment face-to-face and the findings will be the basis to determine the member's level of functioning in the following areas as currently required for program

eligibility: self-care, receptive or expressive language, learning, mobility, self-determination, and capacity for independent living.

APS will use nationally accredited, research-based criteria with a clinically sound basis in order to recommend policy related to authorizing services. We will make recommendations regarding policy, procedures, and best practice to the Bureau annually or more frequently.

Maintain Agency Selection Forms

The requirements of this section do not apply to the I/DD Waiver management program.

Quality Assurance Activities

APS will continue to conduct quality assurance activities with members, families, agencies, stakeholders and the general community. Quality assurance and improvement is a core tenet of APS-WV's philosophy and business practice. We tackle quality with a holistic approach and constantly seek out opportunities to improve quality within and outside the organization; ultimately with effort to improve the quality of services to members served. With this, we will continue to provide ongoing technical assistance at the request of the agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report. We will monitor vendor the quality of our own services

On-site Quality Reviews

APS began conducting I/DD Waiver provider reviews in 2007. APS used the initial review process to educate all I/DD Waiver providers about utilization management, proper documentation of a person-centered plan and services, and incorporating assessment results into those plans. APS continues to improve the review process and review tool at the discretion of the Bureau. The current on-site provider review tool (developed by APS and approved by the Bureau) is easy to adapt to capture new quality/performance measures, new services, and new policy. Table 11 shows the results of our efforts in the context of provider satisfaction – demonstrating provider support for our approach.

Table 11 Comparison of Satisfaction Ratings

Factor	2013	2014	2015
Overall Satisfaction Rating (5-Point Likert Scale), as scored by I/DD Providers' Staff following an on-site Quality Review by APS Healthcare.	4.5	4.7	4.5

At the conclusion of each provider review, APS-WV request that review participants complete a satisfaction survey. A 5-point Likert scale is used, with "5" being strongly agree and "1" being strongly disagree. The following data shows the overall satisfaction of providers during a sample quarter (Q4, FY15). We include the following general review items on the survey and show results in Figure 11:

1. Item 1: "The APS Review was well organized."
2. Item 2: "The written materials and reports provided during the APS review were useful."
3. Item 3: "The information presented has better prepared my agency to comply with standards."
4. Item 4: "Overall, I am satisfied with the manner in which the APS review was conducted."
5. Item 5: "Average of all satisfaction ratings."

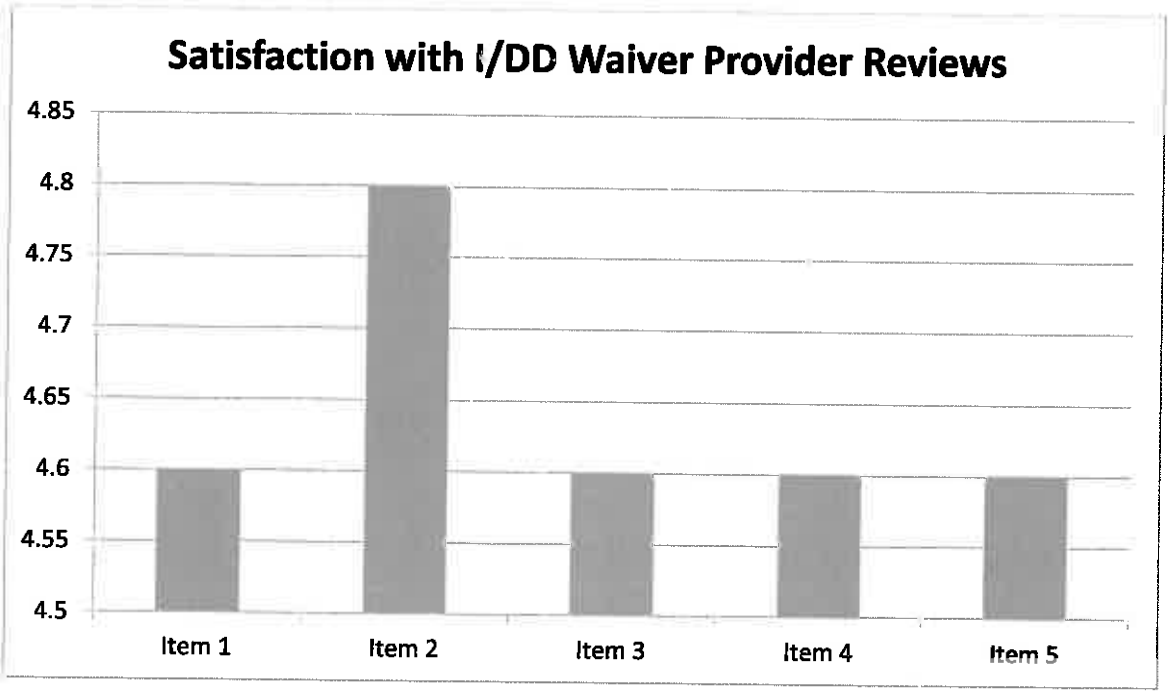


Figure 11 Provider Experience Results

APS-WV also collects information about each Provider Educator (reviewer) to be able to address any issues or concerns about staff customer service or performance individually and systemically. We describe overall results below.

Item – As collected from providers following reviews conducted Q4, FY15	Score (out of 5 – with 5 being strongly agree)
The PE provided useful technical assistance throughout the review.	4.4
The PE was courteous throughout the review.	4.7
The PE was knowledgeable about I/DD Waiver policies and procedures.	4.4
The PE was responsive to my needs during the review.	4.3
The PE was available for questions during the review process.	4.7
The PE clearly conveyed the review findings during the Exit Interview.	4.4

APS-WV will increase staff to meet the Bureau's request to double the review volume and review each I/DD Waiver provider every year. Upon this review, APS-WV will verify compliance with current state and federal policy guidelines, appropriate utilization management, and documentation of authorized services. APS-WV will notify the Bureau of the review schedule a quarter in advance. APS-WV will continue with the imperative technical assistance component of the review so that providers can continue to grow their knowledge and understanding of policy and requirements.

APS-WV will provide comprehensive draft reports within 10 days of the review to the Bureau and to the provider. These reports will include the Review and Disallowance Reports along with the Plan of

Correction. The provider will have up to 30 days to respond to their draft reports. Upon receipt and reconciliation of the provider's response, APS-WV will prepare and send all components to the Bureau for final consideration. APS-WV will participate in Review Committees where the Bureau, the Office of Program Integrity, and APS-WV will discuss final disallowance amounts. APS-WV will prepare the final reports for the Bureau to disseminate to the provider.

APS-WV is eager to incorporate a follow-up review of providers who must submit a Plan of Correction because of unsatisfactory findings during an on-site review. We believe this process is imperative to improving the overall quality of services for our members. Depending on the severity of unsatisfactory findings, APS-WV will conduct either a desk or on-site visit of the provider to verify they did in fact implement their Plan of Correction.

Quality Improvement Advisory Council

On-site provider review findings are an integral way of capturing statewide quality and performance management data as necessary for the CMS reports. Cumulative review findings will be shared with the Quality Improvement Advisory Council. APS-WV will facilitate meetings of this council quarterly whose purpose is to advise the Bureau on program related matters and concerns. APS-WV will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they wish to receive reimbursement. To enhance program and disability-related knowledge continuously, APS-WV will send I/DD staff to a national conference at the request of the Bureau.

Participant Experience Survey

APS-WV will enhance the Consumer Family Educator role to conduct the Participant Experience Survey with a representative sample of program members annually. We are familiar with the survey, as we have been conducting the Traumatic Brain Injury version with TBI Waiver program members since 2013. Data from the survey results will be compiled, analyzed, and presented to the Bureau with our recommendations to inform program policy and quality.

Complaints

APS-WV will receive, review, track/trend, and/or investigate complaints submitted by providers, members or other stakeholders related to a program member's service(s) through an I/DD Waiver provider. APS-WV follows a consistent procedure in responding to complaints and reporting to BMS on trends and outcomes. Each complaint is taken seriously and is viewed by APS-WV as a potential opportunity for improvement and technical assistance.

APS-WV can receive complaints either verbally or in writing (email or fax). Upon receipt of a formal complaint, APS-WV will document the complaint and request any necessary information for follow-up. If the issue cannot be resolved over the phone through technical assistance and information and referral, APS-WV will investigate the complaint and/or make referrals to appropriate entities.

APS-WV will inform the complainant of procedures in following a chain of command at the provider agency. Every I/DD Waiver provider is required to have a grievance/complaint procedure. It is required that each agency inform program members/legal representatives of this procedure. APS-WV will request information about steps taken thus far to resolve the complaint at the agency level. These steps may include notifying the Service Coordinator, Waiver Supervisor or accessing the agency's

grievance/complaint procedure. It is not required that the complainant initially follows a chain of command at the agency-he or she may make direct complaint to APS-WV. If we suspect:

- Abuse, neglect, or exploitation of a program member, APS-WV will assist the complainant in making a referral to Adult or Child Protective Services (APS/CPS). If the complainant cannot or will not make this referral, APS-WV will do so.
- A provider agency is not following procedures consistent with the Office of Health Facilities Licensure Accreditation and Certification (OHFLAC). APS-WV will refer the issue to and/or work to assist OHFLAC with their investigation. OHFLAC's policy requires unannounced investigations, and the provider will not receive notification of an investigation by OHFLAC.
- A provider or agency is billing for and receiving reimbursement for services inappropriately, APS-WV will refer to, and/or work to investigate with, the Medicaid Fraud Control Unit (MFCU). This process will begin with a referral to the Office of Program Integrity (OPI) at BMS.

APS may receive anonymous complaints. If the complaint contains enough information to follow-up, APS will do so. If there is no way to follow-up based on the information provided, APS will log the complaint and indicate that there was not enough information to follow-up. If complainants request to remain anonymous, we will notify them that we may not able to follow up on the complaint.

- If we suspect the issue of complaint is systemic, APS may request additional information to determine the extent of the complaint.
- When APS conducts an investigation, APS will notify the provider agency of the complaint as long as doing so will not compromise integrity of the investigation or put a program member at risk.
- When appropriate, APS may utilize the provider agency's internal investigation system to acquire necessary information. In this event, APS will request the agency forward specific information for APS to conduct a desk review.
- When appropriate, APS may conduct an on-site investigation at the provider agency after consultation with BMS.
- APS-WV may investigate matters related to I/DD Waiver policy manual compliance. For those matters in which the I/DD Waiver policy manual overlaps with Adult Protective Services/Child Protective Services, OHFLAC or OPI, APS-WV will work with applicable parties or make referrals, as appropriate.

APS-WV will initially respond either verbally or in writing to formal complaints within two business days. An anonymous complaint cannot be considered a formal complaint. Complaints will be handled in a manner that is the least restrictive necessary. Follow-up may require a request for information, interview with staff, the program member/legal representative or other applicable parties and/or an on-site visit.

Incident Management System

At the request of the Bureau, APS participated in development meetings related to the upcoming release of the new Incident Management System. Once available, we will assist the Bureau with system testing until it is in production. Our vast experience with developing and testing our own

systems will prove invaluable. APS will continue to perform daily monitoring and provide monthly and quarterly reports on data entered into the Incident Management System.

Service Authorizations

APS-WV uses the APS System to review and prior authorize services delivered to I/DD Waiver members. Providers submit all data and requests electronically. The interdisciplinary team (IDT) chooses services and supports at the Individual Program Plan (IPP) meeting. The Service Coordinator submits prior authorization requests and chosen providers to APS-WV. Requests are then reviewed by an APS-WV Registration Coordinator to ensure the team's recommended services are within the individualized Waiver budget and rules outlined in the I/DD Waiver policy manual. If the request does not exceed the individualized Waiver budget or service limits, and the IDT addressed all health and safety needs, APS-WV can authorize the requested services, and APS-WV will electronically refer services to all chosen providers and/or the fiscal/employer agent for acceptance or rejection. If service plan does not meet these conditions, the Registration Coordinator will contact the Service Coordinator to discuss requested services, and agree on a budget and service mix that meets the individual's needs. The Prior Authorization process for I/DD Waiver is outlined in Exhibit 28.

Prior Authorization Process

1. The Service Coordinator completes and updates the individual's case information (including demographic and medical data), and reviews assessment and budget information available in the APS System.
2. The individual's IDT convenes to develop/update the IPP and to choose services, service amounts, and service providers.
3. The Service Coordination Agency submits all information through the I/DD Waiver system.
4. The APS Registration Coordinator reviews information received from the Service Coordination Agency to ensure requested services are within the individualized Waiver budget, within the rules outlined in policy, and address all health and safety needs.
5. If all requests meet service criteria, APS distributes service referrals to providers the IDT selected. If not all service requests meet service criteria (noting an exception to service parameters), an APS-WV Registration Coordinator will contact the Service Coordination Agency to negotiate a modification of service(s). This negotiation may involve the Service Coordination Agency providing explanation/additional information based on the IDT recommendations to justify the exception.
6. If selected providers accept service referrals via the APS System, APS-WV creates annualized authorization numbers, which we return to those providers. If selected providers do not accept service referrals, APS forwards this information to the IDT so that they may select an alternate provider. We repeat this process as necessary until a provider accepts the referral for each requested service.

Second Level Negotiation, Prehearing Conference and Medicaid Fair Hearing

In the event that APS and the Service Coordinator (on behalf of the IDT) cannot agree to the amounts and services authorized, the member may request a 2nd Level Negotiation or Medicaid Fair Hearing. APS-WV

will manage and track those cases where the member requests further review. A detailed flow of this process can be found in Exhibit 29.

Providers or members will submit a 2nd Level Negotiation Request form to APS who will then gather all necessary historical and demographic information for the Bureau's review. The Bureau will determine the amounts approvable at the second Level Negotiation stage. If the member is not satisfied with those amounts, the request status will be "Denied," and the member/legal representative will receive a denial notice explaining this adverse determination.

APS-WV notifies the member that they have the option to access a prehearing conference as an interim step before going to Medicaid Fair Hearing. This process allows members to discuss their positions with the Bureau, and allows the Bureau to express its position and/or relevant policy that supports the denial. APS-WV will continue to coordinate prehearing conferences.

If an applicant or member receives an adverse determination, denied I/DD Waiver medical eligibility, or if APS-WV denies a requested service level, we will follow the department's Medicaid Fair Hearing and I/DD Waiver program policy and procedures. We will prepare a written notice of the adverse action and mail it to the member and/or legal representative. This notice will include the applicable policy resulting in the adverse action, what elements for approval were not present and the right to appeal for Medicaid Fair Hearing. APS will coordinate hearings and prepare hearing packets when services are involved.

*Note: A different contractor handles hearings related to medical eligibility; the Department of Health and Human Resources conducts hearings related to financial eligibility. We will coordinate applicable hearings with the State Hearing Officer, member, legal representative and others. We will also make available staff to participate and/or represent the department in member prehearing conferences and/or hearings either telephonically or in-person as required by the Agency.

Fraud, Waste, Abuse Referral

In the event that we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

p. Personal Care Services

p. Personal Care Services

Vendor Response

APS-WV began providing management and oversight of medical eligibility and service level determinations in support of the Bureau's Personal Care program in 2009. Since then, APS participated in policy decision meetings, monthly contract management meetings and provided data for the Bureau. In 2015, APS successfully transitioned all Personal Care work previously performed by a sub-contractor under internal management. As such, we are prepared to continue the work activities and related tasks necessary to fulfill the Bureau's performance requirements as outlined in the RFP.

Review for Prior Authorization

Personal Care provider agencies complete an initial or reevaluation request for Personal Care Services. These providers coordinate with physicians, or complete the Pre-Admission Screening (PAS) and submit it to request prior authorization. Providers submit requests into the Personal Care system. They must

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

Providers must attach the signed PAS as well as any other required documentation (such as physician's orders, plans of care, assessments, or other forms) for review into the system. When all data entry is complete, an APS Registered Nurse reviews the request and any attached documents within 2 days. The workflow for prior authorization of Personal Care can be found in Exhibit 30.

Personal Care System

APS-WV implemented the APS system for the Personal Care program (APS-PAS) in May 2015. This secure web-based electronic system serves as a venue for communication across program stakeholders including the Bureau, providers, the Operating Agency (Bureau for Senior Services) and APS-WV. The system collects and tracks member eligibility status, service level, authorizations and demographic information, selected agencies and transfers as well as many other data elements.

The APS system automatically determines medical eligibility based on the Pre-Admission Screening results and calculates service level for eligible members through an algorithm developed based on policy. The system provides automated authorizations and exports authorization information to the claims payer. The system allows for document upload by various user types. Data necessary for routine and ad hoc reports is maintained within the system and is accessible for reporting and analysis. BMS has made the system mandatory for all agencies and other applicable contractors. The system makes agencies aware of the status of the request in "real time" so they can communicate that status to the member and begin to develop the Plan of Care.

Review Criteria

APS will continue to work with the Bureau as well as the Bureau of Senior Services to make recommendations for new or modified forms. We will continue to research and recommend appropriate criteria related to medical eligibility and service level assignment for Personal Care services. We will continue to make recommendation about policy, procedures, and best practice to the Bureau annually or more often as warranted. Any recommendations will be accompanied by supporting documentation or materials. Prior to making any changes to review criteria or forms, APS will gain approval from the Bureau.

Fraud, Waste, Abuse Referral

In the event that we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

q. Aged and Disabled Waiver Services

q. Aged and Disabled Waiver (ADW) Services

Vendor Response

APS-WV has provided management and oversight of medical eligibility and service level determination in support of the Bureau's Aged and Disabled Waiver program since 2009. Since that time, APS has participated in policy decision meetings, monthly contract management meetings and provided data for the Bureau in relation to the Centers for Medicare and Medicaid Services (CMS) required quality reporting.

For consistency and efficiency, APS has assumed some reporting previously provided by another contractor, the Bureau of Senior Services (BoSS).

In 2015, APS successfully transitioned all work previously performed by a sub-contractor under our direct management. We will continue the work activities and related tasks necessary to fulfill the Bureau's performance requirements as outlined in the RFP. Reviewers will continue to conduct independent medical necessity reviews and service level determinations for the Aged and Disabled Waiver Program consistent with the following high-level process.

Initial and Reevaluation Request for Medical Evaluation

We will receive daily referral requests for PAS Waiver program assessment, including requests for either an initial or re-evaluation. In 2014, APS implemented the Aged and Disabled Waiver system—made mandatory by the Bureau for use by other contractors and providers. We will continue to receive re-evaluation requests for evaluation through this system and initial requests, physician's orders regardless of the mode of receipt.

Once the initial referral is complete, we will mail the applicant (with the Bureau's approved letter) and prompt them to obtain financial eligibility through their local DHHR. At this time, they may also select a Case Management Agency to assist them with this task. Once we receive verification of financial eligibility approval, we will contact the applicant, establish a date, and time for the medical evaluation, abiding by the Cyrus Court Decree and policy related to contacts, appointments, notices and other measures.

A registered nurse will conduct the initial and re-evaluation Pre-Admission Screening (PAS) assessments pursuant to all Bureau prescribed instructions, guidelines and program requirements. APS will make every effort to complete assessments within timeline. When we cannot complete an assessment within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline.

Once the assessment is completed, the nurse will submit the evaluation electronically through the APS System. We will then run the data from the assessment through a computerized algorithm based on current program policy, and establish a determination of medical eligibility and service level for medically eligible individuals. The ADW eligibility process can be found in Exhibit 31.

Managed Enrollment

Medically and financially eligible applicants will be placed on the Managed Enrollment List (if applicable) which we currently maintain – and will continue to do so. Once a funded slot is available, we will "release" the slot and contact the member to request they select their service model (traditional or self-directed) and any applicable agencies. Once we receive verification of the member's choices, we will electronically refer the case to the agency/agencies or Fiscal/Employer Agent vendor. Approved re-evaluation assessments will automatically generate authorizations for services. For purposes of streamlining and efficiencies, communication with the agencies and/or vendors will be through the mandatory Aged and Disabled system whenever possible.

Hearings

If an applicant or member experiences an adverse action (is denied Aged and Disabled Waiver medical eligibility, a service level is reduced for a member, or if a requested service level is denied) we will follow

the department's Medicaid Fair Hearing and Aged and Disabled Waiver program policy procedures. A written notice of the adverse action will be prepared and mailed to the member and/or legal representative. This notice will include the applicable policy resulting in the adverse action, what elements for approval were not met and the right to appeal for state fair hearing. BoSS currently coordinates hearings and accesses the APS System for historical documents to prepare the hearing packet. BoSS schedules and coordinates hearings with the State Hearing Officer, member, legal representative and others. We will make available an RN to participate and/or represent the department in member prehearing conferences and/or hearings either telephonically or in-person as required by the Agency.

Aged and Disabled Waiver System

We implemented the APS System for the Aged and Disabled Waiver in July 2014. This secure web-based electronic system tracks applicant/member statuses, contacts, appointments, selections of service delivery models, agencies and many other data elements. The APS System automatically determines medical eligibility based on the Pre-Admission Screening results and calculates service level for eligible applicants/members through an algorithm developed based on policy. The system provides automated authorizations and allows for the submission and processing of special requests to extend existing authorizations as well as exports attribute and authorization information to the claims payer. The system processes and tracks agency referrals, discharges, letters/notices, PAS assessments and allows for document upload by various user types. Data necessary for routine and ad hoc reports is maintained within the system and is accessible for reporting and analysis. BMS has made the system mandatory for all agencies and other applicable contractors.

Quality Assurance, Evaluation Timelines

Through our Quality Assurance program, we will ensure determinations for initial eligibility and service level occur within 45 calendar days of receiving the referral in accordance with current federal and state policy guidelines and court orders. Re-evaluations will be completed at least 30 days prior to the member's established Anchor Date (dependent on providers submitting the re-evaluation request within timeline). We will complete routine inter-rater reliability and quality assurance/improvement activities. We will make recommendation about policy, procedure, and best practices to the Agency annually about what, if any, changes should be made to the criteria. All materials and data related to criteria recommendations will be provided to the Bureau for consideration. APS-WV will submit any recommended modifications or interpretation of the criteria to the Bureau for consideration and approval prior to implementation.

Fraud, Waste, Abuse Referral

In the event that we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

r. Take Me Home Services

r. Take Me Home (TMH) Services

Vendor Response

APS-WV began our involvement and collaboration with the Take Me Home-WV (TMH) program since its approval in 2011. This Money Follows the Person demonstration program successfully supports the

transition of eligible participants from long-term care facilities to their own homes and communities. APS has prepared and disseminated correspondence to program stakeholders (such as Traumatic Brain Injury Waiver providers) on behalf of the TMH program. We participated in TMH Advisory Council and quarterly meetings and conference calls. APS is prepared to continue these efforts and to incorporate TMH services into existing systems and procedures.

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

APS will prepare monthly status reports on the status of TMH participants accessing Waiver and State Plan Personal Care services – as based on the member's eligibility status. The TMH monthly report shall include:

- Medical eligibility status for initials and reevaluation assessments,
- Fair Hearing status (if applicable),
- Current service delivery model selection and
- Current selection of provider.

APS will work with TMH staff to determine the elements and documentation requirements necessary for best practice related to provision of TMH Services. Upon development of an approved review tool, APS will conduct on-site and/or desk reviews of these services and prepare a summary report of review findings. APS proposes that a documentation/desk review is conducted initially with providers of TMH Services for a representative sample of members. If review findings are not satisfactory as determined by the Bureau's threshold, we will provide on-site follow-up review and education/technical assistance.

s. Lab/Genetics Services

s. Lab/Genetics Services

Vendor Response

In the last several years, APS sees an increased demand for the development and implementation of a more robust UM system to authorize high-cost laboratory services, particularly laboratory/molecular diagnostic tests and/or pathology services to aid in the treatment of diagnosed conditions. The increased number and types of laboratory services covered by the Bureau for Medical Services that require prior authorization include:

a. BRCA testing;
b. Oncotype Diagnostic Testing;
c. Genetic testing for specific conditions or markers;
d. Molecular diagnostic and pathology tests;

e. Drug Screening
f. Other identified high-cost and/or high utilization laboratory services.

Over the last several years, as CPT and/or HCPCS coding systems expanded to incorporate numerous genetic testing and drug screening codes, APS-WV assists the Bureau by:

a. Assisting with form creation (e.g. Oncotype Diagnosis);
b. Researching codes and making coverage recommendations (e.g. genetic testing codes added in 2015);
c. Researching and recommending criteria (e.g. BRAC criteria);
d. Developing criteria when criteria is not available (Drug Screening/G Codes);
e. Provider education, webinars, and training (Drug Screening/ G codes and BRAC).

APS will continue to assist the agency when InterQual criteria are not available by providing recommendations to the Bureau for Medical Services based on research of clinically sound and research-based criteria endorsed by APS' Medical Director and physicians in the specialty of the criteria under review. These criteria can also be edited to create local medical policies (LMP's) that conform to BMS specific policies. Local Medical policies may also be developed for existing criteria sets, as policy is updated or clinical practices changes. Recommendations are sent to the Bureau for Medical services for approval, and once approved are implemented by APS. Providers are updated regarding criteria changes and if the criteria are not proprietary, they are available to providers unless otherwise specified by BMS. Proprietary criteria, such as InterQual, may not be disclosed to providers; however, InterQual has developed SmartSheets in many review areas that can be made available to providers upon request. A flow chart of this process contained in Exhibit 32.

APS will update the review criteria annually, and alert BMS to any recommended changes in the criteria, taking into account the WV State Plan, any applicable federal regulations and policy comparisons to other state agencies. Any recommended changes in criteria will be included in the annual report provided to the agency. Since InterQual criteria is utilized in a number of review areas it is not within the purview of APS or BMS to make major modifications to the proprietary criteria set- however, recommendations will be made to the agency for any additions or edits that may need to be approved to conform to BMS policies. For all other policies, recommended changes will be presented to the agency for consideration. The Bureau may reject current or recommended criteria and specify different criteria to be used. APS will provide the agency with access to a complete set of materials associated with the criteria annually. APS assumes responsibility for the cost of InterQual review materials and any other criteria set adopted that is not public domain.

Further, APS will develop a Molecular Diagnostic Services Program:

a. Make coverage recommendations related to new testing codes as well as codes that move from investigational/experimental to standard medical practice;
b. Assist BMS with coding and pricing for services where pricing is not available in the Medicare Clinical Laboratory Fee Schedule, taking into account the WV State Plan, any applicable federal regulations and policy comparisons to other state agencies. ;
c. Request agency approval of the criteria for: 1) Tier 1 81200-81383 CPT code range; 2) Tier 2- 81400-81479 CPT code range; 3) Micro-dissection 88380-88381; 4) HCPCS- G0452; 5) Not

Otherwise Classified Codes (NOC)- 81479, 84999, 85999, 86849, 87999, 88199, 88299, 88399, 89398, and; 6) other laboratory/codes as requested by the agency.

We describe the prior authorization process for laboratory/genetic testing services below, with the workflow included in Exhibit 32.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for lab/genetics services by Direct Data Entry (DDE), fax, or mail. APS-WV will use The APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, below**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

   d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently local medical policies, NCCN criteria, Medicaid approved criteria and BMS Manual Chapter 529 Laboratory Services are utilized to authorize laboratory/genetics services requests.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will develop educational trainings for laboratory/genetic testing stakeholders on topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all Laboratory/Genetics service providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will provide the following services to the Bureau for Medical Services to ensure appropriate utilization management of laboratory/genetic testing services:

- Participate in conference calls at the request of the agency;
- Develop a reference manual for providers;
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the APS website;
- Hold initial orientations to the APS System with key stakeholders, as requested by the Department;
- Provide support to the Department related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials;
- Provide a toll free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request;
- Make recommendations or develop forms upon request of the agency;
- Represent the agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.

APS will also coordinate with Molina, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. APS will also monitor over- and under-

utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

t. Out-of-Network Services

t. Out-of-Network Services

Vendor Response

APS-WV fully understands that services must be provided by in-network providers whenever practicable but that in some instances out-of-network providers are needed because services may not be available from in-network providers or special circumstances exist that require an out-of-network provider perform a service. When a prior authorization request for a medical or behavioral health service is submitted and the eligibility verification process identifies a provider who is not enrolled in the network, options for in-network providers of the service are explored and the WV Medicaid enrolled referring physician and requested out-of-network provider are contacted. If we determine an in-network provider is available to provide the service, the initial request is closed and the referring physician and member are apprised of available in-network providers who are enrolled to provide the service. If it is determined that the out-of-network provider is appropriate and medically necessary, an authorization is granted but cannot be exported to the MMIS system until the out-of-network provider is enrolled. Call tracking is initiated with Molina enrollment, the provider is referred for enrollment via letter and telephonic notification, and the request is placed in a status- Hold for Provider Enrollment. Once the provider is enrolled, the authorization is exported to Molina. If the provider fails to enroll, the referring physician and member are notified. In the event the provider is denied enrollment the referring physician and the member are informed and the authorization may either be assigned to another designated out-of-network provider or closed. If a different out-of-network provider is selected the process begins again until the authorization can be assigned. The flowchart (in Exhibit 33) outlines the process for review for out-of-network providers.

APS-WV will prior authorize necessary services provided by out-of-network providers. Providers will be informed of the enrollment process and any prior authorizations will be time limited. Referrals to out-of-network must come from a West Virginia Medicaid practitioner and the request must be supported with sufficient documentation to determine the prior authorization is medically necessary and the service cannot be obtained through an in-network provider.

We currently provide out-of-network services for BMS on a case-by-case basis and understand the value of consistent monitoring of these providers for management of the fiscal requirements of the Medicaid Program and the best interests of the Medicaid members. APS-WV understands the BMS requirement that out-of-network prior authorization periods and enrollment time must coincide. We are familiar with program requirements including the requirement that services, which can be provided by an in-state or border provider, should not be authorized out-of-network, unless deemed as a medical emergency. Additionally, the services must be requested by a WV Medicaid enrolled practitioner. We are also aware the specified providers have been designated as in-network providers when services they provide are not available in-state or from border providers.

Currently, border facilities are not considered out-of-network and are enrolled as border or in-state providers. The out-of-network process does not apply to any out-of-state provider designated as in-

network. APS has worked diligently with the Bureau for Medical Services to develop and document a more streamlined approach to handling out-of-network services and:

1) Improve the Bureau's ability to control such addition of provider;
2) Ensure that each request is treated consistently;
3) Ensure that members can access out-of-network services in a timely fashion, and;
4) Ensure that out-of-network providers can be paid in a timely manner for authorized services rendered to WV Medicaid members.

The medical necessity review process conforms to the required process for the specific service requested out-of-network but always contains the following steps:

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for an out-of-network service by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (We then follow the process in this section.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

   d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT

requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse/consultant/physician reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review.

4. *If approved by the RN reviewer*: The authorization number is held until the out-of-network provider enrolls then is exported to the claims payer, Molina in a daily file and is available in the APS System record and the reports tab for the referring and out-of-network provider. Providers who are unable to access the online system and have notified APS of their inability to do so receive notification by fax or telephonically.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will develop educational trainings and webinars for stakeholders on referring and providing out-of-network services as requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all providers when changes in out-of-network policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will provide the following services to the Bureau for Medical Services to ensure appropriate utilization management of imaging services:

- Participate in conference calls at the request of the agency;
- Develop a reference manual for providers;
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the APS website;
- Hold initial orientations to the system with key stakeholders, as requested by the Department;
- Provide support to the Department related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials;
- Provide a toll free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request;
- Make recommendations or develop forms upon request of the agency;

- Represent the agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.

APS will also coordinate with Molina, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. APS will also monitor over- and under-utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

u. Cardiac Rehabilitation

u. Cardiac Rehabilitation

Vendor Response

Cardiac Rehabilitation is a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active, productive lives. The central component of cardiac rehabilitation is a prescribed regimen of physical exercises intended to improve functional work capacity and overall well-being.

The program consists of a series of supervised exercise sessions with continuous electrocardiograph monitoring. Cardiac rehabilitation can be performed in a freestanding physician directed clinic or in an outpatient hospital department. The goals of cardiac rehabilitation are:

- To increase exercise tolerance
- To reduce symptoms of chest pain and shortness of breath
- To improve blood cholesterol levels
- To improve psychosocial well-being
- To reduce mortality

APS actively worked with the Bureau for Medical Services during the current contract cycle to define the practitioner groups that may provide Cardiac Rehabilitation as well as the medical necessity review criteria for the service. The process for the prior authorization of cardiac rehabilitation services has been outlined below. In addition, an illustration of this process as a workflow is in Exhibit 34:

1. *Verification of:*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for cardiac rehabilitation services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before

establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be

approved or referred to physician review. Currently Chapter 519, local medical policies, and BMS approved criteria are utilized for medical necessity review of this service.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS-WV will refer requests for Cardiac Rehabilitation to our medical case management nurse for appropriate follow-up in that program, as deemed necessary. This will not only serve the member's best

interests by ensuring that he/she receives all needed services and is not subjected to any unnecessary procedures, but will also serve the Bureau's need to control costs through utilization management to ensure that services are appropriate, unduplicated and as non-intrusive as possible. In the event of a denial, nurses in our case management program will be able to provide referrals for other services that may be more appropriate and available to the member.

v. General and Acute Care Inpatient Hospital Admission and Continued Stay Review

v. General and Acute Care Inpatient Hospital Admission and Continued Stay Review

Vendor Response

The workflow diagram in Exhibit 35 illustrates the process for the submission and review of General and Acute Inpatient Hospital admissions. General and Acute Inpatient Hospital admissions are those inpatient procedures that are most of emergent/urgent or unscheduled or are direct admissions for surgical services or other procedures performed on an inpatient basis. The manual requirements for prior authorization are as follows:

Chapter 510 defines an inpatient member admission as a "person who has been admitted to an inpatient facility for bed occupancy for purpose of receiving inpatient hospital facility services." Inpatient Hospital Services must be medically necessary to diagnose and treat an eligible member.

> "Inpatient and outpatient hospital services, including tests furnished by participating hospitals, are covered only when ordered by a licensed medical practitioner for the care and treatment indicated in the management of illness, injury, or maternity care, or for the purpose of determining existence of an illness or disease. All Medicaid covered items and services must be medically necessary. The physician's order and appropriate documentation of medical necessity must be on file in the patient's record. The fact that a provider has prescribed, recommended, or approved medical care, goods, or a service, does not in itself make such care, goods or services medically necessary or a covered service."

The definition of medically necessary, per Chapter 200, Definitions is:" **Medically Necessary** – Services or supplies that are proper and needed to diagnose or treat a medical condition." Medically necessary services are not for the convenience of the member or the provider. Covered inpatient services include:

- General acute care admissions
- Critical access hospitalizations
- Medicare certified distinct part medical rehabilitation inpatient units (for members under 21) (these services are discussed in section ff)
- Medicare certified, distinct part Psychiatric Hospitals (children and adults) (these services are discussed in section a of the Behavioral Health Services Utilization Management Technical Requirements)

Prior authorization requirements include:

- Prior authorization is required for all medical inpatient admissions except for those related to maternity services (labor and delivery).
- Services rendered by an eligible provider must be:
    - covered and authorized;
    - rendered by a West Virginia Medicaid enrolled provider;
    - within the scope of the provider's license; and
    - in accordance with all state and federal requirements.

The inpatient facility obtains prior authorization (PA), or the attending physician obtains PA on behalf of the facility. Adjunct services provided by inpatient physician (e.g., pathology, Emergency Room, anesthesia, radiology, and laboratory) are covered under the prior authorization unless a specific exception is noted. Inpatient authorizations are DRG driven. According to Chapter 510, covered services are limited to those inpatient admissions prior authorized by the Bureau's Utilization Management Contractor, APS-WV. APS-WV uses the following for inpatient medical/surgical review requests:

1. *Verification of*

    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for inpatient hospital services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

    c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

    d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and

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

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use McKesson's Health Solutions' InterQual Criteria sets (InterQual Adult & Pediatric; InterQual Procedures & Acute; InterQual Acute) as previously approved by the Bureau for Medical Services.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS System. This notification includes the policies and criteria that were not met and information about the reconsideration process. We

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

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

w. Pulmonary Rehabilitation

w. Pulmonary Rehabilitation

Vendor Response

Pulmonary Rehabilitation (PR) is an individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease. Pulmonary Rehabilitation offers members a chance to reduce hospitalizations, increase their knowledge about pulmonary disease and its management, the ability to control and alleviate the symptoms of pulmonary disease, and the ability to carry out activities of daily living with less shortness of breath. Pulmonary rehabilitation programs include exercise training, psychosocial support, and education, which are intended to improve the member's functioning and quality of life.

The program includes the following components:

- A team assessment which normally includes input from the physician, a respiratory care practitioner, a nurse, a psychologist and a nutritionist;
- Member training which includes breathing retraining, bronchial hygiene, medication education and proper nutrition;

- Psychosocial intervention addressing the member's emotional support systems, anxiety and dependency issues;
- Exercise training, which includes strengthening and conditioning which may include stair climbing, inspiratory muscle training, treadmill walking and cycle training;
- Member follow-up, which includes a structured and ongoing home pulmonary rehabilitation program

The goals of Pulmonary Rehabilitation are:

- Restore the member to the highest possible level of independent function
- Educate the member and significant others about the disease, treatment options and strategies
- Reduce and control breathing difficulties and symptoms
- Maintain healthy behaviors such as good nutrition and exercise
- Encourage members to be actively involved in their own healthcare.

APS actively worked with the Bureau for Medical Services during the current contract cycle to define the practitioner groups that may provide Pulmonary Rehabilitation as well as the medical necessity review criteria for the service. The process for the prior authorization of pulmonary rehabilitation services has been outlined below. In addition, an illustration of this process has been provided as a workflow. This workflow has been included as Exhibit 36.

1. *Verification of*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for pulmonary rehabilitation services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently Chapter 519, local medical policies, and BMS approved criteria are utilized for medical necessity review of this service.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the

authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will refer requests for Pulmonary Rehabilitation to our medical case management nurse for appropriate follow-up in that program, as deemed necessary. This will not only serve the member's best interests by ensuring that he/she receives all needed services and is not subjected to any unnecessary procedures, but will also serve BMS' need to control costs through utilization management to ensure that services are appropriate, unduplicated and as non-intrusive as possible. In the event of a denial, nurses in our case management program will be able to provide referrals for other services that may be more appropriate and available to the member.

x. Chiropractic Services

x. Chiropractic Services

Vendor Response

APS serves as the prior authorization agent for BMS for Chiropractic services. We propose to continue to provide this service subject to BMS approval. We understand that prior authorization is required for Chiropractic care beyond the initial twelve services in a calendar year. WV Medicaid coverage of chiropractic services includes the following:

- Coverage is limited to manual manipulation (by use of hands) for subluxation of the spine and certain diagnostic radiological examinations related to chiropractic services.
- Chiropractors may use manual devices in performing manual manipulation of the spine but no additional payment is available for use of device by Medicaid and Medicaid will not reimburse extra charges for the device itself.
- WV Medicaid limits its coverage of Chiropractic Services to treatment by means of manual manipulation to correct a subluxation of the spine, demonstrated by an x-ray.
- WV Medicaid waives the X-ray requirement for initially covered services for pregnant women and children. Services requested above the initial 12 visits for children require an X-ray.
- Taking the X-ray must occur no more than 3 months prior to the initiation date of the course of treatment. In certain cases of an acute exacerbation of a chronic subluxation, we will accept an x-ray no older than a year.
- X-ray equipment must be certified radiology equipment that complies with all applicable State and Federal requirements.
- Medicaid reimburses chiropractors for the professional and technical components of covered diagnostic radiology services (CPT 72010-CPT 72120) if the chiropractor performs both parts of the procedure.
- Medicaid will provide reimbursement for only one interpretation of an x-ray and will not pay for a second confirmatory x-ray.

Below is the prior authorization process for chiropractic services. An illustration of this process has been provided in a workflow. This workflow has been included in Exhibit 37.

1. *Verification of*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for Chiropractic services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating

provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

   Determine if the service is medically necessary and appropriate: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Chapter 504 (now included in Chapter 519 as part of policy remediation) and InterQual Procedures for review of medical necessity and Chiropractic Consultant Review is utilized for requests over the 12 session per year limit that do not meet criteria.

3. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.
4. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.
5. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS System. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
6. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board certified MD/DO with specialty match for a final determination.
7. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
8. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
9. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
10. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will develop educational trainings for providers regarding chiropractic policy (Chapter 504), available services, service delivery models, and any other topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all Chiropractic providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will participate in and conduct training for members and other stakeholders as requested by the agency. APS will participate in conference calls at the request of the agency.

y. Podiatry Services

y. Podiatry Services

Vendor Response

APS-WV understands that podiatry services encompass foot and ankle procedures that are provided by a WV-licensed podiatrist. APS currently reviews for surgical foot and ankle procedures that require prior authorization, such as bunionectomies, tarsal-tunnel release, calcaneal spur removal, removal of nail beds (matrixectomy), and hammer toe corrections. A podiatrist or a board certified MD/DO will conduct required physician level reviews. Below is the prior authorization process for podiatry services. A workflow of this process is in Exhibit 38.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for podiatry services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

   d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we

determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Chapter 520 (now included in Chapter 519 as part of policy remediation) and InterQual Procedures for review of medical necessity.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

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

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

8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider

and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

APS will develop educational trainings for providers regarding policy (particularly Chapter 520 and inclusion of podiatry services in Chapter 519), available services, service delivery models, and any other topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all podiatric providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will participate in and conduct training for members and other stakeholders as requested by the agency. APS will participate in conference calls at the request of the agency.

z. Medical Case Management

z. Medical Case Management

Vendor Response

Medical Case Management relevant to the UMC contract encompasses coordinating and monitoring healthcare services for members identified by the Bureau for Medical Services or who receive authorization for a service(s) specifically identified as requiring case management during the authorization period or for some designated period following authorization of the service. The primary goal is to monitor progress during or following delivery of intensive or high cost services. We will notify the member and the referring physician requesting prior authorization of the service(s) that trigger medical case management concerning provision of the service.

APS-WV understands the importance of ensuring that high-cost cases such as private duty nursing and organ transplant patients are using appropriate services that meet their medical needs. Medical Case Management for BMS is currently conducted by a dedicated case manager. These case managers will continue to work under subcontract to APS-WV subject to BMS approval, identifying opportunities to improve care of Medicaid members while reducing cost.

Certain categories of review receive automatic assignment to case management, including organ transplant services, private duty nursing services, bariatric patients and members receiving Inpatient Medical Rehabilitation Services <21. We may refer Cardiac and Pulmonary Rehabilitation patients to medical case management when the authorization review of these services shows utilization of high cost services, high utilization patterns, and increased risk of high utilization. APS-WV has also recommended

that EPSDT referrals for medical/enteral foods also be subject to medical case management post-authorization. We may also assign other high-cost or service-intensive cases to case management at the request of the agency, owing to utilization review reporting, or claims data review by the agency. Case management staff from the preauthorization unit, hospitals, physician's offices, and BMS may refer patients for case management. Members or their legal representatives may also request case management services. In addition to those services mandated for medical case management services by the agency, APS-WV proposes case management follow-up as noted in other service areas of this proposal and described above, i.e., Hospice, Cardiac Rehabilitation, Pulmonary Rehabilitation, and EPSDT.

The process for Medical Case Management has been illustrated in a workflow, which has been included in Exhibit 39. This process describes the relationship of medical case management to the initial prior authorization and the reassessment process.

Notifications related to participation in the medical case management services program include:

1. Notification/Confirmation to Member of Engagement into the medical case management services program. Whether we engage the member/legal representative via telephone or not, we will send a notification letter to the member/legal representative within two business days after the confirming the member status is suitable for the program. The letter will inform members that their current and future providers will also receive notification.
2. Notification/Confirmation to Provider(s) of Member's Engagement into the medical case management services program. APS-WV will send a notification letter to all treating provider(s) within two business days after the approving the member's case for the program. The letter will also notify members and legal representatives. Any providers treating the member under medical case management services will receive the notification letter within two business days of the member's first date of treatment with the provider.
3. APS-WV sends Notification/Confirmation of Member's Declination/Discharge of the medical case management services program to the member/legal representative and all treating providers within two business days after receipt of the member's written or verbal notification of the declination or discharge.

Members receiving medical case management services will continue to be case managed until one of the following conditions exists:

- The member is stable, has reached maximum potential, and no longer requires case management services;
- The member is admitted to long term care;
- The member fails to respond to inquiries or to follow treatment plans;
- The member is no longer Medicaid eligible.

Cost savings is an important part of any medical case management program. Each referral will be evaluated to determine the feasibility of achieving cost savings while achieving significant improvements in member outcomes. Cost savings related to recommendation and/or approval of less costly care options, efficacious and less costly equipment or other cost savings will be reported to the Bureau for Medical Services. APS will apply the BMS approved medical necessity criteria for prior authorization of the specific

services that trigger medical case management and will deliver medical case management services within nationally accepted standards for case management that are compliant with applicable federal regulations and BMS policies.

APS will develop educational trainings for providers regarding medical case management, available services, service delivery models, and any other topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all providers when changes in policy or updates in the system occur. APS will plan, advertise, and conduct statewide training and webinars as requested by the agency and communicate announcement of the training to providers. APS will participate in and conduct training for members and other stakeholders as requested by the agency. APS will participate in conference calls at the request of the agency.

APS will also coordinate with Molina, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. APS will also monitor over- and under-utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

aa. Expanded EPSDT Services and Criteria Development

aa. Expanded EPSDT Services and Criteria Development

Vendor Response

Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services have been managed by APS related to services requiring prior authorization to exceed limits. The APS system was built to allow a provider to indicate that a request was related to an EPSDT screening, and therefore was subject to more expansive medical necessity criteria. It became evident that more coordination of services was required between the entities involved in the EPSDT process and certain types of services required oversight. The EPSDT process as it relates to the ASO was expanded to include:

- Non-covered pharmacy service;
- Non-covered medical services and supplies;
- Requests to exceed limits for any service for which an EPSDT eligible child may receive under the Medicaid benefit;
- Policy exceptions to age restrictions, prohibition of investigational treatments etc. as approved by BMS, and;
- Medical/Enteral foods

The EPSDT service allows members under the age of 21 to receive services outside usual coverage when an EPSDT enrolled physician believes the service is medically necessary. The physician must submit a signed referral using a BMS approved form and submit a signed order for it along with the EPSDT Periodic/Inter-periodic form. These requests are reviewed using the EPSDT guidelines in BMS Manual Chapter 527. To ensure all EPSDT services provided to West Virginia Medicaid Program members <21 receive prior authorization, when appropriate, the following requirements and procedures were developed by APS and approved by BMS to evaluate and authorize EPSDT requests:

Requirements:

- Any EPSDT request for a WV Medicaid member (except transportation) must be requested through the UMC. NOTE: APS-WV enters authorization requests for non-covered pharmaceutical products into the APS System (DME) and forwarded to BMS Pharmacy Services staff who directs the request to Rational Drug to assign the NDC and enter the authorization in the MMIS system.
- The request must indicate it is EPSDT (EPSDT must be enabled=yes); the member must be Medicaid enrolled and <21 years of age AND the EPSDT referral form must be attached to the request. The request date AND SSD must be ≤ 6 months of the periodic/inter-periodic EPSDT exam and the date the EPSDT physician signs the form.
- The requesting/referring provider must be Medicaid enrolled and in-network AND must be an EPSDT provider.
- If the service provider requested is an out-of-network non-enrolled provider for an EPSDT referral for specific service(s) to a WV Medicaid Member, we will follow the out-of-network procedures. If the out-of-network provider fails to enroll, or is ineligible to enroll, the claim cannot be paid and the EPSDT OON servicing provider is notified that any prior authorization cannot be sent to the claims payer and will be closed. The member and WV enrolled EPSDT referring provider are also notified.
- The requesting provider must be registered in the APS system in order to process the request (either the referring or servicing provider must be registered). APS staff entering the request for a non-covered service will select the registered provider (in cases where BOTH the referring and servicing are registered the SERVICING will be used as requesting so they can track the authorization within the APS System.
- Retrospective requests for EPSDT services will NOT be subject to retrospective timelines BUT the requested SSD must be within timelines indicated on the EPSDT referral and the prior authorization request must be made within 6 months of the applicable EPSDT visit.

Procedure:

- Request is entered in the APS System in the applicable review area (either directly by referring physician or servicing provider or by APS staff on their behalf). The EPSDT link must be enabled when the request is made in order to open the service grid to accept ANY CPT/HCPCS code. Items/services for which no CPT/HCPCS code is available will be coded under a general code (e.g., nail clippers would be assigned A9999). If the request is not indicated as an EPSDT request it will be treated as a usual PA request and all applicable policies, service limits, and timelines will be applied. Additionally, unless EPSDT is indicated ONLY codes normally requiring PA may be requested.
- Non-covered service requests MUST be entered by APS and the EPSDT form utilized to initiate the request.
- Referring provider is confirmed as an in-network provider **and** the member's Medicaid eligibility is confirmed. If the member is enrolled in an HMO, the referring provider is notified and directed

to the HMO. If the member is ineligible for Medicaid and/or has TPL, the request is closed and the provider and member are notified of the reason.

- EPSDT referral (attachment) is confirmed AND SSD is confirmed as within 6 months of the referral.
- Following confirmation of EPSDT status the following criteria must be met:
  - The child must be <21 years of age (system only allows EPSDT to be enabled when <21);
  - The child's diagnosis of a chronic condition must be documented (this is either a chronic diagnosis OR documentation of the chronicity of the primary diagnosis- BMS cannot provide a comprehensive list of conditions considered chronic for EPSDT as ANY chronic condition impeding a child's health, wellness or ability to perform ADL's may be considered chronic);
  - The EPSDT referral and justification of medical necessity completed by the EPSDT practitioner must indicate that the service/ treatment and amount are necessary to address the chronic condition. NOTE: Services normally non-covered may be approved under EPSDT and limits for covered services may be exceeded (e.g., nutritional supplements usually non-covered may be approved; PT/OT may be provided at a higher frequency etc.).
- If the above criteria are met after administrative review, the request may be authorized. Medical necessity criteria is not applied to EPSDT requests since the above criteria is considered adequate medical necessity justification for an EPSDT request.
- If the request is for an item that could be considered recreational (e.g. swimming pool) or is investigational in terms of practice (e.g. hyperbaric chamber for autism treatment) the referral must be sent (e-mail) to the Policy Unit at the Bureau for Medical Services before authorization is granted. BMS will assign the case to the appropriate member of the policy unit for review and guidance/decision. If BMS indicates the service is denied, the denial reason will be provided by BMS (will be entered in the APS System review screen) and all appropriate denial notifications are to be sent by APS.
- APS will not require invoices for non-covered services since the intent of EPSDT is to provide whatever is necessary to treat or ameliorate the child's identified conditions. Unaltered cost invoices are likely to be required by the claims payer when billing is submitted to determine amount to be remitted for non-covered services that are authorized. The prior authorization will indicate the treatment/service to be authorized, the amount approved and the start and end date of the authorization (based on the EPSDT referral).
- Non-covered services must be priced (as approved by BMS) and the authorization is MANUALLY entered in the Molina system. The WXUTH number is copied to the APS Care connection record AND the record Request ID and prior authorization are entered on the EPSDT Form (which is attached to the APS System record). The form is faxed to the referring and servicing provider, BMS and Molina. The servicing provider is reminded of the following: 1) paper claims must be utilized; 2) the EP modifier must be on the claim; 3)the EPSDT form must be attached to the claim; 4) the claim must be sent to Molina: ATTN: EPSDT claim and the 2 page EPSDT form must be attached to the claim.
- Non-covered Pharmacy requests follow the same procedure EXCEPT: 1) the form is sent to BMS Pharmacy staff who direct the request to Rational Drug to list the NDC and issue the authorization

AND 2) the authorization is NOT entered in Molina by APS or placed on the EPSDT form- the authorization # line indicates authorization has been issued by Rational Drug.

- A report of all EPSDT requests received by APS (including outcomes (closed, authorized, denied, pending BMS decision) will be provided on the 5th working day of the month of July and January for the previous six month data. This will include all review areas and services where EPSDT is indicated (both covered and non-covered).

The workflow Exhibit 40 outlines the process for prior authorization of EPSDT services.

APS will continue to work with the relevant Departments within the agency to ensure the EPSDT program meets all federal requirements and policy requirements of the Department. APS will work with the agency to develop EPSDT procedures for emergency room visits and any other services as requested by the Department. APS will comply with all requirements for entering and tracking EPSDT requests in other databases and will continue to collaborate with the EPSDT, Children with Special Health Care Needs (CSHCN) and the Bureau for Medical Services to ensure improved access to, and tracking of, EPSDT medical foods requests to avoid service duplication. The process will be expanded as requested by the Department to other services as necessary.

APS will work with the Bureau to develop more robust guidelines for the referral and prior authorization of EPSDT services, including clarifying the Bureau's intent regarding evidence based review criteria since these services by their very nature are exceptions and are subject to more expansive criteria than non-EPSDT services. APS will reports of EPSDT activity in compliance with requirements in Appendix 3.

bb. Health Home Services

bb. Health Home Services

Vendor Response

As a healthcare company whose foundations include managing psychiatric services, APS-WV completely supports the WV Health Homes project and looks forward to the opportunity to manage multiple Health Homes for our state. Our local office began participating as a stakeholder in the early research and planning stages of WV Health Homes and became a standing member of the work committee in January 2013. Eventually we received a change order in December 2013 to operationalize the program. From beginning to end, APS-WV will continue to support the Bureau and Health Home providers by offer continuous quality data reporting and analysis, technical assistance, training and consultation regarding outcome measures, clinical issues, and administrative functions.

1. The current Health Homes are in Cabell, Kanawha, Mercer, Putnam, Raleigh, and Wayne County and are for individuals diagnosed with Bipolar Disorder and at risk of Hepatitis. Providers cannot be reimbursed by Medicaid for services without obtaining a prior authorization from APS-WV, which is associated with the following Health Home services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services and Referral to Community and Social Support Services. APS established a two tiered prior authorization system to accommodate service requests for standard and intensive health home services.

2. The same system also functions to annually establish and re-establish the member's eligibility for Health Homes program. In order for a provider to establish a member's eligibility and obtain a prior authorization, they must input data required by the Bureau to track outcome measures including the CMS required Adult Quality Measures recommended for Health Homes.
3. This system allows providers to send supporting documentation such as physician's orders and plans of care directly with each submission through system. However, it is also accepted via other modes of transmission.
4. The required data elements must submitted through our secure web based system within five days of a referral and/or be updated a minimum of three times per year. Providers may also log on to the secure system to obtain outcome of their Health Home service requests. In coordination with the communication of the prior authorization results to the providers, APS will export authorization and Health Home attribute files to the contracted claims payer.
5. Also any forms requiring modification or creation will be approved by the Bureau before implementation and recommendations will also be included in the annual report.
6. Authorizations/Reviews:

Medical Necessity Authorizations

Requests for health homes services will be screened for clinical appropriateness and authorizations will be process for request that meet the criteria set forth by the Bureau. In the event of a clinical denial, the provider is informed that based on the nurses review their request does not appear to meet medical necessity and given the opportunity to provide any extra documentation or information. Upon review of any extra information if the nurse still does not determine there is evidence that the Utilization Management Guidelines criteria is met the request and supporting documentation is sent to a physician of the same specialty as the provider has on their Health Home team for review. If the APS physician reviewer determines the evidence supports the UM Guidelines criteria are met an authorization will be issued. Conversely, if the APS physician review determines there is no evidence that the UM criteria is met a denial is issued and the determination sent to the provider and member outlining the specific criteria that was not met and informing them of the steps needed to initiate a second level review and the member's right to a fair hearing. If the level one physician denied the service and a second level review is requested, the service request and all the supporting documentation will be sent to a different physician with appropriate credentials. Again, if the second physician does not overturn the denial, the provider and member will be notified outlining the criteria the decision was based upon and information regarding the member's right to a fair hearing. In the event a fair hearing is sought by the member, APS-WV will have the required staff available to co-ordinate and/or participate in the hearing. Any policy/administrative denials issued to providers and members will indicate the specific policy or administrative reason for the denial and the member's rights to a fair hearing.

Recertification/Retrospective Consultative Reviews

APS has also implemented the required annual provider certification for the Health Homes program. The certification date is established for each Health Home based upon the date of their first admission. This becomes their annual renewal date. Based on this date the provider is sent a notification 60 days prior to the review and again at 30 days prior. Fourteen days before the

review the Health Home provider is sent a secure e-mail containing a 10% sample of members. If 10% of their member roster is less than ten then ten individuals will be reviewed. On the day of the review, the APS staff member meets with the director to review the recertification process and then begins reviewing the clinical and personnel records utilizing the tools approved by the Bureau. At the completion of the review, an exit conference is held to discuss the early findings. Once APS finalizes the report it is sent to BMS for approval. If we find no deficiencies, a certification letter along with a copy of the review tools are sent to the provider's executive director and the claims payer is notified of their continued certification. If the provider does not receive full recertification status, the provider will receive both verbally and by secure email, a Provider Certification Status Letter along with the Plan of Correction (POC) recommendations. The POC will need completed by the Provider within 30 calendar days of receipt and submitted to APS-WV WV Health Homes Program Director or RN Reviewer. APS will then review the POC within three (3) business days and if all of the requested recommended POC criteria are met it will then be presented to the BMS for approval. The WV Health Homes Provider will then be notified verbally and by secure email with the approval of the POC and full recertification. If the request does not meet recommended POC criteria, the provider will be notified verbally. The POC will be returned by secure email to be completed and returned for further review to APS within three (3) business days. APS-WV WV Health Homes Program Director will review the POC and make a recommendation for either approval or denial of POC to the Bureau. The provider will be notified verbally and by secure email of the final decision. Here are the steps currently being implemented broken down into steps.

Criteria:

APS-WV will continue to work with the Bureau regarding the use of national and/or evidence-based criteria for use in the Health Homes Utilization Management System and provide the Bureau feedback from the Health Home providers gathered through the provider roundtables.

Criteria Update/Recommendations

An annual report regarding Health Homes will be provided to the Bureau with recommendations about policy, procedures, and best practices. The Bureau will be provided with the complete set of materials associated with the recommendations at the time they are formally presented.

Approval of Modifications:

If at any time, the review criteria need modified or updated by APS-WV the Bureau's approval will be obtained first. We acknowledge the Bureau may specify a different criteria or guideline must be used at any time and APS-WV will be responsible for the associated cost.

cc. Child Residential Services

cc. Child Residential Services

Vendor Response

1. APS-WV is familiar with WV Medicaid Children's Residential in-state and out-of-state service providers and recognizes the Department's wishes for annual reassessments to re-determine eligibility. This new function will assist in ensuring the child's assessed needs are recognized and that the level of

care is appropriate to meet their needs best. APS-WV looks forward to working collaboratively with the Department in operationalizing this new requirement.

2. As mentioned above, Children's Residential providers are familiar with APS-WV and the prior authorization process. Providers of children's residential services 1-4 submit service requests along with any additional documentation needed to demonstrate medical necessity. In addition to those services, APS-WV also works with providers of non-Medicaid funded residential children's services that are reimbursed by the Bureau for Children and Families.
3. APS will review all documentation pertinent to service requests, including independent evaluations and pre-discharge recommendations.
4. APS-WV will determine the medical necessity of preadmission, continued stay, and retrospective reviews through use of national and/or state criteria as approved by the Agency. All authorization requests will be completed in accordance with current federal and state policy guidelines. Any modifications to these criteria will receive Bureau approval before being implemented. All provider denial notices will be sent via secure email. All materials will be shared with the Bureau and the decisions regarding criteria will be made at their request.
5. APS will continue to provide testimony and documentation at member fair hearings.
6. APS-WV will perform several additional functions: participate in the service development, certificate of need, summary review processes, and the writing of requests for information (RFI) for all residential program development.
7. Secure e-mail will be used for the transmission of denial notices to providers.
8. Diagnostic reporting will be completed for the Bureau.
9. Quality assurance activities with members, families, and stakeholders will be completed at the request of BMS.
10. We will provide educational trainings to members, providers, agencies and the general community to enhance understanding and increase awareness of this level of care.

dd. School-based Health Services

dd. School-based Health Services

Vendor Response

APS-WV will establish a system to review School Based Health Services Chapter 538 retrospectively that will serve as the primary means of monitoring the quality of services. APS-WV will conduct on-site and desk documentation provider reviews for specific school-based health services targeted by the Bureau for Medical Services. Any provider review below a satisfactory threshold (as identified by the Bureau for Medical Services) will trigger a Plan of Correction (POC) to be submitted by the provider within 30 days of the on-site visit and which addresses all deficiencies noted in the review. Additionally, required technical assistance and training will be scheduled at the time of the on-site visit (or within 10 business days if scheduling during the review is not practicable). All reviews will review documentation per BMS policies and address CMS quality assurance standards.

Site visits will be scheduled outside of the normal review cycle in response to an Incident Management Report, complaint data, or to monitor a Plan of Correction (POC). These reviews may include face-to-face

member/legal representative and staff interviews to validate documentation as necessary to address the issue that triggered the review.

Comprehensive Utilization Management Guidelines (UM) will be created for each service available within Chapter 538 establishing a clear understanding of the definition of "medically necessary services." Medical Necessity as defined in Chapter 538 applies to Services and Supplies that are:

1. Appropriate and medically necessary for the symptoms, diagnosis or treatment of an illness;
2. Provided for the diagnosis or direct care of an illness;
3. Within the standards of good practice;
4. Not primarily for the convenience of the plan member or provider; and
5. The most appropriate level of care that can be safely provided.

Medical Necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

The UM manual will contain the service definitions; benefit limits, admission/continued stay/discharge criteria, clinical & service exclusions, required credentials and the documentation requirements. As these guidelines are developed, retrospective review tools will be concurrently created to ensure all requirements are addressed for each service. These guidelines and review tools will be approved by the Bureau and published on the APS website so they are available to every provider. These approved guidelines function as policy as indicated in Chapter 538.5.

All Lead Education Agencies (LEA) will be established with APS-WV as providers and assigned a trainer consultant. Initially, one introductory training will be held inviting each school board to learn about

- APS-WV,
- our role as a contractor,
- the purpose performing retrospective reviews and
- the utilization guidelines they are to follow.

The trainer consultants will then start reviewing on an 18-month cycle the service documentation of each LEAs office using a 20% sample of each service billed by the LEA for the period under review. TC's will be reviewing to ensure the county provided services sufficient in extent, duration and scope as well as appropriately documented and the provider was properly credentialed.

At the completion of each review, an exit conference will be held with the provider's choice of staff to discuss a summary of the findings/deficiencies found. Following the exit summation, the APS-WV will give the provider an electronic draft exit report and a POC to be completed by the provider. A POC must contain how each deficiency will be corrected, processes that will be enacted to prevent re-occurrences, and the

expected completion date of each deficiency. The LEA must also identify on the POC their training needs. When potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send their POC back to APS-WV. After the 30-day comment period has ended and APS has deemed the POC acceptable, BMS will be given the provider's POC and report draft to review. BMS will then issue a final report to the Provider's Executive Director copying APS. The final report will reflect the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Services. If no potential disallowances are identified during the review, then the Provider will receive a final letter and a final report from BMS. APS Trainer Consultants will work with each LEA to provide the training and technical assistance documented on the LEA's Plan of Correction either on site or via webinar. Utilizing the same review tools and consistent claims sampling methodology each retrospective review will enable scores to be monitored over time for improvement. Once the Bureau approves the POC, the APS TC will review the provider a minimum of one more time within the 18-month period to complete another review and assess the POC.

Brief Implementation Steps:

Hire staff
Train staff
Establish Utilization Management Guidelines
Develop retro review tools
Train Providers
Begin Retro Reviews

ee. Medical Services Criteria Development

ee. Medical Services Criteria Development

Vendor Response

APS utilizes the nationally accredited, research-based McKesson InterQual criteria sets for any services for which it is available and approved by the Bureau for Medical Services for use. Criteria are reviewed to assure alignment with the Bureau's policy intent and specific policy requirements. Criteria sets may contain local edits to conform to local policies.

When InterQual criteria are not available APS provides recommendations to the Bureau for medical services based on research of clinically sound and research-based criteria that have been endorsed by APS' Medical Director and physicians in the specialty of the criteria under review. These criteria can also be edited to create local medical policies (LMP's) that conform to BMS specific policies. Local Medical policies may also be developed for existing criteria sets, as policy is updated or clinical practices changes. Recommendations are sent to the Bureau for Medical services for approval, and once approved are implemented by APS. Providers are updated regarding criteria changes and if the criteria are not proprietary, it is available to providers unless otherwise specified by BMS. Proprietary criteria, such as InterQual, may not be disclosed to providers; however, InterQual has developed SmartSheets in many review areas that can be made available to providers upon request. A flow chart of this process contained in Exhibit 41.

APS will update the review criteria annually, and alert BMS to any changes in the criteria. Any recommended changes in criteria will be included in the annual report provided to the agency. Since InterQual criteria is utilized in a number of review areas it is not within the purview of APS or BMS to make major modifications to the proprietary criteria set- however, recommendations will be made to the agency for any additions or edits that may need to be approved to conform to BMS policies. For all other policies, recommended changes will be presented to the agency for consideration. The Bureau may reject current or recommended criteria and specify different criteria to be used. APS will provide the agency with access to a complete set of materials associated with the criteria annually. APS assumes responsibility for the cost of InterQual review materials and any other criteria set adopted that is not public domain.

APS has provided the agency with a listing of the current criteria for each review area in Exhibit 42. This includes all review areas that are the responsibility of the utilization management contractor. All listed review areas are currently reviewed by APS under our existing contract (except Ambulance Transportation) and all of these services are contained in the APS System automated rules driven system that is currently in use and has been extensively described in other segments of the RFP response.

ff. Inpatient Rehabilitation Services

ff. Inpatient Rehabilitation Services

Vendor Response

APS-WV understands inpatient rehabilitation services are a valuable resource to the individuals who qualify for this benefit through age 20. Successful rehabilitation will lead to a more independent member. Utilization management with case management follow-up of these cases assists BMS in containing cost and delivering medically necessary rehabilitation in the appropriate setting and in the most cost effective manner. The prior authorization process for inpatient rehabilitation services for individuals through 20 years of age in freestanding rehabilitation facilities has been described below. In addition, the workflow for this process has been included in Exhibit 43.

Prior Authorization is obtained by the inpatient facility or the attending physician on behalf of the facility. Adjunct services provided by inpatient physician (e.g., pathology, Emergency Room, anesthesia, radiology, and laboratory) are covered under the prior authorization unless a specific exception is noted. Inpatient authorizations are DRG driven. APS-WV uses the following for inpatient rehabilitation requests:

1. *Verification of*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for an inpatient rehabilitation services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS System, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network**

Services, above, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS System. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS System has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Medicare Regulations for Rehabilitation Care (CMS Regulations to review requests for medical necessity for admission and continued stay.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing

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

If the Inpatient Rehabilitation admission is authorized medical case management is implemented to monitor member service utilization, possible duplication of service and outcomes for the member (refer to Exhibit 39 for a flow chart of the medical case management process). If the service is denied medical case management is initiated to make recommendations for alternative services to meet the member's needs.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

   If the Inpatient rehabilitation admission is authorized by the physician medical case management is implemented to monitor member service utilization, possible duplication of service and outcomes for the member (refer to Exhibit 39 for a flow chart of the medical case management process). If the service is denied, medical case management is initiated to make recommendations for alternative services to meet the member's needs.

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

   If the Inpatient rehabilitation admission is denied by the physician medical case management is initiated to make recommendations for alternative services to meet the member's needs.

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

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

9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.

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

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

1. TECHNICAL REQUIREMENTS

APS-WV has a wealth of experience in providing utilization management functions for the West Virginia behavioral health services identified in the CRFP. While each service is discussed in detail below, it is necessary to identify the common approach that APS-WV uses to support compliance with state and federal medical necessity requirements. According to the Q&A response from BMS, Federally Qualified Health Centers, Rural Health Clinics, and Partial Hospitalization programs were inadvertently omitted in the CRFP from the service listing. APS-WV began working with Partial Hospitalization programs in 2010 and Federally Qualified Health Centers/Rural Health Clinics in 2013. Specific information regarding these service options will be included within this section.

Since our initial contract award in 2000, APS-WV has tailored the development of the APS System to meet the needs of the State of West Virginia. Existing behavioral health providers utilize electronic modes of submission (i.e., web-based and file layouts) which present several benefits for providers:

- The ability to access the system 24 hours a day, 365 per year (with the exception of periodic system maintenance),
- a reduction of data entry errors, and
- access to a copy and repeat feature for concurrent review requests that helps providers avoid time-consuming re-entry of information that is repeated from the original prior authorization, for added efficiency and data quality.

This data driven, web-based application accommodates a variety of WV Medicaid behavioral health providers by providing a submission mechanism for prior authorization requests that relies on business and clinical rules, a means of eligibility determination for a date of service, and as a utilization management tool. APS understands from the Q&A responses that existing submission requirements for behavioral health providers will remain in effect, as previously directed by the Bureau.

All behavioral health provider types are eligible to access the APS System site for submissions. Providers who have a large volume of requests (e.g., Comprehensive Behavioral Health Providers) elect to submit through electronic data interface (EDI). This submission method allows providers to gather information in-house and extract one or more files to APS each day rather than direct data entry of each request into the website.

Requests are subject to eligibility determination to ensure only eligible members are able to attain an authorization under the WV Medicaid, BCF Special Medical and BBHHF Indigent Care systems. Providers are notified in the event eligibility is not present for a member along with any other funding sources available. The automatic authorization may occur for an eligible member depending on the service requested and the case disposition and the authorization history.

Prior authorization and eligibility review will occur within 48 hours of the request, in accordance with current federal and state policy guidelines, as directed by BMS. Requests that do not automatically

authorize are placed in a "pend" status for further clinical review by a qualified behavioral health professional. From this point, we may authorize the request, place it in "review" status waiting for documentation from the provider, place it in "closed" due to an incorrect service requested or other factor, or place it in "denied" status following completion of the physician review process or when an administrative policy denial is issued. WV licensed psychiatrists perform both levels of physician reviews to ensure medical necessity requirements are achieved. APS electronically transmits final case dispositions to the provider and claims payer in the prescribed format.

a. Inpatient Psychiatric Services

a. Inpatient Psychiatric Services

Vendor Response

APS-WV has issued prior authorizations for Inpatient Psychiatric services for WV Medicaid members since July 1, 2010. This includes acute inpatient psychiatric hospitalization for adults and for members under the age of 21. Providers utilize the web-based, rules driven system for prior authorization requests and submit supporting documentation to demonstrate medical necessity. Documentation requested for clinical review must be received from the provider within three business days from notification to achieve timely determinations. Requests that do not meet medical necessity upon review from our RN's are submitted for physician review.

While alternative routes of submission are available, the Bureau previously endorsed APS's recommendation that all providers be encouraged to move to web-based submissions. This undertaking was successful to the point all existing provider of this service submit electronically over the web-based application. APS-WV will continue to emphasize web submission to maintain provider efficiencies already established.

APS-WV's system notifies the provider at the time of submission whether WV Medicaid eligibility is present for a date of service. In the event eligibility cannot initially be determined by the application, the request is reviewed by our Eligibility Specialists to ensure the accuracy of the eligibility determination. When eligibility is not found for the member, APS-WV will notify the provider of the absence of funding by Medicaid or any other funding source.

Request may be identified as urgent/emergent or non-emergent, voluntary or involuntary, depending on the individual member's clinical presentation. Those identified as urgent/emergent are indicated within the system for prompt clinical review. Each authorization request, whether a new admission, continued stay or retrospective admission request, is reviewed according to Bureau approved medical necessity criteria and/or national criteria (e.g., InterQual). Non-emergency admission requests submitted prior to a planned date of admission will be reviewed; however, we anticipate the volume to be low based upon criteria to qualify for inpatient acute services.

Providers receive authorization notifications, which contain the authorization number, beginning date of service, number of days authorized, and the end date of the authorization. Providers are encouraged to submit for continued stay prior to the end date of the existing authorization in order to minimize the possibility of non-authorized days. APS will provide a daily listing to notify the hospitals 48 hours in advance of the end date of any existing inpatient psychiatric authorization. Continued stay requests will be clinically reviewed on the date of receipt resulting in an authorization or provider notification when

further clinical documentation is needed. Continued stay authorization request for those members who have been discharged will be reviewed within 24 hours.

Providers are encouraged to utilize the discharge feature of the APS System. This feature allows the provider to enter the date of discharge, indicate the discharge was planned or unexpected, and identification of any follow-up services.

Requests for weekend and holiday admissions, in addition to retrospective requests, will receive eligibility verification and clinical review by the date of receipt. Requests for inpatient psychiatric services for members under age 21 must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

APS-WV will complete on-site retrospective reviews of inpatient psychiatric services. If the Bureau chooses to maintain the existing process currently applied to other provider types, APS will perform on-site reviews at least once during an 18-month cycle of those facilities attaining an authorization. A 10% sample will be utilized for each reviewer with a minimum of three charts- whichever is greater. APS' psychiatric nurse will also review corrective action plans when required and make recommendations to the provider. A retrospective review tool will be established in conjunction with the Bureau; once approved, no changes will occur to the tool without Bureau approval. If the Bureau desires a different process for this provider type, APS-WV will modify the approach to facilitate the new process.

b. Targeted Case Management

b. Targeted Case Management

Vendor Response

APS-WV will prior authorize targeted case management services for WV Medicaid eligible members and has done so for the last fifteen years. Service requests will be clinically reviewed according to WV approved criteria and policies. APS-WV has an extensive history with the WV Medicaid providers. This background includes reviewing plans of care and documentation notes for case management, providing training, and conducting individual documentation reviews to promote accurate service provisions. Since 2012, APS has also provided service authorizations for this service to providers of BBHHF Indigent Care Services according to the same criteria applied for WV Medicaid members.

APS will continue to adhere to WV approved criteria and policies. All authorization requests, regardless of a new admission, continued stay, or retrospective status, will be reviewed to ensure criteria are met. APS will continue to provide retrospective on-site reviews of this service on an 18-month cycle. We look forward to working with both Bureaus to verify the current review tool meets their needs or to modify it accordingly. We recognize the Bureau's commitment updating policy manuals for providers every two years; APS regularly participated during the most recent review of the Targeted Case Management policy manual and State Plan Amendment.

APS recognizes the requirement that a member have only one provider of TCM at a time unless approved by the Bureau. APS will identify and resolve instances of more than one provider providing targeted case management services. The selected provider will receive authorization to provide TCM services after all eligibility and medical necessity criteria have been met.

c. Clinic and Rehabilitative Services

c. Clinic and Rehabilitative Services

Vendor Response

APS-WV has a tenured relationship with the WV providers of clinic and rehabilitation services, beginning in late 2000. This relationship continues through prior authorization activities and on-site retrospective reviews, trainings, and consultations. Since 2012, APS has also provided service authorizations for this service to providers of BBHHF Indigent Care Services according to the same criteria applied for WV Medicaid members. APS-WV will adhere to the policy requirements for clinic and rehabilitation services when prior authorizing service requests for WV Medicaid/BBHHF Indigent Care eligible members and performing provider retrospective reviews. We appreciate the opportunity participate with the Bureaus in the planned policy review meetings and will continue to do so upon their request. APS was involved in the state specific Assertive Community Treatment fidelity factors and looks forward to performing future certification and re-certification reviews.

Providers submit document to convey clinical and demographic information on the WV Medicaid/BBHHF Indigent Care funded member. Submissions from this provider group currently occur through the web-based APS System or via Electronic Data Interface (EDI). Several years ago, the Bureau for Medical Services mandated submissions for this group occur through the above formats. Eligibility review occurs through this module and the system conveys the results to the provider. The level of data required for submission is dependent on the service selected and whether the service has previously been authorized. Supporting clinical documentation will be requested and reviewed to determine medical necessity for the service in question. Providers will supply clinical information including, but not limited to, current clinical presentation, progress status of the member, and potential discharge plans and timeline. Clinical review will be based on WV Medicaid policy, guidelines, and national criteria, depending on Bureau direction.

Medical necessity review considers all of the above factors in addition to any supporting documentation shared by the provider. All of these items are reviewed for changes or modifications in the clinical presentation, either demonstrating progress or a lack there of, and whether services alone or in combination are sufficient to meet the assessed needs of the member. APS will continue to provide retrospective on-site reviews of this service on an 18-month cycle.

d. Psychological Services

d. Psychological Services

Vendor Response

APS-WV performs prior authorization review and eligibility determination for WV Medicaid members seeking services from enrolled licensed and supervised psychologists. Services identified in the WV Medicaid psychological manual as requiring prior authorization are submitted using the APS application. This application serves as a means to receive service requests and perform member eligibility determination.

Requests are reviewed, along with supporting documentation from the provider, plans of care and any other documentation the provider believes demonstrated medical necessity for the requested service.

Since 2004, Psychological practices have submitted through the web-based application. APS will continue to receive requests in the existing approved format.

The level of data required for submission is dependent on the service selected and whether the service has previously been authorized. Providers will supply clinical information including, but not limited to, current clinical presentation, progress status of the member, and potential discharge plans and timeline. Clinical review will be based on WV Medicaid policy, guidelines, and national criteria, depending on the wishes of the Bureau.

Medical necessity review considers all of the above components. Each of the items are reviewed for changes or modifications in the clinical presentation, either demonstrating progress or a lack there of, and whether services alone or in combination are sufficient to meet the assessed needs of the member. APS will continue to provide retrospective on-site reviews of this service on an 18-month cycle.

e. Licensed Independent Clinical Social Workers

e. Licensed Independent Clinical Social Workers

Vendor Response

Licensed Independent Clinical Social Workers (LICSW) is newly eligible for WV Medicaid provider enrollment to provide behavioral health services. APS-WV is familiar with the services available to this group and those requiring prior authorization. APS-WV utilizes a proprietary system for receipt of prior authorization requests and for verification of members' payer eligibility.

Requests are reviewed, along with supporting documentation from the provider, plans of care and any other documentation the provider believes demonstrated medical necessity for the requested service. Services eligible for performance by an LICSW for WV Medicaid members also exist in the current psychological and psychiatric manuals. For this reason, LICSW's have received training for submissions using the web-based application. APS encourages this practice to continue; however, we will accept any required mode of receipt based upon the wishes of the Bureau.

The level of data required for submission is dependent on the service selected and whether the service has previously been authorized. Providers will supply clinical information including, but not limited to, current clinical presentation, progress status of the member, and potential discharge plans and timeline. Clinical review will be based on WV Medicaid policy, guidelines, and national criteria, depending on the wishes of the Bureau.

Medical necessity review considers all of the above components. Each of the items are reviewed for changes or modifications in the clinical presentation, either demonstrating progress or a lack there of, and whether services alone or in combination are sufficient to meet the assessed needs of the member.

f. Psychiatric Services

f. Psychiatric Services

Vendor Response

WV enrolled Psychiatrists serving WV Medicaid members have sought prior authorization through APS-WV since 2004. During that time, Psychiatrists have received prior authorizations according to WV Medicaid policies and service guidelines within the provider manual.

Prior authorization service requests for WV Medicaid eligible members will be reviewed along with clinical documentation, plans of care, and other forms of documentation to demonstrate medical necessity. APS-WV will utilize WV Medicaid policy and approved criteria for medical necessity determinations.

Service requests will also be evaluated to ensure the members' needs are being addressed within the most appropriate level of care. A review of progress, through provider discussion and comparison of clinical presentation and documentation, will regularly occur to ensure medical necessity continues to be demonstrated. APS will continue to provide retrospective on-site reviews of this service on an 18-month cycle. We look forward to working with the Bureau either to verify the current tool meets their needs or to modify it accordingly.

g. Psychiatric Residential Treatment Facility Services

g. Psychiatric Residential Treatment Facility Services

Vendor Response

APS-WV will continue to work with both in-state and out-of-state Psychiatric Residential Treatment Facilities (PRTF) to promote the most appropriate level of care for WV Medicaid members. PRTF's target members who are under the age of twenty-one (21) with a severe and persistent behavioral health condition. Emergent admissions are not appropriate for a PRTF; in that case, a higher level of care should be pursued. Children appropriate for admission must have previous treatment exposure and failure at a less restrictive Level of care. All initial requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

APS-WV will review clinical documentation submitted by any mode of receipt for eligible Medicaid members. Since 2010, providers have submitted electronically through the APS system . Doing so allows a shorter timelines from receiving an authorization to clinical review and responses shared with providers. Requests reviewed will include clinical information and any subsequent documentation submitted by the provider. Authorization is based upon the diagnostic condition, symptom acuity, level of functioning and progress to date and/or the likelihood of progress occurring.

An APS-WV staff member will serve as the Bureau for Medical Services representative to perform multi-agency certification reviews along with the Bureau for Children& Families and the West Virginia Department of Education. APS-WV also provides information to the Bureau regarding members involved in the clinical review team process with the Bureau for children and families.

Requests are reviewed for medical necessity by APS-WV registered nurses. Authorizations are not issued without determining eligibility, medical necessity and an appropriate MCM-1 document.

APS will complete on site reviews of all providers receiving an authorizations for PRTF services at least one time in an 18-month cycle. A 10% sample will be utilized for each review or a minimum of three charts-whichever is greater. The retrospective reports consisting of a policy review, clinical review, and areas that need to be improved to meet WV's standards will be provided to BCF and BMS within 30 business days of the exit conference.

h. Inpatient Psychiatric Services for Individuals under 21 years of age

h. Inpatient Psychiatric Services for Individuals under 21 years of age

Vendor Response

APS-WV will review information from to determine the appropriateness of admission for WV Medicaid members under the age of 21 into Inpatient Psychiatric Services. Admission referrals, the proposed treatment plan and a review of supporting clinical documentation supplied by the provider will be reviewed to make a determination. All requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

APS-WV authorization requests are reviewed for those members with established WV Medicaid eligibility at the time of service. The APS system notifies the provider at the time of submission whether WV Medicaid eligibility is present for a date of service. In the event we cannot initially determine eligibility by the application, the request is reviewed by our Eligibility Specialists. When we cannot find eligibility for the member, APS-WV notifies the provider that Medicaid or other funding source is absent.

Request may be identified as urgent/emergent or non-emergent, voluntary or involuntary, depending on the individual member's clinical presentation. Those identified as urgent/emergent are indicated within the APS system for prompt review. Each authorization request, whether a new admission, continued stay or retrospective admission request, is reviewed according to Bureau approved medical necessity criteria and/or national criteria (e.g., InterQual). Non-emergency admission requests submitted prior to a planned date of admission will be reviewed; however, we anticipate the volume to be low based upon criteria to qualify for inpatient acute services.

Providers receive authorization notifications, which contain the authorization number, beginning date of service, number of days authorized, and the end date of the authorization. Authorization requests for this service addressed by APS-WV registered nurses. Providers are encouraged to submit prior to the end date of the existing authorization in order to minimize the possibility of non-authorized days.

APS will provide a daily listing to notify the hospitals 48 hours in advance of the end date of any existing inpatient psychiatric authorization. Continued stay requests will be clinically reviewed on the date of receipt resulting in an authorization or provider notification when further clinical documentation is needed. Continued stay authorization requests for those members who have been discharged will be reviewed within 24 hours.

Providers are encouraged to utilize the discharge feature of the APS system. This feature allows the provider to enter the date of discharge, indicate the discharge was planned or unexpected, and identification of any follow-up services.

Requests for weekend and holiday admissions, in addition to retrospective requests, will receive eligibility verification and clinical review by the date of receipt. All requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

APS-WV will complete on-site retrospective reviews of inpatient psychiatric services. If the Bureau chooses to maintain the existing process currently applied to other provider types, APS will perform on-site reviews at least once during an 18-month cycle of those facilities attaining an authorization. A 10% sample will be utilized for each reviewer with a minimum of three charts- whichever is greater. APS' psychiatric nurse will also review corrective action plans when required and make recommendations to the provider. A retrospective review tool will be established in conjunction with the Bureau; once approved, no changes will occur to the tool without Bureau approval. If the Bureau desires a different process for this provider type, APS-WV will modify the approach to facilitate the new process.

Partial Hospitalization Services:

APS-WV has provided prior authorizations for partial hospitalization services since July 2010. Medical necessity is determined based upon state and national criteria, as approved by the Bureau. Requests are submitted via the APS system, which collects data regarding diagnosis, symptom acuity, and functional abilities associated with the behavioral health condition.

WV Medicaid eligibility is established prior to issuance of authorizations. APS informs the provider of the eligibility status prior to submission of requests, and identifies if any other payer source is available. Requests that pend for eligibility and clinical review will be addressed, yielding either an authorization, closure or review status to await further documentation.

Federally Qualified Health Centers and Rural Health Clinics:

APS began working with these providers in October of 2013 at the direction of the Bureau for Medical Services. The APS system application reports total authorized encounters along with the specific behavioral health service eligible for use during those encounters. Eligibility is determined prior auth the issuance of any authorizations. These two provider types received training on medical necessity determination and use of the electronic APS system module. They were intended to receive on-site retrospective reviews. As indicated within the Q&A responses, retrospective on-site reviews are not planned for the future scope of work detailed in the RFP for these provider groups.

APS will perform timely medical necessity reviews. Auto adjudication is possible for these services so long as no other authorization exists by any provider. Requests that pend for eligibility and clinical review will be addressed, yielding either an authorization, closure or review status to await further documentation. As with other review areas detailed in this section, retrospective review submissions are allowable in accordance with WV Medicaid policy.

i. Behavioral Health Services Criteria Development

i. Behavioral Health Services Criteria Development

Vendor Response

APS-WV has demonstrated experience with outcomes and evidenced-based practices and has provided consultation to DHHR about areas of implementation of targeted best practices. APS-WV will continue this approach across the entire scope of work for the Bureau, ensuring the promotion of evidence-based practice through use of current, nationally recognized criteria, such as McKesson Health Systems InterQual and Milliman Care Guidelines. Current changes within the West Virginia Medicaid behavioral health system warrant the most effective and efficient service practices. APS-WV is familiar with West Virginia Medicaid policies and demonstrated their ability to research covered and non-covered services for potential modifications or service array inclusion. APS-WV looks forward to continued consultation in these areas to promote an effective and efficient service delivery system.

APS will review criteria continually and make recommendations to the Bureau for any potential changes. Changes will not be implemented without the Bureau's approval. If there is no comparable national criterion that meet WV service definitions (e.g., Psychiatric Residential Treatment Facilities), APS-WV will obtain approval for criteria used for medical necessity determination. Ultimately, APS-WV will utilize criteria approved by BMS and be responsible for any incurred cost.

APS-WV will continue to utilize state and national criteria, where present, to determine medical necessity for services. Each service will be detailed in Utilization Management guidelines that provide admission, continued stay, and discharge criteria. Service exclusions and documentation requirements are also conveyed in these guidelines to assist providers in recognizing medical necessity criteria to be achieved. These guidelines are in conformance with the state's definition of medical necessity. In the 1999 Managed Care position paper, the State of West Virginia introduced the following definition of medical necessity:

> "services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis of direct care of an illness; (3) within the standard of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided."

Medical necessity as defined by the state indicates focusing on a member's symptoms, diagnosis, level of functioning and available supports; these factors are required to determine appropriate levels of care per established care criterion such as InterQual, Milliman or American Society of Addictive Medicine (ASAM). APS-WV will continue to use established clinical criteria that align with state and federal Medicaid requirements.

2. DENTAL AND ORAL HEALTH SERVICES UTILIZATION MANAGEMENT TECHNICAL REQUIREMENTS

Dental, orthodontic, and oral health services requiring prior authorization as outlined in Chapter 505 of the BMS Provider Manual have been the responsibility of APS-WV since 2009.

Enrolled children up to 21 years of age are eligible for diagnostic, preventive, restorative, periodontal, and prosthodontics services; maxillofacial prosthetics, oral and maxillofacial surgery, and orthodontics. Dental

screenings are covered to any child under the age of 21 years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. Refer to www.aap.org for the American Academy of Pediatrics Dental (AAPD) periodicity schedule. Appropriate patient (and/or responsible adult) education and self-management of nutrition, hydration and cleaning routines are essential to maintain oral health and prevent disease.

Covered dental services for enrolled adults 21 years of age and older are limited to emergent procedures to treat fractures, reduce pain, or eliminate infection. An oral evaluation for limited fractures, pain, or infection is covered. Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age AND the needed surgery is documented in the original orthodontic request.

Coverage decisions are based upon the member's age, medical necessity, and the member's care needs. Services may be provided in a practitioner's office, ambulatory surgical center, and outpatient or inpatient hospital. If a Current Dental Terminology (CDT) code requires prior authorization, the service requires prior authorization regardless of place of service. All inpatient hospitalizations require prior authorization (PA) by BMS' Utilization Management Contractor (UMC). Inpatient hospitalization shall not be reimbursed when the service could be provided in an outpatient setting.

As per Chapter 505 of the Department of Health and Human Resources, Bureau of Medical Services, West Virginia Medicaid Program Provider Chapter, general dentists and specialty dentists may provide a variety of covered dental services in accordance with his/her licensure in the state in which they practice. Licensed practitioners may assign intra-oral tasks to employed dental hygienists or dental assistants. Refer to West Virginia State Code *§30-4-17 and §30-4-18* for the scope of practice for dental hygienists and dental assistants. Dental hygienists and dental assistants are not eligible to enroll individually as a Medicaid provider or receive direct reimbursement for services rendered. Services are to be billed via the assigning/prescribing dentist's NPI.

Medical doctors who possess a medical or osteopathic license in addition to a dental license will be assigned both a medical and a dental provider number to be used in billing for services.

The West Virginia Medicaid program offers a comprehensive scope of dental services for members under 21 years of age, and limited coverage for the adult population. BMS uses prior authorization in this service area to ensure that services provided are medically necessary and do not exceed service limits. The need for prior authorization and review of specified dental, orthodontic, oral, and maxillofacial dental surgery services is necessary given increased utilization and possible overutilization of some services.

a. Dental Services

a. Dental Services

Vendor Response

Currently prior authorization is required for dental services specified by the agency in BMS Medicaid Policy Manual Chapter 505. Services requiring PA include, but are not limited to prefabricated crowns, root canals, and other dental surgeries performed in the office setting. As required, a lead dental consultant will be appointed to evaluate training needs, assist with criteria development, and assist other dental consultants.

The process for dental services review has been outlined below and illustrated in a workflow that has been included in Exhibit 44.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for dental services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS system, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS system. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

   d. *The service requested is a covered service*: The APS system has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

   e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

2. *Determine if the request is complete:* If a request is incomplete (i.e. does not have all the required information), APS-WV will suspend the request and place it in a pending status documentation requested. The provider receives a message in the system and contacted within one business day to obtain the necessary additional information and/or correct errors. If we do not receive

additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the nurse reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Chapter 505, BMS Approved Policy, and Dental Consultant Review for medical necessity review of requests.
4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.
5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.
6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS system. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.
7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board certified MD/DO with specialty match for a final determination.
8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.

11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

As required, a lead orthodontic consultant will be appointed to evaluate training needs, assist with criteria development, and assist other orthodontic consultants.

b. Oral and Maxillofacial Dental Surgery Services

b. Oral and Maxillofacial Dental Surgery Services

Vendor Response

Oral & Maxillofacial Dental Surgery Services may be provided in the office setting or in an outpatient surgical setting. When provided in the office setting the appropriate Current Dental Terminology (CDT) code is authorized. For procedures provided in outpatient surgery settings, the equivalent Current Procedural Terminology (CPT) is used.

The process for oral and maxillofacial dental surgery services review has been outlined below and illustrated in a workflow that has been included in Exhibit 45. This process corresponds to the workflow for any outpatient surgery and appropriate medical justification and documentation must be provided to support the surgical request.

1. *Verification of*

   a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for dental services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS system, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.

   b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS system. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.

   c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.

d. *The service requested is a covered service*: The APS system has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use the McKesson Health Solutions InterQual Criteria sets (InterQual Adult & Pediatric; InterQual Procedures & Acute) if the surgery is included in these sets, otherwise the request goes directly to the physician reviewer step.

4. *If approved by the RN reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the nurse level for physician review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

6. *If denied after physician review determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS system. This notification includes the policies and criteria that were not met and information about the reconsideration process. We

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

7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board certified MD/DO with specialty match for a final determination.
8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

c. Orthodontia Services

c. Orthodontia Services

Vendor Response

Currently prior authorization is required for all orthodontia services. Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. BMS reimburses one treatment of comprehensive orthodontia (CDT Codes D8070, D8080, and D8090) per lifetime per member. If any of the comprehensive orthodontia codes are billed then none of the remaining can be billed; they are a one per lifetime limit for any of the three and are not looked at as per code lifetime limit.

Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age AND the needed surgery is documented in the original orthodontic request. Requests for prior authorization of orthodontia services must include the following:

- Patient's name, address, Medicaid number and date of birth;
- Provider name, address, provider number, fax and phone numbers;
- Ordering physician's name and phone number;
- Date patient examined;

- Complete diagnosis;
- Current treatment status;
- Recommendations for comprehensive orthodontic treatment;
- Comprehensive orthodontic treatment procedure code;
- Post-treatment stabilization procedure code;
- Total fee (usual and customary charge);
- Orthodontist signature and date;
- Additional information required for assessing handicapping malocclusion;
- Dental molds and/or x-rays as appropriate.

The process for orthodontia services review has been outlined below and illustrated in a workflow in Exhibit 46.

1. *Verification of*
    a. *Member Medicaid eligibility, coverage, service eligibility: APS-WV* receives requests for dental services by Direct Data Entry (DDE), fax, or mail. APS-WV will use the APS system, which allows providers who enroll in the system to enter demographics and information and submit their requests electronically.
    b. *Provider Medicaid status:* APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see section **t. Out-of-Network Services, above**, for more details on this process.) Additionally, enrolled providers must register with APS to gain access to the APS system. A referring provider grid and a servicing provider grid document provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. The BMS Policy Manual and the specific chapter(s) relevant to the review area form the basis of these grids.
    c. *Other payer sources*: APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer may be responsible for the services requested. If APS-WV can establish an alternative payer, we will notify the provider through messaging on the request.
    d. *The service requested is a covered service*: The APS system has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. APS-WV's staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see EPSDT section aa for a description of this

program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

e. *Service limitations:* APS-WV verifies that the request is within any service limitations attached to the coverage at the time of the request.

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

3. *Determine if the service is medically necessary and appropriate*: Following verification of covered service status and completeness, an APS nurse reviewer will review the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use Chapter 505, BMS Approved Policy, and Dental Consultant Review for medical necessity review of requests.

4. *If approved by the Consultant reviewer*: The system exports the authorization number to the claims payer in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability by fax or telephone.

5. *After referral from the first level for Orthodontic review*: APS-WV will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payer in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified APS of their inability to do so by fax or telephone.

6. *If denied after Orthodontic reviewer determination:* APS-WV will attach denial notices to the provider, referring practitioner and servicing provider in the APS system. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

7. *Requesting reconsiderations:* Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration

request, and additional information to another board certified MD/DO with specialty match for a final determination.

8. *Response to reconsideration requests:* APS-WV will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.
9. *Reconsiderations resulting in reversals:* If we reverse the initial decision, APS-WV will send the approval decision to the MMIS. The process for reconsideration is in the workflow in Exhibit 9.
10. *Obtaining an appeal:* Members may request an appeal of a denial of services not yet provided. APS-WV will prepare documentation necessary to process the member's appeal.
11. *Retrospective requests follow the same review process:* APS-WV completes reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services (Exhibit 10).

d. Dental Services Criteria Development

d. Dental Services Criteria Development

Vendor Response

In the next contract cycle, the Bureau for Medical Services has requested the development of more robust Dental Services criteria. APS-WV will utilize its' WV Dental and Orthodontic Consultants, Dental and Orthodontic Consultants throughout the APS-WV program, and consultation with practitioners within West Virginia to develop and recommend a revised West Virginia Dental criteria set that is based on review of :

- Current published medical necessity criteria for dental service that is peer-reviewed;
- Evidence-based guidelines or criteria developed by national organizations and recognized dental authorities;
- In compliance with the requirements of the State Plan, The current dental policy manual, Chapter 505, and other federal and state guidelines.

APS will submit the criteria for BMS approval and will implement the criteria once it is approved by BMS. Upon criteria approval, APS will conduct technical assistance webinars to educate providers on the selected criteria set and its' application.

4. BUREAU FOR MEDICAL SERVICES-OPTIONAL SERVICES

a. Clinical/Medical Consulting Services

a. Clinical/Medical Consulting Services

Vendor Response

APS will provide clinical/medical consultation at an hourly rate through the APS-WV Medical Director, Dr. Norman Montalto or the Dental Consulting lead, to assist the Agency in addressing medical necessity issues, researching new technology, or procedures, developing medical policies, addressing quality issues, or other clinical/medical consultation needs identified by the Agency. Consultation related to behavioral health issues will be provided through our contracted WV licensed psychiatrists.

In addition to APS-WV's local physician reviewers, KEPRO maintains a contracted panel of over 4500 physicians who are board-certified, actively practicing, specialty-matched reviewers who render medical necessity for Medicaid treatment determinations. Specialties represented on the review panel include, but are not limited to, the following areas of practice:

- General, Family and/or Internal Medicine
- ENT
- General Surgeon
- Geneticist
- Nephrologist
- Neurologist
- Neurosurgeon
- Oncologist
- Orthopedist
- Urologist
- Pathologist
- Pediatrician
- Podiatrist
- Radiologist
- Thoracic Surgeon
- Cardiologist
- Obstetrics & Gynecology
- Chiropractor
- Ophthalmology
- Dentist
- Orthodontist
- Spinal Cord Injury Specialist

Additionally, APS –WV has RN staff knowledgeable of all areas of West Virginia Medicaid policy, as well as other professional staff-Licensed Professional Counselors, Licensed Social Workers (LCSW and LICSW), Psychologists, Certified TBI Specialists and subject matter experts in the various Home and Community Based Waiver programs, Children's Services (BCF and Medicaid programs), Behavioral Health Services, Health Homes and other programs.

APS-WV can provide consultation to the Bureau related to the various types of healthcare specialties represented on its' panel and local staff. Subject matter expertise can be provided on a number of programs and services, including, but not limited to, the development and implementation of service delivery models, quality review and monitoring, service development, and a variety of other healthcare issues.

The process for requesting consultation services through APS' clinical staff is as follows:

- A consultation request form is completed by the agency, which outlines the type of consultation desired; the target audience for the consultation report; and the timeframe for completing the consultation.

- APS develops a scope of work, which includes the delivery date for the consultation report, the format of the report and target audience, the scope of the consultation, and the consultant(s) or SME assigned to complete the report.
- The assigned consultant prepares a consulting plan which outlines how information is to be gathered (e.g. literature search, focus groups etc.) and the proposed number of hours to complete the consultation by the specified due date.
- The consultation is approved by the Bureau, completed, and the report is delivered.

b. Children with Disabilities Community Services Program

b. Children with Disabilities Community Services Program (CDCSP)

Vendor Response

The Children with Disabilities Community Services Program (CDCSP) is an optional WV Medicaid program that allows a child up to age 18 with a severe disability who is eligible to receive the level of care provided in a medical institution to receive medical assistance (i.e. Medicaid card). APS proposes that our experience with the population served and comparable processes in other programs uniquely enables APS to incorporate the Bureau's expectations related to the CDCSP.

APS-WV, under our current contract, makes eligibility decisions for all three levels of care (Nursing Facility, ICF/IID, and Acute Care Hospital). For example, in order to be eligible for the I/DD Home and Community Based Waiver, an applicant must require the same level of care as received in an ICF/IDD. APS's medical unit currently authorizes Acute Care and Nursing Home stays. A CDCSP applicant must meet one of these levels of care. APS proposes the following eligibility flow:

- We will receive and time stamp applications; they will be reviewed on a first come, first reviewed basis.
- We will review each application packet for all necessary information/completeness; incomplete applications will be returned to the applicant's guardian.
- Approvals will be issued based on documentation substantiating requirements as outlined in chapter 526 as well as the level of care eligibility criteria.

Should the Bureau decide to release this optional service, we will:

1. Evaluate assessments and documentation submitted for eligibility of the CDCSP.
2. Develop a process and procedural manual for eligibility and evaluation process for children served within 30 days or contract aware and ensure Agency approval of the manual and any updates 14 calendar days prior to implementation. To avoid disruption to existing stakeholders, it is recommended that the existing procedural manual be used as a basis for the new one.
3. Develop a quality management manual within 30 calendar days of contract award which include a quality management plan for both quality assurance and improvement for each CDCSP process (with Agency approval 14 days prior to implementation).
4. APS-WV currently participates in contract management meeting for numerous programs. We will add contract management for the CDCSP program.

5. Provide administrative operational functions necessary to support CDCSP medical eligibility.
6. Continually evaluate quality of services provided through quality assurance and improvement activities and report on those activities monthly during contract management.
7. House the CDCSP Program Manager at our office location at 100 Capitol Street Charleston, WV 25301. This manager will be equipped with a computer system with programs compatible with the WV Office of Technology-supported versions of the Microsoft Operating System, Microsoft Office Suite, and Internet Explorer. We will also ensure the Manager's system has current technologies for data interchange, appropriate clerical/data support, provisions for storage of all member eligibility/medical records as required by law, and/or regulation in electronic format within 30 days of contract aware.
8. Provide 1-4 statewide trainings per year through face-to-face, web-based or telephone conference on the CDCSP program related to eligibility determinations, with all training and materials submitted to the Agency 14 calendar days in advance of the training.
9. Complete the assessment of and determination of required initial and reevaluation medical eligibility.
10. Review and determine eligibility for the CDCSP within 30 days of receipt of a complete application.
11. Complete annual redeterminations of medical eligibility for the CDCSP within 30 days of the individual's date of medical eligibility.
12. Utilize evaluations submitted by the applicant to determine the level of care for the CDCSP.
13. Notify in writing the applicant/member or legal representative, local county DHHR office, the Agency and provider within program timelines regarding the eligibility decision and appeal rights for the CDCSP.
14. Conduct all clerical and/or administrative functions associated with the determination of medical eligibility for the CDCSP, which will include: written notification and tracking of eligibility, applicant tracking, information and referral about the program, tracking of certified/trained/approved evaluators, and tracking of Medicaid Fair Hearing status.

c. ICF/IID Program Eligibility

c. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Program Eligibility

Vendor Response

Intermediate Care Facilities for Individual with Intellectual Disabilities (ICF/IID) are facilities where services are provided for individuals with intellectual disabilities and/or related conditions. APS is familiar with the ICF/IID program in West Virginia, as the eligibility criteria are the same for the I/DD Waiver program, which we currently administer. We are familiar with tracking of applications, administrative functions, administering the ICAP, tracking fair hearings, and conducting provider reviews. We are fully prepared to take on the additional work as requested by the Bureau related to the ICF/IID program. APS-WV will:

1. Provide administrative operational functions necessary to support the medical eligibility process for the ICF/IID program. Our experience in operations and administration of the I/DD Waiver, Nursing Facility and other programs will prove useful.
2. Conduct quality assurance and improvement activities within the eligibility process for ICF/IID. APS-WV will assess, recommend improvements, implement changes/training, etc. and continually reevaluate for effectiveness of quality improvement activities.

3. Provide a WV licensed psychologist to determine eligibility for ICF/IID levels of care
4. Determine ICF/IID eligibility within 90 days of admission to an ICF/IID facility and annual determination evaluations within 30 days of the anniversary date of initial eligibility.
5. Conduct and document on-site reviews of Inventory for Client and Agency Planning (ICAP) assessment implementations for accuracy in scores that are used to establish medical eligibility and service level within ICF/IID facilities. Our experience with on-site reviews in I/DD and TBI Waivers proves a quality experience conducting provider reviews.
6. Provide the fiscal claims agent with information required to generate a prior authorization for services that include the ICAP level score and start/stop dates for ICF/IID facility participants. **APS recommends that because of our familiarity with generating authorization we be permitted to enter the authorization directly into the claims payer system.
7. Use evaluations submitted by the applicant to determine the level of care for ICF/IID facilities.
8. Perform an on-site review of ICAP assessments at each ICF/IID facility annually.
9. Visit 100% of all ICF/IID facilities in the first year of the contract and then 33% per additional contract year.
10. Notify in writing, the individual/member or legal representative, local county DHHR office and provider within program timelines regarding eligibility decisions and the right to appeal the decision through Medicaid Fair Hearing.
11. Conduct all clerical and/or administrative functions associated with the determination of eligibility for ICF/IID facilities. Functions will include written notice of eligibility decisions, tracking of applicants and eligibility decisions, providing information regarding eligibility upon request, and tracking Medicaid Fair Hearing status.

d. TBI Waiver Functions

d. TBI Waiver Functions

Vendor Response

APS currently administers the TBI Waiver program on behalf of the Bureau. Our Certified Brain Injury Specialists will continue to complete initial requests for medical eligibility within 45 days and annual requests for medical eligibility at least 30 days prior to the member's anchor date. APS could easily accommodate the optional request by the Bureau to employ a Registered Nurse to accompany the CBIS on these evaluations. We would recommend, though, that if the Bureau considers implementing this optional service, they consider our hiring RNs to complete the assessments who are already (or will be trained) as a Certified Brain Injury Specialist to eliminate avoidable duplication of effort.

e. Aged and Disabled Waiver Functions

e. Aged and Disabled Waiver (ADW) Functions

Vendor Response

APS-WV currently conducts medical evaluations for the Aged and Disabled Waiver (ADW) program. We are familiar with the program policies and procedures, participate in contract management meetings, and provide the majority of data for the Bureau as reported in our secure and comprehensive system. APS

already performs the majority of the outlined ADW optional functions in the I/DD Waiver and TBI Waiver programs. It would be a natural transition for us to assume this work with the ADW program.

1. APS-WV already manages a portion of program enrollment (medical eligibility) for the ADW program. We already receive financial eligibility for persons on the managed enrolment list. All data is tracked within our system.
2. During ADW initial and annual assessments, APS educates members/families/agencies and others about policy available services, service delivery models and choice between Waiver and institutional care. Our knowledge of these processes and policies for the ADW and other Waiver programs easily translates to ADW. We are prepared to convene monthly conference calls with providers, face-to-face provider meetings up to 4 times per year and statewide trainings and webinars upon request by the Bureau.
3. APS already provides information to applicants and members during our medical eligibility assessment about how to recognize and report abuse, neglect, exploitation and other critical incidents.
4. During the initial and reevaluation assessments, APS can disseminate the approved ADW Member Handbook. APS will maintain and update this handbook and submit to the Bureau for approval with any updates.
5. APS suggests implementing the same methodology for initial and continuing certification reviews as are currently implemented through our work in the TBI Waiver program. The certification requirements and processes are essentially identical between the programs.
6. APS is very familiar with conducting on-site quality provider reviews. We are happy to continue this work with the ADW program to verify compliance with policy and appropriate utilization management and documentation of authorized services. APS developed the template that is used across multiple programs to document disallowances per provider reviews and we are well versed on how to complete the reports. Each quarter, we will notify the Bureau of upcoming providers to be reviewed and will provide ongoing technical assistance for providers, members, and stakeholders via email, telephone, webinars, or other methods.
7. We will provide a program manager who will attend a national conference. This will allow us to remain current with of issues pertaining to the aging and disability populations and state and federal best practices for Waiver programs.
8. We currently manage and facilitate the Quality Improvement Advisory (QIA) Council for both the I/DD Waiver and TBI Waiver programs. We will facilitate the QIA Council for the ADW program to include quarterly face-to-face meetings as needed. We will fund travel expenses including mileage and overnight stay for Medicaid members on the council when they live more than 60 miles away from the meeting location.
9. We will monitor the quality of services through on-site and desk audits, receiving/tracking/investigating complaints and through other sources.
10. We will conduct face-to-face Participant Experience Survey (PES) interviews using a representative sample of enrolled members.

11. Upon contract award, we are prepared to receive, track and triage or investigate complaints submitted by providers, members, or other stakeholders. We currently perform these functions in both I/DD and TBI Waiver programs.
12. We are familiar with the state's Incident Management System and currently monitor it daily in I/DD Waiver. We can fulfill this function with ADW as well.
13. APS already houses the electronic health records for all ADW members. Records and history are stored in the ADW system that is already available to the current vendor, the Fiscal/Employer Agent, providers, the Bureau and APS.
14. APS will maintain a reference guide of all available providers, services provided and counties in which services are provided.
15. We will maintain agency selection forms.
16. We will communicate program announcements to providers, members and other stakeholders as necessary through electronic communication methods.
17. We will provide daily monitoring, monthly, and quarterly reporting in the state's Incident Management System. Upon the request of the agency, we will test any updates or changes to the system.
18. APS already collects, processes, and refers requests for self-directed services to the Fiscal/Employer Agent Vendor in accordance with state and federal guidelines.
19. We will act as a liaison with members, their employees, and vendors to resolve any issues related to the members self-directing their services.
20. We will review the self-directing member's PAS initially and upon reevaluation to determine the need for a legal representative as related to dementia or related conditions.
21. We will work with the Fiscal/Employer Agent to assure that legal representatives do not become paid employees of the member who is self-directing.
22. We will review and determine approval for requests for Participant-Directed Goods and Services. **Note: The 2015 ADW Renewal removed PDGS as an allowable service. If the Agency reinstates this service, we will review requests.
23. We will provide technical assistance to providers in relation to members transferring from Traditional services to self-directed services (and vice versa) to assure no gap in service.
24. We will work with the local DHHR to establish financial eligibility for members who choose to self-direct their services.
25. We will provide training to the Fiscal/Employer Agent staff on program policy.
26. We will access the Fiscal/Employer Agent's portal for purposes of tracking members who self-direct.
27. We will review incident reports in the WVIMS system and follow up with DHHR Adult Protective Services when necessary.

28. We will make reports/referrals to the Medical Fraud Control Unit when necessary. **Note: APS is currently required to make referrals to the Office of Program Integrity who then tracks and reports to Medicaid Fraud Control Unit.
29. We will continue to research federal issues related to self-direction and make recommendations to the Bureau.
30. We will attend the ADW Quality Improvement Advisory Board and report on the self-directed program.
31. APS already reviews and makes authorization determination for members who quality for Dual Services (ADW and Personal Care). All requests and authorizations are currently handled in our Aged and Disabled Waiver and Personal Care systems.
32. Following quality provider reviews, will monitor approved plans of correction through either a desk or on-site audit depending on the severity of the infraction.

f. Personal Care Functions

f. Personal Care Functions

Vendor Response

APS currently houses all Personal Care program electronic records for members within our secure, comprehensive Personal Care system. We are prepared to expand our services within the program should the Bureau choose to implement these optional services.

1. APS has provided Registered Nurses to conduct initial and reevaluation assessments for Aged and Disabled Waiver members statewide. We are prepared to employ and train RNs to complete initial medical eligibility assessments for Personal Care services within 7 days of referral (2 days if the member is being discharged from a medical facility).
2. APS will provide RNs to conduct reevaluation assessments for Personal Care at least 30 days prior to the member's anchor date.
3. APS will educate members, families, agencies and other stakeholders about policy and available services during the initial/reevaluation assessment. We will provide ongoing training and technical assistance through monthly conference calls with providers and statewide trainings and webinars at the request of the Bureau.
4. During our initial and reevaluation assessments, we will provide education to all members/applicants about how to recognize and report abuse/neglect, exploitation and other critical incidents.
5. We will collaborate with and remain involved in stakeholder activities.
6. Should the Bureau choose to offer self-directed services to Personal Care members, we will refer requests received for Personal Options to the Fiscal/Employer Agent by enhancing the Personal Care system, allowing access to the Fiscal/Employer Agent
7. We will process approved special requests upon request from the Bureau.

8. We will conduct initial and continuing certification reviews of new/existing Personal Care providers including both on-site and desk reviews as necessary.
9. We will conduct annual on-site quality reviews of all Personal Care providers to verify compliance with policy, appropriate utilization management, and documentation of services. We will calculate disallowance amounts per provider review. Each quarter, we will notify the Bureau of upcoming provider reviews. We will provide ongoing technical assistance via email, telephone, and webinars or through other means.
10. We will continue to consult with the Bureau and make recommendation about policy and procedures. We will continue to draft policy recommendations upon request by the Bureau.
11. APS will draft responses to CMS on quality measures upon request.
12. We will receive, track and triage or investigate complaints submitted by providers, members or other stakeholders.
13. We will manage and report on incidents as reported by providers, members and other stakeholders.
14. We will manage application and referrals for determining eligibility at the initial assessment and the annual reevaluation assessment include correspondence to all applicable parties.

g. I/DD Waiver Functions

g. I/DD Waiver Functions

Vendor Response

APS is the current Administrative Service Organization for West Virginia's I/DD Waiver program. From initial program application through Managed Enrollment and even discharge, all I/DD members' statuses are tracked within our system. The work currently performed by a co-vendor related to determining program eligibility is housed within our system. It is a natural progression for this work to transition into our purview.

1. APS will make sure initial eligibility assessments completed by Independent Psychologists (IPs) are conducted in a setting and with circumstances consistent with professional standards and environmental factors that do not interfere with the applicant's or member's performance. We will train IPs to note any variation to these factors in their evaluations.
2. We will develop a process and procedural manual for the eligibility and/or evaluation process for the I/DD Waiver program within 30 days of contract award. We will present the manual and/or any updates to the Bureau for approval 14 days prior to implementation.
3. We will complete initial determinations of medical eligibility within 90 days of a complete initial application for services. Application, referral to an IP and the determination of medical eligibility is already tracked in APS's I/DD Waiver system.
4. We will complete annual determination of medical eligibility prior to each member's anchor date. APS currently conducts the reevaluation assessments from which the current co-vendor determines eligibility. It would be an easy transition to do this work ourselves. All work is already currently tracked through our I/DD Waiver system.

5. APS is happy to develop and coordinate the Independent Psychological Network (IPN) comprised of WV Licensed Psychologists to ensure completion of the Independent Psychological Evaluation (IPE) assessments used to determine initial medical eligibility and for second medical evaluations.
6. Through our established network of behavioral health providers who come to us for authorization, we will recruit, approve and train WV Licensed Psychologists throughout the state to conduct I/DD Waiver evaluations. We will oversee the accuracy of the reports and review claims billed by the IPs. We will re-educate IPs as necessary.
7. We will ensure accurate reporting of quarterly data pertaining to evaluations completed, timelines and eligibility decisions, and hearings. Our I/DD Waiver system already tracks most of this information.
8. We will provide administrative operational functions necessary to support the medical eligibility process for the I/DD Waiver program. Since APS already does this for various components of the program, it will be an easy addition.
9. We will perform ongoing quality assurance and improvement activities in addition to those projects we already monitor for the I/DD Waiver program.
10. We will provide one WV Licensed Psychologist to determine medical eligibility for I/DD Waiver.
11. We will survey each I/DD Waiver Facility-Based Day Habilitation site and each agency-owned leased or rented residential site to determine if the site meets the CMS Integrated Setting rule. **This task is also indicated as a mandatory task under I/DD Waiver.
12. APS already reviews and monitors the Fiscal/Employer Agent Vendor for the I/DD Waiver program. We will continue to perform this task at the request of the Bureau.

h. Children with SED Waiver Functions

h. Children with Serious Emotional Disturbance (SED) Waiver Services

Vendor Response

The criteria for program eligibility has not been fully developed, other than Medicaid members who are children with an SED condition are targeted, and it has not been determined whether the SED Waiver program would be rolled out incrementally by geographic area or statewide. For this reason, APS proposes a conservative start up on based on 400 children that we can expand as the Agency provides details.

The 1915 (C) Waiver was initiated in 1994 so states could establish home and community-based services (HCBS) to meet the needs of children and adults who prefer to receive long-term care services in their respective communities rather than in an institutional setting. There are currently at least 35 states with this type of waiver. However, only ten states have used this waiver to target children with severe emotional disturbances. Some of the examples of services for children receiving this waiver in other states include respite, adaptive aids, and supports, community living supports, family supports, minor home modifications, paraprofessional services, specialized therapies, supportive family-based alternatives, foster care, community integration, behavioral interventions, counseling and therapeutic services, specialized transportation, attendant care, and parent support and training.

Each state establishes their target population within parameter from CMS. In reviewing the issues with WV's over reliance on residential care and the changes that are currently being made in the service

delivery system to address this problem, WV should consider matching the target population that will be served in the Safe at Home WV Title IVE Waiver. While WV worked to reduce residential care, especially out of state placements for many years, the finding from the Department of Justice that we do not comply with the Americans with Disabilities Act brought even more attention to our state. APS would like to bring our experience with children's behavioral health services and administering three waiver programs in WV together to assist the Department to design and implement a Children's SED waiver for our state.

APS proposes a process of annual medical eligibility determination that will be timely, equitable, person-centered, and include relevant stakeholders in the determination process. Through this process, we will document the member's initial and continuing medical eligibility for participation in the Waiver, and provide notification to relevant parties to ensure a thorough understanding of the process as well as the member's Fair Hearing rights and process.

We will receive daily referral requests for Waiver program assessment, including requests for either an initial or reevaluation. Applications will be considered on a first-in, first-out basis. We will conduct an initial screening of the application to ensure that it is complete, correct and includes all components necessary. We will notify the applicant in the event additional information is required. Once the application is complete, we will mail the applicant (with the Bureau's approved letter) and prompt them to obtain financial eligibility through their local DHHR. At this time, we also suggest they select a Case Management Agency to assist them with this task.

Once verification/approval of financial eligibility is received, we will contact the member to establish a date and time for the medical evaluation, abiding by policy related to contacts, appointments, notices and other measures. If the assessments cannot be completed, we will discontinue the medical eligibility process and notify the relevant parties to reinitiate the process should they wish to pursue application. The Department may also want to consider reversing this process in order to lower costs by requiring financial eligibility be completed before medical eligibility. The flow discussed below would be altered slightly to match this change.

APS will conduct the initial and re-evaluation assessments with the instruments decided upon by the Bureau. Initial assessments will be scheduled and completed within 14 days of receipt of financial eligibility approval. Reevaluation assessments will be completed at least 30 days prior to the member's established Anchor Date. In addition to the proposed assessments, APS will review all pertinent physician's orders, assessments, and other documentation available during the assessment.

APS will make every effort to complete assessments within timeline. When an assessment cannot be completed within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline.

APS will then run the data from the assessment through a computerized algorithm based on current program policy, and establish a determination of medical eligibility.

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

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

Authorization

The member service plan will be prepared by the member's Service Plan team using information from the assessments as well as information about the member's preferences. This service plan will be documented in our information system when complete. APS will then review the plan to ensure assessed needs have been taken into account, the member has been involved in the decision-making, and other issues such as medical care, health, and safety have been addressed. APS will then review the service plan and provide authorizations to the fiscal system so that the provider can submit claims. APS will notify the member and provider when services have been authorized. A budget amount per member will be established based on the total cost of the services deemed necessary by assessment and the Service Plan team

Managed Enrollment

When no slot is available, those applicants determined medically eligible will be placed on the SED Waiver Managed Enrollment List. When a funded slot becomes available, APS will prepare correspondence to the eligible applicant/legal representative informing them they will be contacted for an assessment and instructing them to obtain financial eligibility at their local DHHR (if it has expired from previously acquiring). Only after the member is determined both medically and financially eligible will APS enroll the new program member.

The APS System

We will develop a SED Waiver system to comply with all security requirements. The system will incorporate the ability for providers to request authorization, authorization to be generated and authorization and SED Waiver attribute information to be exported to the claims payer. The APS System will serve as a database from which we will produce data for state and federal reporting. The system will incorporate a Service Delivery Model module through which requests for self-directed services can be referred to the Fiscal/Employer Agent vendor.

Education, Training and Technical Assistance

APS will develop training for the Bureau and stakeholders related to policy, available services, service delivery models, the choice between SED Waiver and institutional care, and other relevant topics. Training has been geared toward multiple audiences, including but not limited to: members, families, agencies, advocacy groups, and others. Training evaluations will be monitored to ensure satisfaction with the training conducted by APS staff.

- APS will plan, advertise, and produce statewide training and webinars at the request of the Bureau. For efficiency, APS will advertise electronically using an established email distribution list that includes numerous stakeholders involved in the SED Waiver program.
- APS will host a SED Waiver Quarterly Provider Meeting up to 4 times per year at the request of the Bureau, which will include conference room rental and hospitality for attendees.

- APS will refine existing training on recognizing and reporting abuse, neglect and exploitation or other critical incidents. APS will continue to train on this topic and make the training available to providers (so they can train new staff) at the Bureau's request.
- APS will collaborate with a SED Fund Board and other stakeholder activities to stay aware of current issues related to the program and the population served in general.
- APS will develop and make available the SED Waiver Program <Member> Handbook and a reference guide of available providers/services to be made available to members during their annual functional assessments.
- Using the established email distribution list, APS will continue to communicate program announcements to providers, members, and stakeholders on behalf of the Bureau.
- APS will continue to participate in conference calls with providers, trainings, and webinars.
- APS will continue to develop program forms and make recommendations to meet the needs of the program best.
- APS will continue to conduct general community and specified outreach to grow program enrollment.

Review Criteria

As directed by current policy, APS will utilize nationally accredited research based criteria with a clinically sound basis. APS staff administering assessments will undergo a comprehensive orientation program where they are trained (classroom style). Orientation of new staff will last approximately 2 weeks, but can last up to a month, depending on the new staff's previous experience and comfort level with conducting assessments and performance.

APS will develop interpretive guidelines for all program eligibility assessments administered, and will submit to the Bureau upon request. APS will regularly conducts inter-rater reliability activities with staff and updates interpretive guidelines as necessary. Any updates will be presented to the Bureau as recommendations for approval. All services approved will be based upon nationally accredited, research-based criteria with a clinically sound basis in the Agency-approved manual or automated review of each prior authorization request or eligibility review.

Quality Assurance Activities

APS will continue to conduct quality assurance activities with members, families, agencies, stakeholders and the general community. Quality assurance and improvement is a core tenet of APS-WV's philosophy and business practice. We tackle quality with a holistic approach and constantly seek out opportunities to improve quality within and outside the organization; ultimately with effort to improve the quality of services to members served. With this, we will provide ongoing technical assistance at the request of the agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report. We will monitor our own performance and the quality of our services.

Initial and Continued Certification Reviews

An annual provider certification will be established based on the involved Bureau's policy and procedures and any requirements set for in the waiver application after approval by CMS. Our experience with completing provider certifications in the Health Homes and TBI Waiver program would also be leveraged. Following the receipt of a completed Certification Application (Initial) which occurs when the provider makes their first enquiry to APS, APS will conduct an onsite review if required, to verify that the prospective provider meets certification requirements. This requirement may be waived if the prospective provider is a current LBHC or is enrolled as an ADW, PC, or IDDW provider at the time of application.

APS will notify BMS 'fiscal agent upon satisfactory completion of the onsite review OR verification of LBHC, ADW, PC or IDDW status. BMS fiscal agent will provide the provider applicant with an enrollment packet that includes the SED Provider Agreement. BMS fiscal agent will send a letter to the Provider and the UMC, informing the certified provider agency it may begin providing and billing for SED services.

There are three possible determinations that may result from the review process:

- Full Certification. We will notify the provider, the Bureau, and the fiscal agent that the provider has been certified to deliver services as of a specific date. The provider will be added to the Agency Selection forms, which we will maintain per county.
- Provisional Certification. Provisionally certified providers will be requested to develop a Plan of Correction that addresses deficiencies identified during review. After the plan has been received and reviewed, we will schedule a follow-up review to identify the extent to which providers have implemented the plan of correction. If successful, providers will then be fully certified.
- Not certified. For providers that are not certified, we will provide notification in writing with an explanation of the rationale for our certification determination. Providers may then reapply after a period of time that we will establish in collaboration with the Bureau.

Upon exit, we will conduct an exit interview to communicate preliminary findings of the review. At that time, the provider may submit any additional documentation and provide technical assistance/training as necessary for any deficient areas. Within the Bureau's established timeline, we will finalize and submit completed reports.

APS will conduct on-site quality reviews of SED Waiver providers annually. We will provide the Bureau with the schedule of upcoming reviews a quarter in advance. During this review, APS will verify compliance with current state and federal policy guidelines and appropriate utilization management and documentation of authorized services. APS will continue with the imperative technical assistance component of the review so that provider can continue to grow their knowledge and understanding of policy and requirements.

APS will provide comprehensive draft reports within 10 days of the review to the Bureau and to the provider. These reports will include the Review and Disallowance Reports along with the Plan of Correction. The provider will have up to 30 days to respond to their draft reports. Upon receipt and reconciliation of the provider's response, APS will prepare and send all components to the Bureau for final consideration. We will work with the provider until they have an approvable Plan of Correction. We will participate in Review Committee where the Bureau, the Office of Program Integrity, and APS will discuss

final disallowance amounts. APS will prepare the final reports for the Bureau to disseminate to the provider. APS-WV will complete a follow-up review of providers who must submit a Plan of Correction because of unsatisfactory findings during an on-site review. Depending on the severity of unsatisfactory findings, Staff will conduct either a desk or on-site visit of the provider to verify they did implement their Plan of Correction.

APS-WV will facilitate meetings of a Quality Improvement Advisory Council quarterly whose purpose is to advise the Bureau on program related matters and concerns. APS will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they wish to be reimbursed. We will also send a SED Waiver staff to a national conference at the request of the Bureau.

Participant Experience Survey

APS proposes to:

- Conduct face-to-face Participant Experience Surveys with a representative sample of program members. Data from the survey results will be compiled, analyzed, and presented to the Bureau with effort to improve program quality.
- Receive, review, track/trend, and/or investigate complaints submitted by providers, members or other stakeholders related to a program member's service(s) through a SED Waiver provider. APS will follow a consistent procedure in responding to complaints and reporting to BMS on trends and outcomes.

APS can receive complaints either verbally or in writing (email or fax). Upon receipt of a formal complaint, APS will document the complaint and request any necessary information for follow-up. If the issue cannot be resolved over the phone through technical assistance and information and referral, APS will investigate the complaint and/or make referrals to appropriate entities. Additionally, APS-WV will:

- Provide daily monitoring, monthly reporting, and quarterly reporting, as necessary of the State's Incident Management System.
- Analyze and conduct an individualized statistical budget model.
- Provide ongoing technical assistance via e-mail, telephone, or on site.
- Develop and publish process and procedural manuals for eligibility and/or evaluation process for the SED Waiver Program.

i. SUD Waiver Services

i. Substance Use Disorder (SUD) Waiver Services

Vendor Response

APS understand the Bureau is pursuing CMS Substance Use Disorder (SUD) Waiver. This opportunity permits changes in service delivery models to include prevention and early treatment intervention, community integration, along with coordination of care across behavioral, physical health, and long-term support services. The criteria for program eligibility have not yet been fully developed, other than that members would be Medicaid members with a SUD diagnosis. Additionally, the Bureau has not determined

whether the SUD Waiver program would be rolled out incrementally by geographic area statewide. For these reasons, APS proposes a conservative start up model that can later be adapted as more details are provided by the Agency.

APS proposes a process of annual medical eligibility determination that will be timely, equitable, person-centered, and include relevant stakeholders in the determination process. Through this process, we will document the member's initial and continuing medical eligibility for participation in the Waiver, and provide notification to relevant parties to ensure a thorough understanding of the process as well as the member's Fair Hearing rights and process.

We will receive daily referral requests for Waiver program assessment, including requests for either an initial or reevaluation. Applications will be considered on a first-in, first-out basis. We will conduct an initial screening of the application to ensure that it is complete, correct and includes all components necessary. We will notify the applicant in the event additional information is required. Once the application is complete, we will mail the applicant (with the Bureau's approved letter) and prompt them to obtain financial eligibility through their local DHHR. At this time, we also suggest they select a Case Management Agency to assist them with this task.

Once verification/approval of financial eligibility is received, we will contact the member to establish a date and time for the medical evaluation, abiding by policy related to contacts, appointments, notices and other measures. If the assessments cannot be completed, we will discontinue the medical eligibility process and notify the relevant parties to reinitiate the process should they wish to pursue application. The Department may also want to consider reversing this process in order to lower costs by requiring financial eligibility be completed before medical eligibility. The flow discussed below would be altered slightly to match this change.

APS will conduct the initial and re-evaluation assessments with the instruments decided upon by the Bureau. Initial assessments will be scheduled and completed within 14 days of receipt of financial eligibility approval. Reevaluation assessments will be completed at least 30 days prior to the member's established Anchor Date. In addition to the proposed assessments, APS will review all pertinent physician's orders, assessments, and other documentation available during the assessment.

APS will make every effort to complete assessments within timeline. When an assessment cannot be completed within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline.

APS will then run the data from the assessment through a computerized algorithm based on current program policy, and establish a determination of medical eligibility.

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

If a member is ultimately eligible, we will notify all parties. Members who are eligible when no Waiver slot is available will be placed on a managed enrollment list. When there is no managed enrollment list, the

provider agency will be prompted to complete and submit a Service Plan taking into consideration the assessments.

Authorization

The member service plan will be prepared by the member's Service Plan team using information from the assessments as well as information about the member's preferences. This service plan will be documented in our information system when complete. APS will then review the plan to ensure assessed needs have been taken into account, the member has been involved in the decision-making, and other issues such as medical care, health, and safety have been addressed. APS will then review the service plan and provide authorizations to the fiscal system so that the provider can submit claims. APS will notify the member and provider when services have been authorized. A budget amount per member will be established based on the total cost of the services deemed necessary by assessment and the Service Plan team

Managed Enrollment

When no slot is available, those applicants determined medically eligible will be placed on the SUD Waiver Managed Enrollment List. When a funded slot becomes available, APS will prepare correspondence to the eligible applicant/legal representative informing them they will be contacted for an assessment and instructing them to obtain financial eligibility at their local DHHR (if it has expired from previously acquiring). Only after the member is determined both medically and financially eligible will APS enroll the new program member.

The APS System

We will develop a SUD Waiver system to comply with all security requirements. The system will incorporate the ability for providers to request authorization, authorization to be generated and authorization and SUD Waiver attribute information to be exported to the claims payer. The APS System will serve as a database from which we will produce data for state and federal reporting. The system will incorporate a Service Delivery Model module through which requests for self-directed services can be referred to the Fiscal/Employer Agent vendor.

Education, Training and Technical Assistance

APS will develop training for the Bureau and stakeholders related to policy, available services, service delivery models, the choice between SUD Waiver and institutional care, and other relevant topics. Training has been geared toward multiple audiences, including but not limited to: members, families, agencies, advocacy groups, and others. Training evaluations will be monitored to ensure satisfaction with the training conducted by APS staff.

- APS will plan, advertise, and produce statewide training and webinars at the request of the Bureau. For efficiency, APS will advertise electronically using an established email distribution list that includes numerous stakeholders involved in the SUD Waiver program.
- APS will host a SUD Waiver Quarterly Provider Meeting up to 4 times per year at the request of the Bureau, which will include conference room rental and hospitality for attendees.

- APS will refine existing training on recognizing and reporting abuse, neglect and exploitation or other critical incidents. APS will continue to train on this topic and make the training available to providers (so they can train new staff) at the Bureau's request.
- APS will collaborate with SUD providers and other stakeholder activities for awareness of current issues related to the program and the population served in general.
- APS will develop and make available the SUD Waiver Program Member Handbook and a reference guide of available providers/services to be made available to members during their annual functional assessments.
- Using the established email distribution list, APS will continue to communicate program announcements to providers, members, and stakeholders on behalf of the Bureau.
- APS will continue to participate in conference calls with providers, trainings, and webinars.
- APS will continue to develop program forms and make recommendations to meet the needs of the program best.
- APS will continue to conduct general community and specified outreach to grow program enrollment.

Review Criteria

As directed by current policy, APS will utilize nationally accredited research based criteria with a clinically sound basis. APS staff administering assessments will undergo a comprehensive orientation program where they are trained (classroom style). Orientation of new staff will last approximately 2 weeks, but can last up to a month, depending on the new staff's previous experience and comfort level with conducting assessments and performance.

APS will develop interpretive guidelines for all program eligibility assessments administered, and will submit to the Bureau upon request. APS will regularly conducts inter-rater reliability activities with staff and updates interpretive guidelines as necessary. Any updates will be presented to the Bureau as recommendations for approval. All services approved will be based upon nationally accredited, research-based criteria with a clinically sound basis in the Agency-approved manual or automated review of each prior authorization request or eligibility review.

Quality Assurance Activities

APS will continue to conduct quality assurance activities with members, families, agencies, stakeholders and the general community. Quality assurance and improvement is a core tenet of APS-WV's philosophy and business practice. We tackle quality with a holistic approach and constantly seek out opportunities to improve quality within and outside the organization; ultimately with effort to improve the quality of services to members served. With this, we will provide ongoing technical assistance at the request of the agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report. We will monitor our own performance and the quality of our services.

Initial and Continued Certification Reviews

An annual provider certification will be established based on the involved Bureau's policy and procedures and any requirements set for in the waiver application after approval by CMS. Our experience with completing provider certifications in the Health Homes and TBI Waiver program would also be leveraged. Following the receipt of a completed Certification Application (Initial) which occurs when the provider makes their first enquiry to APS, APS will conduct an onsite review if required, to verify that the prospective provider meets certification requirements. This requirement may be waived if the prospective provider is a current LBHC or is enrolled as an ADW, PC, or IDDW provider at the time of application.

APS will notify BMS's fiscal agent upon satisfactory completion of the onsite review OR verification of LBHC, ADW, PC or IDDW status. BMS fiscal agent will provide the provider applicant with an enrollment packet that includes the SUD Provider Agreement. BMS fiscal agent will send a letter to the Provider and the UMC, informing the certified provider agency it may begin providing and billing for SUD services.

There are three possible determinations that may result from the review process:

- Full Certification. We will notify the provider, the Bureau, and the fiscal agent that the provider has been certified to deliver services as of a specific date. The provider will be added to the Agency Selection forms, which we will maintain per county.
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final disallowance amounts. APS will prepare the final reports for the Bureau to disseminate to the provider. APS-WV will complete a follow-up review of providers who must submit a Plan of Correction because of unsatisfactory findings during an on-site review. Depending on the severity of unsatisfactory findings, staff will conduct either a desk or on-site visit of the provider to verify they did implement their Plan of Correction.

APS-WV will facilitate meetings of a Quality Improvement Advisory Council quarterly whose purpose is to advise the Bureau on program related matters and concerns. APS will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they wish to be reimbursed. We will also send a SUD Waiver staff to a national conference at the request of the Bureau.

Participant Experience Survey

APS proposes to:

- Conduct face-to-face Participant Experience Surveys with a representative sample of program members. Data from the survey results will be compiled, analyzed, and presented to the Bureau with effort to improve program quality.
- Receive, review, track/trend, and/or investigate complaints submitted by providers, members or other stakeholders related to a program member's service(s) through a SUD Waiver provider. APS will follow a consistent procedure in responding to complaints and reporting to BMS on trends and outcomes.

APS can receive complaints either verbally or in writing (email or fax). Upon receipt of a formal complaint, APS will document the complaint and request any necessary information for follow-up. If the issue cannot be resolved over the phone through technical assistance and information and referral, APS will investigate the complaint and/or make referrals to appropriate entities. Additionally, APS-WV will:

- Provide daily monitoring, monthly reporting, and quarterly reporting, as necessary of the State's Incident Management System.
- Analyze and conduct an individualized statistical budget model.
- Provide ongoing technical assistance via e-mail, telephone, or on site.
- Develop and publish process and procedural manuals for eligibility and/or evaluation process for the SUD Waiver Program.

j. PASRR Level II Evaluations

j. PASRR Level II Evaluations

Vendor Response

All WV Nursing Home PAS requests are currently maintained within the APS-PAS secure web-based system. Upon review by our RNs, if it is determined the applicant/member should be evaluated for Level II, we notify the referent of the need to obtain a Level II evaluation.

1. APS will provide administrative operational functions necessary to support the medical eligibility process for PASRR Level II evaluations.

2. We will participate in and represent the Bureau in Fair Hearings in PASRR Level II assessments.
3. We will ensure ongoing quality assurance and improvement within the eligibility process for PASRR Level II evaluations.
4. We will provide one WV Licensed Psychologist to determine eligibility for levels of care for nursing facility services, PASRR Level II.
5. We will conduct independent reviews for PASRR Level II evaluations for individuals who may need nursing facility level of care and trigger Level II evaluations.
6. We will notify the referring entity of the results and findings of the PASRR Level II desk review evaluation in writing via completing Page 6 of the PAS and written report within 7-9 days after referral.
7. We will determine eligibility for nursing facility placement through the PASRR Level II process.
8. We will provide face-to-face or web-based training and certification at least annually related to the PASRR evaluation process for WV Licensed Psychologists who will be conducting eligibility evaluations for PASRR Level II determinations.
9. We will recruit and train WV Licensed Psychologists throughout the state to conduct PASRR Level II evaluations. We will oversee the accuracy of their reports and review the claims billed. We will provide reeducation, as necessary.
10. We will conduct clerical and administrative work associated with the functions associated with the determination of eligibility for PASRR Level II evaluations, which consist of written eligibility notifications, tracking of applicants, handling requests for information regarding eligibility, tracking eligibility decisions, and tracking of certified, trained, approved evaluators. We will also track status of Medicaid Fair Hearings.

C. The Bureau of Children & Families (BCF)

1. GENERAL REQUIREMENTS

The Vendor should describe their plan to provide UM/PA services in accordance with Federal and State rules and regulations for the following:

a. Needs Assessment/Service Plan
b. Case Management
c. Adult Life Skills
d. General Parenting
e. Individualized Parenting
f. Public Transportation Family
g. Private Transportation
h. Agency Transportation
i. Safety Services
j. Emergency Respite
k. Supervision
l. Social/ Emotional Support
m. Comprehensive Assessment and Planning System (CAPS) Family Assessment
n. Case Management (CAPS)
o. Family Crisis Response
p. Respite
q. Home Maker Services
r. Supervised Visitation One
s. Supervised Visitation Two
t. Multi-disciplinary Treatment Team (MDT) Attendance
u. In State Home Study
v. Out of State Home Study
w. Intervention Travel Time
x. Transport Time
y. Connection Visit
z. Daily Respite
aa. Tutoring
bb. Lodging
cc. Meals
dd. Intensive Therapeutic Recreation
ee. Pre-Reunification Support
ff. Away From Supervision Support
gg. Public Transportation One
hh. Public Transportation Two
ii. Public Transportation Three
jj. Private Transportation One Foster Family
kk. Private Transportation Two Foster Family
ll. Private Transportation Three Foster Family
mm. Agency Transportation One
nn. Agency Transportation Two
oo. Agency Transportation Three
pp. Chafee Pre Placement
qq. Chafee 211
rr. Chafee 212
ss. Crisis Respite
tt. Lodging Pre Adoptive
uu. Meals Pre Adoptive
vv. Family and Needs Assessment
ww. Individual Review
xx. Community Based Teams

Vendor Response

APS-WV will continue to provide the UM/PA services in accordance with Federal and State rules and regulations as we have for the entire contract period. We do this with an understanding that there needs to be flexibility to change as BCF embarks on the implementation of "Safe at Home." APS-WV will proceed with the knowledge that there will be service changes that will affect the current Utilization Management Guidelines service array, definitions, authorization limits, target populations, naming conventions, and programming of our current APS System. However, changes will be only be made at the direction/with the approval of the Bureau.

The overall basic flow of operations will continue to be the same. BCF enrolls providers and notifies APS-WV so the provider may gain access to our secure web system. New provider orientation will be scheduled by an APS Trainer Consultant. Referral and rollback files will be received from the Bureau and APS will send authorizations and rollback files to the Bureau through an established secure FTP site. Only those services identified in the referral file may be requested by the specific provider assigned and the select items such as FACTS Client ID and FACTS Control Number found within the referral file will remain un-modifiable to make the processing of files and payments smoother. APS trainer consultants will then review the provider's service documentation either onsite or via desk audit with review tools approved by the Bureau. Technical assistance and training will then be arranged based upon their results. Reports will be provided to the Bureau at the ASO meeting to review the provider's performance.

2. BCF – SOCIALLY NECESSARY SERVICES (SNS) PROGRAM

Vendor Response

a. Eligibility

APS-WV will authorize services based on the eligibility guidelines for socially necessary services.

b. Use of Current State Policy

APS-WV will prior authorize all socially necessary services in accordance with current state policy guidelines.

c. Receive Materials

As indicated in section 4.11 all socially necessary service requests will be received by a secure web based system. Other forms of supporting documentation as requested will be reviewed regardless of the mode of receipt.

1. APS WV technical liaisons and supporting local staff will manage web user's passwords and security for the APS System.
2. APS will continue to create daily authorization files and rollback files in the formats approved by the Bureau and place them on the specified secure FTP site. APS will also post daily prior authorization response and rollback files to all providers submitting service requests via the secure APS System.
3. APS will retrieve/accept socially necessary referral and rollback files from the Bureau's secure FTP site on a daily basis.

d. System Usage Guide

APS will continue to publish, maintain, and modify when necessary guides for the use and understanding of our secure web based APS System including Utilization Management Guidelines, Provider Manual, System Instructions, and a Web User's Manual. Utilization Management Guidelines will also be provider to BCF in order to be posted on the Bureau's web pages. Per section 4.11, only web-based submissions maybe received for all socially necessary services providers so Electronic Data Interface file formats will not be necessary.

e. Criteria Guide

APS will continue to develop, publish, and modify a user's guide for BCF Social Service Workers detailing the eligibility criteria for each service.

f. Retrospective Review

After prior authorization, APS-WV Trainer/Consultants implement a retrospective review of provider documentation practices and utilization management processes. Trainer/Consultants (TC) will review service invoices provided by BCF or continue to review invoices provided directly from the provider and provider credentialing information while on site for the retrospective review. Each SNS provider will receive at least one review every eighteen-month cycle. Additional reviews may be warranted based on:

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

Providers with 10 or more unduplicated consumers authorized for Socially Necessary Services will receive an on-site review. Providers with less than 10 unduplicated consumers will receive a desk audit. A random sample is pulled based upon the volume and complexity of the service array of the enrolled providers. Consultations with SNS providers will be scheduled at least four to six weeks in advance by the designated Trainer/Consultant. If the provider cannot be immediately reached by phone, the TC will leave a message for the provider to return a call to the TC's cell phone. If the call is not returned the same day, the TC will attempt to contact the provider daily for three business days. If no return call is received within three business days, the TC will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Director of Socially Necessary Services should immediately be apprised of the situation. During the phone call to schedule the consultation, the TC outlines the consultation process and its purposes. The TC confirms the provider mail and email addresses during this phone call, and asks to whom the sample should be sent. The TC then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The TCs maintains confidentiality according to HIPAA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. The following tools are required:

- Social Necessity Services UM Guidelines manual
- Copies of review instruments
- APS-WV Interpretive Guidelines
- Copy of each consumer's APS System record with demographic information, current living situation, and service plan summary, presenting problems, level of support questions, guardianship status, and free text field information.

Once on-site, the TC begins the review by interviewing the primary contact person for the agency or the actual SNS provider. This person is queried regarding how referrals are received, what information is

received at first contact, how is information gathered for the APS System, and whether there are concerns about the referral process. Using the sample printout a record is selected by the TC for review. The start date, service category, and service are noted for the most recent authorizations. If there are multiple services for the same period, all documentation referring to that service is reviewed. The Referral Form is reviewed for justification of the service, category of service and any information from the DHHR worker that indicates the consumer's deficits and needs as related to the definition of the authorized service being reviewed for the specific period. The consumer's APS Social System copy with fields reflecting the consumer's functional deficits and the focus of the service plan should also be compared to any information in the record and the service plan for consistency. If there are multiple re-authorizations for the same service, the TC reviews case notes, service plans, any documentation that indicates the worker was contacted at the re-authorization period, that progress towards service objectives was addressed, and all agreed that the services should continue. Provider personnel charts will also be reviewed to ensure that the proper credentials and requisite background and safety checks such as the OIG list have been completed. A portion of the review report will directly address the results of each personnel chart. If questions or concerns about specific records arise during the consultation, they can be discussed by phone with the Director of Social Necessary Services or an SNS Care Manager.

APS-WV meets with providers at the conclusion of the on-site review. We discuss the most important findings of the review, and assess strengths and areas of improvement for the provider. The TC addresses any provider questions brought up during the entrance meeting or during the review process. After the meeting, the provider completes an Exit Technical Assistance form and returns it to APS-WV.

g. Retrospective Review Reporting

APS-WV provides a Consultation Report, which presents results and recommendations for improvement. We distribute this report electronically to the provider immediately following the exist conference.

h. Contact to Provider

A consultation Follow-up Technical Assistance call addresses areas for improvement identified through the review process and is made within 10 days of the provider's receipt of report. A consultation Follow-up Technical Assistance call addresses areas for improvement identified through the review process and is made within 10 days of the provider's receipt of report.

i. Produce Utilization Reports

APS-WV submits reports to the Bureau on a county, regional, and statewide basis, describing utilization at the provider level.

j. Process Socially Necessary Services

APS-WV processes Socially Necessary Services requests within two working days of receipt. This process includes:

- Authorization
- Review
- Contacting the Bureau Social Worker
- Re-Authorization

- Closure (if necessary).

k. Technical Assistance

Providers who receive less than 80% on a retrospective review will be required to receive mandatory technical assistance on each individual service scoring under 80% on the BCF approved retrospective review tools. Once the technical assistance is completed, the trainer will conduct a follow up review to determine if the provider has made improvements. The outcomes of these reviews will also be provided to BCF and reviewed with the ASO Group to determine if any further action is required. For all providers scoring 80% or above on a retrospective review, training and technical assistance will be available for the provider but is not mandatory.

l. Process for Service Denials

APS-WV will continue to follow the ASO Standard Operating Procedure for Denials from December 2014 and the secondary review process outlined in the APS Socially Necessary Services Provider manual that includes a secondary internal review prior.

m. Rollback Process

APS will continue to obtain and process daily a rollback file for BCF to enable the closure of cases by the Bureau's social workers. Providers may send a rollback/roll forward sheet requesting adding or reducing units within their authorizations. Providers and DHHR workers may also contact the APS care managers at any time via phone, e-mail or fax requesting an action be made on an authorization and if it within the permissions granted by the Bureau alterations will be made. As always any time an authorization is altered, an update will be sent in the electron response file placed on the Department's secure FTP site. In addition, if the Bureau approves an APS Care Manager may become a parent or BCF foster parent's web user and submit their request for authorization of mileage, meals, and transportation services only. The authorization will be processed and the parent or worker contacted to confirm the number of units required. An invoice will be populated with the authorization numbers and units only and sent to the parent/foster parent to attach supporting receipts, sign and mail to BCF Accounts Office of Finance and Administration for processing and payment.

n. Develop Educational Trainings

APS will continue to develop/provide educational training and technical assistance to all stakeholders identified by the Bureau regarding policy, services available, service delivery models, the various types of services other than socially necessary services available. Specifically, providers and workers will be kept apprised of service issues, the authorization process, as well as training on any new Utilization Management Guidelines approved by the Bureau. New providers will continue to receive Provider Orientation within 60 days and have their first retrospective review within six months of their company's initial authorization. The specific training for parents and foster parents as providers will continue to cover enrollment, registration, referral, authorization requests, and invoicing.

o. Quality Assurance Activities

APS believes involving those receiving the service; the Bureau staff and other stakeholders we manage for the Bureau helps provide quality assurance. In order to do this APS will provide at least 10 educational forums each year with a written summary of the event within two weeks to contract management. At

least six focus groups per contract year will be completed utilizing the Bureau's approved list of questions for biological parents, foster parents, children and youth as well as Bureau workers and their supervisors. A written report of each focus group will be completed within two weeks of the event and provided to contract management. APS will collaborate with the Bureau's Continuous Quality Improvement staff in this area.

p. Reports and Notifications

APS will provide the following reports and notifications regarding Socially Necessary Services to BCF:

- Data analysis
- Annual Consumer Focus Group Summary and Analysis
- Case Summaries for all requests sent to the DHHR Review Committee or when requested by the Bureau
- Denial notifications to providers
- Denial notifications as outlined in the December 2014 Denial SOP

q. Provide Consultation and Research

SNS Program staff will research and remain current on evidenced based practices for child welfare, behavioral health, and physical health services. APS-WV will provide consultation to the Bureau regarding evidenced based practices and make recommendations when needed regarding the specific area and/or how to integrate them. SNS staff will continue in the consultative role to BCF regarding areas of practice including child protective and youth services. For example, APS-WV will continue to participate in the Out of Home Placement Committee through participation in the assigned subcommittees, as well as activities related to the Certificate of Need Summary Review Committee.

r. Service Array Development

APS-WV will work with BCF to continue to develop the service array needed to meet state and federal mandates related to services for children and families. Any new services will have their definition, authorization level, units, admission criteria, continued stay, discharge criteria, service exclusions, clinical exclusions, documentation requirements, and staff credential level created through the ASO Group's Utilization Management Guidelines subcommittee.

s. Referring Suspected Fraud

APS-WV is dedicated to the integrity of West Virginia's health and social services programs, and is vigilant in identifying and reporting suspected fraud to the appropriate agencies. We understand that instances of suspected fraud related to socially necessary services will be reported to the BCF Office of Finance and Administration. APS-WV will go beyond the mandatory requirements of this item to help ensure the most effective approach to preventing waste, fraud, and abuse.

3. BCF – BH SERVICES CHILDREN'S IN-STATE RESIDENTIAL PROGRAMS

Vendor Response

a. West Virginia Bureau for Children and Families covers in-state residential services for members who meet eligibility guidelines. Members will begin receiving annual assessments to determine re-eligibility guidelines. These activities will be detrimental to successfully implementing Safe at Home WV and a potential waiver for children with severe emotional disturbances based on the Department of Justice findings from June 2015.

b. APS Healthcare currently issues the necessary prior authorization for providers to receive reimbursement for residential services based upon medical necessity through the data reported by the provider via the APS System.

c. Any additional physician's orders, plans of care, assessments and other forms or documentation are also considered in these decisions.

d. The criteria for residential levels of care 1-4 have not been revised since 2000.
    1. APS will continue to use the original guidelines that were approved by the DHHR while assisting the Bureau to update review criteria for residential services to recent nationally accredited, research based criteria. Criteria for Psychiatric Residential Treatment Facilities and Inpatient Psychiatric Services Under 21 years of age have been updated in the last two years. These criteria will continue to be refined based on the nationally accredited, research -based criteria as well. Recommendations on policy, procedure, and best practices will be made annually to BCF regarding residential criteria and any forms that need modifications.
    2. When the review criteria have been updated a complete set of will be made available to the Bureau.
    3. The Bureau does have the right to require a different set of criteria of which APS will be responsible for the cost.
    4. The Bureau does have the right to require a different set of criteria of which APS will be responsible for the cost.

e. When BCF is funding residential in-patient services the same policies, procedures and workflow including checking for eligibility will be used as when a request is for the same level of care covered by WV Medicaid. The only exception will be denial notices with the reasons listed will also be sent to BCF's social worker, community services managers, and regional program managers via secure e-mail.

f. When BCF is any behavioral health services the same policies, procedures and workflow including checking for eligibility will be used as when a request is for the same level of care covered by WV Medicaid. The only exception will be denial notices with the reasons listed will be sent to BCF's social worker, community services managers, and regional program managers via secure e-mail.

g. APS will supply staff to provide necessary testimony and documentation for member fair hearings.

h. When BCF is any behavioral health services the same policies, procedures and workflow including checking for eligibility will be used as when a request is for the same level of care covered by WV Medicaid.

i. APS will continue to participate in the service development, certificate of need, summary review process as well as the writing of requests for information for all residential program development.

j. APS will continue the use of a secure e-mail system for sending denial letters and all other clinically relevant information shared with the Bureau.

k. As a follow up to obtaining authorizations, providers of child residential services will be subject to retrospective review on an 18-month cycle. The same review tools currently approved by contract management will be utilized regardless of payer source until criteria changes are made. Any changes made to retrospective review tools based on new criteria will also be approved by BCF.

l. 1. Data analysis reports as requested will be completed for BCF.
   2. The annual focus group summary and analysis will be completed within 10 working days of the contract year.
   3. Denial notices with the reasons listed will be sent to BCF's social worker, community services managers, and regional program managers via secure e-mail.
   4. Shelter reports if restarted will be completed for BCF on a weekly basis.
   5. Diagnostic reporting for all children in the Bureau's custody will be completed.

m. APS believes involving those receiving the service, the Bureau staff, and other stakeholders we manage for the Bureau helps provide quality assurance.
   1. In order to do this APS will provide at least 10 educational forums each year with a written summary of the event within two weeks to contract management.
   2. At least six focus groups per contract year will be completed utilizing the Bureau's approved list of questions for biological parents, foster parents, children and youth as well as Bureau workers and their supervisors. A written report of each focus group will be completed within two weeks of the event and provided to contract management.

n. APS will continue to develop/provide educational training and technical assistance to all stakeholders identified by the Bureau regarding policy, services available, service delivery models, the various types of services other than socially necessary services available. Specifically, providers and workers will be kept apprised of service issues, the authorization process, as well as training on any new Utilization Management Guidelines approved by the Bureau. New providers will continue to receive Provider Orientation within 60 days and have their first retrospective review within six months of their company's initial authorization. The specific training for parents and foster parents as providers will continue to cover enrollment, registration, referral, authorization requests, and invoicing.

4. BCF – BH SERVICES CHILDREN'S OUT-OF-STATE RESIDENTIAL PROGRAMS

Vendor Response

West Virginia Bureau for Children and Families covers out of-state residential services for members who meet eligibility guidelines. Members will begin receiving annual assessments to determine re-eligibility guidelines. APS-WV currently issues the necessary prior authorization for providers to receive reimbursement for residential services based upon medical necessity through the data reported by the provider via the APS System. Any additional physician's orders, plans of care, assessments and other forms or documentation are also considered in these decisions. The criteria for residential levels of care 1-4 have not been revised since 2000. APS will continue to use the original guidelines that were approved by the DHHR while assisting the Bureau to update review criteria for residential services to recent nationally accredited, research based criteria. Criterial for Psychiatric Residential Treatment Facilities and Inpatient Psychiatric Services Under 21 years of age have been updated in the last two years. These criteria will continue to be refined based on the nationally accredited, research based criteria as well. Recommendations on policy, procedure, and best practices will be made annually to BCF regarding residential criteria and any forms needing modifications. When the review criteria have been updated a complete set of will be made available to the Bureau. The Bureau does have the right to require a different set of criteria of which APS will be responsible for the cost. These activities will be detrimental to successfully implementing Safe at Home WV and a potential waiver for children with severe emotional disturbances, owing to the Department of Justice findings from June 2015. When BCF is funding residential services the same policies, procedures and workflow including checking for eligibility will be used as when a request is for the same level of care covered by WV Medicaid. The only exception will be denial notices with the reasons listed will be sent to BCF's social worker, community services managers, and regional program managers via secure e-mail. APS will supply staff to provide necessary testimony and documentation for member fair hearings.

As a follow up to obtaining authorizations, children's residential providers will be subject to retrospective review on an 18-month cycle. The same review tools currently approved by contract management will be utilized regardless of payer source until criteria changes are made. Any changes made to retrospective review tools based on new criteria will also be approved by BCF. For out of state residential providers a psychiatric nurse will complete the retrospective reviews that will include medication administration, restraint/seclusion incidents, nursing services, physician's orders, and medication management practices.

Data analysis reports, annual focus group summary within 10 working days of completion, shelter reports if restarted and diagnostic reporting will be completed for BCF.

APS believes involving those receiving the service, the Bureau staff, and other stakeholders we manage for the Bureau helps provide quality assurance. In order to do this APS will provide at least 10 educational forums each year with a written summary of the event within two weeks to contract management. At least six focus groups per contract year will be completed utilizing the Bureau's approved list of questions for biological parents, foster parents, children and youth as well as Bureau workers and their supervisors. A written report of each focus group will be completed within two weeks of the event and provided to contract management.

APS will continue to develop/provide educational training and technical assistance to all stakeholders identified by the Bureau regarding policy, services available, service delivery models, the various types of

services other than socially necessary services available. Specifically, providers and workers will be kept apprised of service issues, the authorization process, as well as training on any new Utilization Management Guidelines approved by the Bureau. New providers will continue to receive Provider Orientation within 60 days and have their first retrospective review within six months of their company's initial authorization. The specific training for parents and foster parents as providers will continue to cover enrollment, registration, referral, authorization requests, and invoicing.

4.h APS will continue to review the agency self-assessments to determine the level of care on any new out of state providers who contract with BCF.

4.k.4 Clinical summaries will be completed on all youth in the custody of the Department, under the age of 11, and placed in out of state residential facilities. These summaries will include: diagnosis, functional assessment, symptom acuity, level of support, treatment history, and recommendations.

4.k.5 Clinical summaries will be completed on all youth in the custody of the Department, 17 years old or older, and placed in out of state residential facilities. These summaries will include: diagnosis, functional assessment, symptom acuity, level of support, treatment history, and recommendations.

4.k.6 APS will provide monthly reports regarding the number of post adoptive and parentally placed youth are in out of state facilities by location as well as a summary of those whose guardians are reported not to be participating in their child's treatment.

4.k.l APS staff member will provide consultation and support to BCF's field staff and supervisors regarding specific clinical cases and the youth's treatment needs for both in state and out of state children residential treatment.

5. BCF – PSYCHOLOGICAL EVALUATIONS

Vendor Response

APS-WV will require a PhD psychologist to determine medical necessity of psychological evaluations requests for cases involving the Bureau for Children and Families. These decisions may be required for instances of Special Evaluation requests and/or prior to Children's Residential placement. These determinations will be made in accordance with current federal and state policy guidelines. Plans of care, physician's orders, assessments, and any other pertinent documentation will be reviewed if available in order to make these determinations.

6. BCF – OPTIONAL SERVICES

a. Psychotropic Medication Review

a. Psychotropic Medication Review

Vendor Response

Fostering Connections was signed into law in 2008. One area in this Act requires the implementation of ongoing oversight and coordination of medical and mental health services by state child welfare and Medicaid agencies for all foster children. It specifically included the use of psychotropic medications. Along with the increased interest and studies triggered from this act, research regarding the effects of trauma on the brain has grown tremendously. Through this attention, we have learned/confirm that

children's reactions to trauma are frequently overlooked as a reason for behavioral issues and many times, mistaken for other mental health disorders. As WV's entry rate into foster care was more than twice the nation average in 2012, the potential for misuse or over use of psychotropic medications is also greater.

- A study completed by TUFTS in 2011 reported, "Over the past decade, psychotropic medication use in the general youth population has more than doubled. Estimated rates of psychotropic medication use in foster care youth, however, are much higher (ranging from 13-52%) than those in the general youth population (4%)."
- December 2013 issue of the *Archives of Psychiatric Nursing*, Julie Bertram, MSN, reported, "High rates of psychotropic medication use, poly-pharmacy and problems in continuity of care have raised alarms about whether youth in the foster care system may be receiving inappropriate treatments for the symptoms they present."

West Virginia is taking a very proactive step by making the review of psychotropic medications for foster children a standard procedure. For this option, we propose a secure web system in which could be designed for a physician's office or pharmacy to submit a prior authorization request for each psychotropic medication prescribed. An APS physician will review the medications for medical necessity as well as verify the medications are diagnostically and age appropriate. Once these determinations are made they would be transmitted to the pharmacy or physician's office and could be entered by APS Staff into the FACTS system if granted access or an electronic file with the determinations could be developed and passed through an FTP site like current SNS authorizations. Along with establishing, an electronic communication link/protocol between the Bureau and APS-WV a protocol should be established to reach the DHHR field staff directly in case immediate action is required.

b. Social Necessary Services Delivery System

b. Social Necessary Services Delivery System

Vendor Response

APS-WV is excited to have the opportunity to consult further about the Socially Necessary Services Delivery System. As BCF's current Vendor, our team members have participated in the design specifications and the ASO Meetings from the first day. The actual service delivery system has only had small modifications since its inception. Overtime through regularly interfacing with the Bureau's administrative, field staff, and all the different socially necessary services providers including parents and foster parents there have been many issues that have not been addressed and missed opportunities to improve child welfare services.

The Title IV-E waiver granted to BCF in October 2014 has provided an opportunity for our state to advance further and improve the State's outcomes for all children through Safe at Home West Virginia. A family's needs are much the same regardless if they enter the systems through a youth services or a child protective services case. It is an exciting opportunity to design a system of care to meet the real needs of children and families. The introduction of community based wraparound services used to return and keep children in their communities through Safe at Home is a dramatic step.

Some stakeholders have voiced concern that WV is returning to a model prior to the Socially Necessary Services program that should never have been abandoned and the Department of Justice's investigation barely scratches the surface of our State's problems. APS-WV sees this as a wonderful opportunity to

blend the structural components of the ASO with Safe at Home West Virginia's community based wraparound. The lack of structure via monitoring outcome measures and standardized implementation were the downfall of previous wraparound practices. We now use Results Based Accountability and evidenced-based practices/models based on ongoing research, and they demonstrate positive outcomes in child welfare practice. One example of successful model is Wraparound Milwaukee. When reviewing a presentation about their "lessons learned" many of the same issues they faced are ones WV continues to address but Wraparound Milwaukee was still successful.

Consulting about the socially necessary delivery system is also exciting because the state has a plan and definite vision. There are refined and raw pieces of a new system of care in this RFP. APS envision the Safe at Home West Virginia, the proposed Children with Serious Emotional Disturbance (SED) Waiver Services and Substance Use Disorder (SUD) Waiver Services working together to truly meet our children and families' needs. We would like to bring our experience with waiver services, behavioral health treatment and child welfare services to the DHHR's team.

k. CANS data Compilation and Distribution System

k. CANS data Compilation and Distribution System

Vendor Response

APS-WV can provide all raw assessment data elements captured in the CANS assessment administered for a client of Health and Human Resources in virtually any required format including CSV files, Excel, and Word. APS-WV also provides secure web-based options for data delivery, primarily via either secure email or SFTP. The APS-WV data warehouse allows our programmers and data analysts to make customize data fields and other information collection without any delay and with no added expense. Our parent organization KEPRO's system offers full transparency of the system and supporting data base structure, allowing for on-demand reports, queries, and extracts. In a recent CMS onsite audit of a contract that includes over 33.8 million covered lives, KEPRO provided on-site, data-driven support and hands-on illustrations that significantly contributed to the success of the audit. Through extensive data collection and analysis, KEPRO was not only able to produce CMS requested data, but a myriad of additional reports and tools that provided a global picture of KEPRO's contract performance.

To ensure the integrity of the data, we employ error-checking routines for all data received. For example, we conduct extensive comparisons of the downloaded file to previous download from that source to ensure that the data is in fact new and up to date. Specifically, we check:

- Compare the header record file creation date, time, and batch number to the same fields in the previously received file. Files with matching date time and batch number will be rejected. The record count in the header or trailer record will also be used as part of this comparison. This ensures that the data to be processed are in fact new and up to date.
- Any unique client ID included in the batch file will be verified.
- Record integrity will be verified using various edits. For example, valid record length, valid date values, field composition such as the presence of valid alpha and numeric values in correct positions, etc.

- The header or trailer record count for file records will be verified against the actual file record count prior to processing.
- A uniquely named copy of the file is stored on our server in the event reprocessing is required. The current date is incorporated in file names to help ensure data is not accidentally reprocessed.
- Check length and integrity of file before processing and report errors if any exceptions are found. All parties involved are notified should the procedure fail. This prompt notification starts the process of error identification and resolution and subsequent resubmission of a successful data transfer.

Once we confirm data are accurate, we upload it into our system and produce an edit/error report to validate the success of the transmission.

I. CANS-based Medical Necessity Establishment System

I. CANS-based Medical Necessity Establishment System

Vendor Response

This assessment, developed by Dr. John Lyons, a faculty member at the University of Ottawa, is meant to improve the lives of children and their families through analyzing what is needed for to serve the child and family best along the lines of service planning and decision making in addition to quality assurance monitoring. APS WV also recognizes that this tool is a pivotal point to assessing the needs of those who will be served in potentially multiple programs that are currently administered by APS-WV and potential future optional services in this RFP.

BCF has been working with Dr. Lyons to create a version of the CANS specifically for West Virginia that also contains a trauma component for longer than seven years. APS has participated in various activities related to the CANS including its use in the CAPS Programs and Individual Reviews. Three APS Socially Necessary Services employees have extensive backgrounds, including:

- Training from Dr. Lyons as CANS trainers.
- Extensive history administering, utilizing, and training trainers on the CAFAS (the tool currently being used to establish medical necessity for those children with mental health and/or substance abuse disorders).
- Direct and administrative experience providing behavioral health services and
- Direct and administrative experience providing child welfare services

With this combined knowledge and experience as well as APS WV's long history of serving as the ASO for all three Bureaus encompassed in this RFP, we feel confident and welcome the chance to develop, implement and maintain a procedure for the analysis of certain CANS data to establish criteria for medically necessary behavioral health services.

D. Bureau for Behavioral Health and Health Facilities

1. General Requirements

BBHHF provides funding for the support of and/or reimbursement for behavioral health services and programs for the citizens of the state of West Virginia. The majority of BBHHF services and programs are designed to supplement and support Medicaid covered services to ensure a statewide system of care and the availability of a full spectrum of services to meet the needs of all applicable individuals. The services to be covered by this contract are those direct services covered under Substance Abuse, Adult Mental Health, Children's Mental Health and Intellectual/Developmental Disability.

Vendor is to utilize established BBHHF definitions according to applicable policies and standards. Any deviation from these service definitions must have BBHHF prior approval. Vendor is to work collaboratively with the BBHHF and to perform functions necessary to support compliance with state and federal requirements including both the Mental Health and Substance Abuse Block Grants. The following is a listing of BBHHF specific services or programs requiring prior authorization. Specific codes or services may be subject to change due to changes in national codes, additions or changes in federal or state regulations, or changes in state BBHHF policy.

a. Indigent Care Program

a. BBHHF Indigent Care Program

Vendor Response

BBHHF administers a designated state funding stream for the purposes of providing Behavioral Health services to the citizens of the State of West Virginia who do not qualify for Medicaid but who are deemed indigent based on BBHHF eligibility criteria.

APS-WV clearly understands the Bureau for Behavioral Health and Health Facilities' (BBHHF) commitment to ensuring the availability and provision of community-based behavioral health services to our State's qualifying residents whom have the need for but no means by which to pay for said services. APS-WV pledges to continue to serve the Bureau through the administration of a two-tiered system, based on BBHHF's criteria for the reimbursement of indigent care services rendered by the comprehensive behavioral health centers. Firstly determining participant-level indigent care eligibility and secondly, evaluating each service requested for prior authorization of medically needed behavioral health or other Bureau-designated services based on established criteria while abiding by federal and state regulations and changes in BBHHF policy.

1. **This funding stream is state-designated to provide Behavioral Health Services for citizens who do not qualify for Medicaid but who are indigent.**
2. **The service array for the Indigent Care Program reflects West Virginia Medicaid's Clinic and Rehabilitation Behavioral Health Services (excluding Children's Residential Services); it should be administered in accordance with the same service delivery and utilization management requirements except as noted in this document.**

To enhance the accountability and ensure the delivery of defined and appropriate services to the State's vulnerable citizens, in 2012, BBHHF implemented a fee-for-service model in which outpatient behavioral health services would be reimbursed from the comprehensive behavioral health centers' indigent care allocations. The new BBHHF fee-for-service model called for utilization management of Medicaid's clinic

and rehabilitation outpatient behavioral health services for eligible indigent care persons, which remains the full service array today.

Since early 2012, APS-WV has managed the utilization of the Bureau's Indigent Care Program for Medicaid-like outpatient behavioral health services while adhering to the applicable West Virginia Medicaid Clinic and Rehabilitation Service requirements for prior authorization, service limits, and medical necessity criteria.

APS-WV, led by a Bureau designee(s) will determine the specifications of the Bureau's desired changes, as indicated in this document, and will make required system and/or practice modifications as appropriate.

1. The Indigent Care program is administered in collaboration with the State's thirteen (13) Comprehensive Behavioral Health Centers and is therefore limited to only those organizations.

   Over the past fifteen years of managing the utilization of Medicaid-funded behavioral health services for West Virginia, APS-WV has established meaningful working relationships with the thirteen comprehensive behavioral health centers, which are strategically located to serve our State. Furthermore, APS appreciates the thirteen comprehensive centers' unique reporting responsibilities to BBHHF resulting from the receipt of additional funding such as that for the Indigent Care program.

   1. Appalachian CHC
   2. Eastridge Health Systems
   3. FMRS Health Systems
   4. Healthways, Inc.
   5. Logan-Mingo Area Mental Health
   6. Northwood Health Systems
   7. Potomac Highlands Guild
   8. Prestera Center
   9. Seneca Health Services
   10. Southern Highlands CMHC
   11. United Summit Center,
   12. Valley Health System
   13. Westbrook Health Services

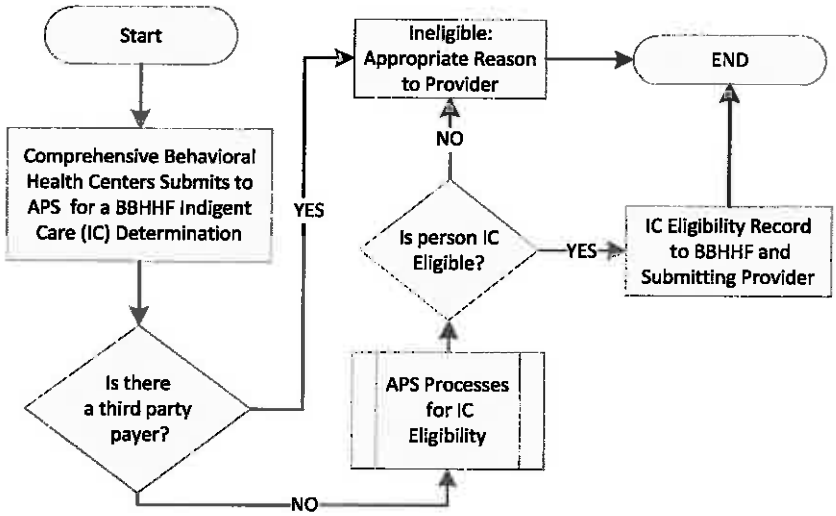
2. The indigent care program utilizes the following criteria for eligibility of participants, to be determined at admission and/or at service delivery:
   a. Individuals who are West Virginia residents;
   b. Individuals who are at or below 200% of Federal Poverty Level
   c. Individuals who have no other form of third party payer for the services they receive
   d. Individuals who are receiving services that are deemed medically or clinically necessary; and
      1) Have an eligible diagnosis consistent with Medicaid criteria; or
      2) Have a history of hospitalization for mental health, substance abuse, or developmental disability; or
      3) Live in a controlled setting such as a group home; or
      4) Receive supportive residential services; or
      5) Receive services as required by West Virginia Code Chapter 27, *Mentally Ill Persons;*
      6) Are in need of crisis services
      7) Are deemed "at risk" of involuntary hospitalization.

Since 2003, with the submission of defined information by a comprehensive center, APS-WV, on behalf of BBHHF, has determined individuals' indigent care eligibility through its APS System for Behavioral Health Services. This person-level eligibility permitted the Bureau to track the use of indigent care allocations to

each comprehensive center by way of the evaluation of rendered indigent care services as reported by each center in the Consumer Service Data Report (CSDR).

APS-WV will incorporate the new Indigent Care eligibility requirements, including that an individual must have *no other form of third party payer* for the needed behavioral health services into its current application). Put in practice, an individual with Medicaid coverage at the time of the BBHHF Indigent Care eligibility determination will not gain indigent care benefits due to failing this eligibility requirement, see *Figure 12 BBHHF Indigent Care Participant-Level Eligibility Determination*.

Figure 12 BBHHF Indigent Care Participant-Level Eligibility Determination



APS-WV will continue to accept necessary information from the comprehensive centers to determine BBHHF Indigent Care eligibility for individuals, including the new third party payer verification criteria.

1. Validate consumer's eligibility and process information through a common system assessment with a unique identifier assigned by the Bureau attributed to indigent care eligibility and utilizing the currently accepted DSM 5. APS-WV will implement the use of the International Statistical Classification of Diseases and Related Health Problems (ICD) Codes in its behavioral health services application.

   APS-WV will validate each individual's BBHHF Indigent Care eligibility for which a provider submits an indigent care funded request for prior authorization of service using the WV DHHR fiscal agent's daily eligibility full file feed. When found to have Indigent Care coverage for the requested start date of service and no other third-party payer, APS-WV will apply the current Medicaid prescribed clinical review applicable to each indigent care-funded request for prior authorization of a Medicaid-like service while adhering to current federal and state guidelines. The diagnostic data for BBHHF providers will include the use of the current International Statistical Classification of Diseases and Related Health Problems (ICD) codes.

2. Ensure all required data elements (enrollment and assessment data) and validations are provided prior to authorization of services.

   APS-WV values the Bureau's need for valid enrollment and assessment data, and will prevent the prior authorization of any Indigent Care funded service without receipt of the prescribed data submitted by the requesting comprehensive behavioral health center. APS-WV will work with the Bureau to determine the specifications of the data elements and the validations from which we can then develop data set collection and systemic validation.

3. Provide for the utilization of a real time online data collection and validation system for prior authorization of services.

   The APS System for Behavioral Health Services currently accepts electronic file transfers of requests for prior authorization of indigent care-funded services from the comprehensive behavioral health centers whom are the sole provider participants of the BBHHF Indigent Care Program. Additionally, the requesting of the prior authorization of Indigent Care-funded services, as well as, the BBHHF Data Segment is available for direct data entry in the online System.

   With the on-line system, validation of incoming data occurs on a real time basis, in that invalid entries, those failing to conform to specification are rejected by the online system, thus until all entries are valid, can the user submit the data set successfully. Conversely, validations of incoming data file records occurs as they process in batch. Accordingly, the system generates and makes available to the provider distinct messages of all validation infractions for each record that fails to validate.

   With Medicaid-like clinical criteria applied to each indigent care-funded request for prior authorization, some service requests can auto-adjudicate, but many require review by a West Virginia licensed professional to evaluate if the individual meets Medicaid's medical necessity standards for services requested, thus the clinical review of indigent care-funded requests is not a real-time activity. However, the provider may see a request's status on-line, and as clinical reviewer posts the outcome of his/her evaluation such as when authorized, the user will see the authorization number, start and end dates of the authorization period, and the units authorized immediately in the web-based System. Additionally, APS-WV makes downloadable files available to all providers via the website, commonly used by many providers to upload in their in-house information systems.

b. Comprehensive Service Data Collection

b. BBHHF Comprehensive Service Data Collection

BBHHF awards funding to community based behavioral health centers for the provision of prevention, treatment, recovery support, and other evidence based practices and programs that demonstrate success in improving outcomes and/or supporting recovery. These programs are all designed to enhance Medicaid, Medicare, and private insurance services, and therefore, many data and reporting elements are not fully integrated into the Medicaid data system.

Vendor Response

APS-WV understands the predominantly Medicaid-based utilization management system, in place since 2003, has not included many data and reporting elements needed for the BBHHF. APS-WV's incorporation of required data into existing data sets and/or the development of a standalone data set for the collection of data to meet the Bureau's reporting needs addresses these requirements in the Medicaid-based system and allows gathering of data critical to the BBHHF.

Collection and Reporting

1. As part of its responsibilities as the State Single Authority, BBHHF must collect and report varying levels of statewide enrollment, diagnosis, service and outcome data from its providers. Specific data sets and information needs are primarily based on the following Federal funds and reporting requirements:

   a. Substance Abuse Block Grant (SABG)

      CFDA Number: 93.959

      Authorization: Public Health Service Act, Subpart II and III, Title XIX, Part B, as amended by Public Health Service Act, Public Law 106-310, 42 U.S.0 300x.,

      http://www.samhsa.gov/sites/default/files/grants/sabg-reporting-16- 17.pdf

   b. Mental Health Block Grant (MHBG)

      CFDA Number: 93.958

      Authorization: Public Health Service Act, Subpart 1 and III, Title XIX, Part B, as amended by Public Health Service Act, Public Law 106-310, 42 U.S.0 300x.

      http://www.samhsa.govisitesidefault/files/grants/mhbg-reporting16-17.pdf

   c. Center for Mental Health Services (CMHS) Uniform Reporting System (URS) The URS data tables and performance measures incorporate indicators such as penetration rates, use of state hospitals, length of stay, employment, homelessness, major funding sources of services, evidence-based services, readmissions to state hospitals, living situations, criminal justice involvement, and school participation/performance.

      http://www.nri-inc.orgniqurs-forms--info/c1xvm

   d. Treatment Episode Data Set (TEDS),

      The Treatment Episode Data Set (TEDS) is a national census data system of annual admissions and discharges to substance abuse treatment facilities. In all States, treatment programs receiving any public funds are required to provide the data on both publicly and privately funded clients.

      http://wwwdasis.samhsa.gov/dasis2/teds.htm

APS-WV appreciates the State's Single Authority, the BBHHF, has the responsibility to garner data of the service, enrollment, diagnostic, etc. variety, which are vital to compliance with the above four Federal Funds' reporting requirements. We understand these requirements. In the next contract period, we will meet them with accurate and efficient data collection.

Basic Enrollment System

2. Develop and/or incorporate a basic enrollment system to include the collection of all data elements necessary to meet the data needs of the BBHHF. This enrollment data will be subject to annual review and modification to maintain consistency with all applicable federal and state requirements. (Attachment 1)

APS-WV will collect the data elements from BBHHF-funded providers necessary to meet the data needs of the Bureau for Behavioral Health and Health Facilities, specifically, the enrollment data presented in the CRFP *Attachment 2 BBHHF Enrollment Data Fields*, of which there are forty-eight.

Historically, the reporting requirements of the federal and state governments have at times differed from their previous version, making modifications necessary to the data collected from the BBHHF participating providers on behalf of BBHHF. Thus, the prescribed BBHHF Enrollment Data Fields annual review may require its revision.

Methodology to Establish Unique Service Counts

3. Utilize the enrollment data collected to establish a methodology for establishing unique and unduplicated numbers of individuals served.

APS-WV will develop a sound methodology for the identification of the distinct persons for which there was enrollment data submitted by a BBHHF participating provider.

While APS will provide the unduplicated counts of individuals reported to APS and receiving service authorization from APS, only the Bureau's fiscal agent can report those served through the compilation of claims paid for services rendered.

Supplemental Consumer Service Data

4. Develop and/or incorporate a supplemental consumer service data report set to capture service level data for BBHHF funded providers. (Attachment 2)
    a. This data set should capture the entirety of an organizations service provision to include Medicaid Services, Medicare Services, Third Party Payer, Indigent Care or Private Pay.
    b. The collection of information for the data may be incorporated into or in addition to service level data collected for Medicaid and Indigent Care.

APS-WV fully grasps the requirement of the BBHHF-funded providers to report all services rendered to their clientele, regardless of payer source. More specifically, the services provided are not restricted to only those paid by Medicaid, Medicare, Indigent Care, other Third Party Payers, or Private Pay, as there are services outside the traditional behavioral health CPT and HCPCS codes rendered and require reporting to the Bureau.

Staying Current with Federal Behavioral Health Reporting Changes

5. Provide a plan to stay current with Federal Behavioral Health Reporting changes and to utilize guidance as it is released and to update and modify the data collection system to meet the applicable requirements.

With the Bureau for Behavioral Health and Health Facilities guidance and approval, APS-WV will establish a meaningful plan to remain up-to-date with Federal Behavioral Health Reporting guidance and reporting changes. APS will share all information that may affect data collection with the Bureau once obtained.

On a scheduled basis, at the time of the annual review of the BBHHF data sets, APS-WV will offer recommendations for change to the data sets: Consumer Service Data Report, Enrollment Data Fields, and Data Segment fields that may be freestanding or incorporated into existing System data sets.

With the Comprehensive Behavioral Health Centers submitting nearly all data to APS-WV through file transfers, when data sets change need made, it requires centers' modification to both file layouts and in-house information systems. With this in mind, the centers need adequate time to understand the specifications, gather the requirements, develop, test, and implement new data sets.

Additionally, it may be judicious to require data set modifications as infrequently as is reasonable due to time constraints and expense the centers experience. Regardless of the frequency, allowing a minimum period from announcement to implementation of new data sets, perhaps five or six months, would be prudent.

Standardized Data Validation Measures

6. Developing and/or incorporating standardized data validation measures, which are subject to annual review and modification to maintain consistency with all applicable federal and state requirements their methods for soliciting and reconciling necessary changes from providers to ensure data accuracy.

Through a robust collaborative effort between the Bureau and APS-WV, we will establish a standardized set of data validation rules for the BBHHF-required data fields. Subsequent to this original development of the validation rules, a complete review of them, on an annual basis, will determine if any federal or state reporting requirements are cause for rule changes.

APS-WV will develop full methodology to identify, advise, then solicit and demand reconciliation of inaccurate data from the Comprehensive Behavioral Health Centers. For those seeking the prior authorization of BBHHF-Funded services, the related data must be correct before APS-WV can make an authorization determination of Indigent Care funded service requests. The enforcement of a defined timeframe for awaiting new data to reconcile faulty data will result in the request closing due to submission of inaccurate data once the time lapsed. The administrative closure of a service request for failing data validation and subsequently not submitting corrected data within timeline is the consequence and likely a motivation to submitting tidy data in order to obtain prior authorization and ultimately reimbursement for services rendered.

However, with no identified consequence for the submission of flawed data regarding non-BBHHF funded individuals and their services in the Consumer Service Data Report, data compliance may continue to suffer. Unarmed, APS-WV will actively provide education, technical assistance, and communication with providers in hopes of obtaining better data validation results. Finally, APS-WV will work with the Bureau to gain further insight and guidance regarding the means of improving valid data submission from participating entities.

Initial Training and On-going Technical Assistance

7. Provide initial training and on-going technical assistance for BBHHF providers regarding the system to ensure data is accurately being reported, validated, and submitted to the system and to troubleshoot any issues providers experience with reporting data to the system.

APS-WV will provide initial and as needed trainings to the Comprehensive Behavioral Health Centers with regard to BBHHF data expectations of their data sets, specific data validation rules, workflows, and communications. Additionally, the delivery of planned or impromptu technical assistance by phone, email, faxes, and when warranted, face-to-face, such as when a specific provider encounters data reporting problems and barriers is an APS priority. We recognize the criticality of premier customer service and are committed to its provision.

Ongoing Review of Submitted Data

8. Conduct an ongoing review of the submitted data in conjunction with the BBHHF and its designees, to resolve data quality and validity issues. This process should include holding data improvement meetings to address submission and transfer of applicable validated data sets to the BBHHF.

APS-WV will facilitate data improvement meetings with the Bureau, the BBHHF Comprehensive Behavioral Health Centers and/or both. Furthermore, APS-WV will develop a data-quality management system that will include the regular examination of submitted data, along with other evaluative measures, which APS-WV will employ in its effort to enhance the quality and validity of provider submitted BBHHF data. Additionally, APS with BBHHF will review submitted data to address quality and validity concerns. With the common goal of securing accurate, meaningful BBHHF data, with APS and the Bureau's support and assistance, the Comprehensive Behavioral Health Centers will clearly understand the criticality of, the reason(s) for, the definitions of, and the dependencies on valid data submission.

APS-WV will continue the transfer of data to the BBHHF, while adhering to the data set validation the Bureau prescribes.

2. BBHHF Optional Services

Vendor Response

Optional Service – Expands Service Data Reporting

a. BBHHF awards funding to numerous community based behavioral health organizations for the provision of prevention, treatment, recovery support, and other evidence based practices and programs that demonstrate success in improving outcomes and/or supporting recovery. These programs are grant funded and designed to supplement standardized services available to individuals in the community, and therefore, may be provided external to approved and standardized treatment services. This optional service expands the service data reporting to BBHHF funded entities that do not provide services on a Fee-For-Service basis or traditionally utilize a claims billing system.

Once BBHHF exercises this option, APS-WV will work diligently with the Bureau for Behavioral Health and Health Facilities on this Optional Service, which is to extend the data reporting of grant-funded programs supporting positive outcomes and recovery support. Rather than rendering defined services and related claims, these organizations provide prevention and (i.e., Prevention Physician Engagement, Prevention

Services - Regional, Prevention Services, (WV SADD) recovery support (i.e., Community Engagement Specialist, Peer Coaches, Peer Operated Recovery Facilities and Homes) outside of traditional treatment.

Support Collection of Data

1. As part of its responsibilities as the State Single Authority, BBHHF must collect and report varying levels of statewide enrollment, diagnosis, service and outcome data from its providers. Specific data sets and information needs are primarily based on the following Federal funds and reporting requirements:
   a. Substance Abuse Block Grant (SABG)
      CFDA Number: 93.959

      Authorization: Public Health Service Act, Subpart II and III, Title XIX, Part B, as amended by Public Health Service Act, Public Law 106-310, 42 U.S.0 300x.,

      http://www.samhsa.gov/sites/default/files/grants/sabg-reporting-16-17.pdf

   b. Mental Health Block Grant (MHBG)

      CFDA Number: 93.958

      Authorization: Public Health Service Act, Subpart 1 and III, Title XIX, Part B, as amended by Public Health Service Act, Public Law 106-310, 42 U.S.0 300x.

      http://www.samhsa.gov/sites/default/files/grants/mhbg-reporting16-17.pdf

   c. Center for Mental Health Services (CMHS) Uniform Reporting System (URS) The URS data tables and performance measures incorporate indicators such as penetration rates, use of state hospitals, length of stay, employment, homelessness, major funding sources of services, evidence-based services, readmissions to state hospitals, living situations, criminal justice involvement, and school participation/performance.

      http://www.nri-inc.org/tHurs-forms--info/c1xvm

   d. Treatment Episode Data Set (TEDS),

      The Treatment Episode Data Set (TEDS) is a national census data system of annual admissions and discharges to substance abuse treatment facilities. In all States, treatment programs receiving any public funds are required to provide the data on both publicly and privately funded clients.

      http://wwwdasis.samhsa.gov/dasis2/teds.htm

   e. National Outcome Measures System (NOMS)
      The NOMS system was developed jointly by SAMHSA, the states, and the District of Columbia and is designed to track and measure real-life outcomes for people in recovery from mental health and substance abuse disorders.

      http://www.samhsa.gov/grants/gpra-measurement-tools

APS-WV appreciates that the Bureau for Behavioral Health and Health Facilities, the State's Single Authority, has the responsibility to gather information and data related not only to activities and services

rendered, and to measure recipient outcomes, which are necessary to meet the above four Federal Funds' and the National Outcome Measures System's reporting requirements.

Develop and/or Incorporate Enrollment System

2. Develop and/or incorporate a basic enrollment system to include the collection of all data elements necessary to meet the data needs of the BBHHF with the enrollment data subject to annual review and modification to maintain consistency with all applicable federal and state requirements. (attachment 2 BBHHF Enrollment Data Fields)

In order to capture BBHHF required data for mandatory reporting, APS-WV will develop or incorporate a data set that includes those fields listed in the Enrollment Data Attachment, understanding on a yearly basis, the enrollment data set may require change to remain in line with federal and state requirements. The submission of the enrollment data set will be a requirement for each consumer served by the BBHHF grant-funded entities.

Use Enrollment Data to Establish Unique Numbers

3. Utilize the enrollment data collected to establish a methodology for establishing unique and unduplicated numbers of individuals served.

APS-WV will utilize incoming data from the grant-funded organizations to identify the unique persons served, which will allow for the reporting of the number of distinct persons served.

Develop Supplement Consumer Service Report

4. Develop and/or incorporate a supplemental consumer service data report set to capture service level data for BBHHF funded providers. This data set will incorporate non Medicaid or non-billable services as defined by the BBHHF (Attachment 3 BBHHF Consumer Service Data Report (CSDR) Fields)

APS – West Virginia understands the BBHHF funded providers are required to report all service level information, regardless of payer, as well as, non-billable services, which will be defined by the Bureau. Providers will submit this information to APS-WV for validation and transfer to BBHHF in the consumer service data report (CSDR) as defined in the CRFP Attachment: BBHHF Consumer Service Data Report (CSDR) Fields.

Collection of National Outcomes Measures

5. Develop and/or incorporate collection of National Outcome Measure System Data as prescribed by the BBHHF and Federal requirements. (Attachment 4 BBHHF Data Segment (BDS) Fields)

The BBHHF specified data elements, as outlined in the CRFP Attachment: BBHHF Data Segment (BDS) Fields will be collected from BBHHF-funded providers, validated, and transferred to the Bureau. The required data fields are dependent upon the applicable Federal requirements, thus may require modification when said requirements change.

Use a Variety of Data Collection Methods

6. Collect the required information through a variety of methods, including (but not limited to) reporting through a secure web-based portal, and/or File Transfer Protocol (FTP) uploads.

APS-WV will collect the data required of BBHHF-funded providers through electronic file transfers of the BBHHF enrollment data, BBHHF Data Segment, and Consumer Service Data Report. Additionally, applicable providers may direct-data enter both the enrollment and data segment data sets via the APS website. When the BBHHF exercises its optional services, a more diverse CSDR will be necessary to gather needed activity data. At that time, with the Bureau, APS-WV will gather the specifications for all newly needed data and develop web-based and/or file transfer protocol uploads as is most appropriate.

Stay Current with Federal Behavioral Health Reporting Changes

7. Stay current with Federal Behavioral Health Reporting changes and to utilize guidance as it is released and to update and modify the data collection system to meet the applicable requirements. This plan should include a process to assure the timely request, modification and implementation of system changes as needed.

With the Bureau for Behavioral Health and Health Facilities' guidance and approval, APS-WV will establish a meaningful plan to remain up-to-date with Federal Behavioral Health Reporting guidance and reporting changes. Essentially, APS will review all related Federal publications and monitor the aforementioned websites to remain current with planning changes, defining changes and coordinating the implementation of changes with the affected providers. As acquired, APS will share all information that may affect data collection with the Bureau.

On a scheduled basis, at the time of the annual review of the BBHHF data sets, APS-WV will offer recommendations for change to the data sets: Consumer Service Data Report, Enrollment Data Fields, and Data Segment fields that may be freestanding or incorporated into existing data sets.

Standardized Data Validation Measures

8. Developing and/or incorporating standardized data validation measures, which are subject to annual review and modification, to maintain consistency with all applicable federal and state requirements.

While likely the validation rules developed during our work regarding the BBHHF Mandatory Services section of the CRFP, this optional service will call for additional collaboration between the Bureau and APS-WV to establish a standardized set of data validation rules for the BBHHF Enrollment, CSDR and BDS data fields. Annually, together, we will conduct a complete review of the validation to determine if any federal or state reporting requirements are cause for rule changes.

Provide Initial Training and Ongoing Technical Assistance

9. Provide initial training and ongoing technical assistance for BBHHF providers regarding the system to ensure data is accurately being reported, validated, and submitted to the system and to troubleshoot any issues providers experience with reporting data to the system.

APS-WV will provide initial and as needed trainings to the BBHHF-funded entities with regard to the BBHHF data expectations of their data sets, specific data validation rules, workflows, and communications. Additionally, technical assistance by phone, email, faxes, and when warranted, face-to-face, such as when a specific provider encounters data reporting problems and barriers is an APS priority. APS-WV is committed to providing timely, relevant customer service to participating organizations.

Conduct Ongoing Review of Data

10. Describe their plan to conduct an ongoing review of the data in conjunction with the BBHHF and its designees, to resolve data quality and validity issues. This process should include holding data improvement meetings to address issues, as appropriate.

APS-WV will marshal data improvement meetings with the Bureau, the BBHHF Comprehensive Behavioral Health Centers and/or both. Furthermore, APS will develop a data-quality management system that will include the regular examination of submitted data, along with other evaluative measures, which APS-WV will employ in its effort to enhance the quality and validity of provider submitted BBHHF data. Additionally, APS with BBHHF will review submitted data to address quality and validity concerns. With the common goal of securing accurate, meaningful BBHHF data, with APS and the Bureau's support and assistance, the Comprehensive Behavioral Health Centers will clearly understand the criticality of, the reason(s) for, the definitions of, and the dependencies on valid data submission.

APS-WV will continue the transfer of data to the BBHHF, while adhering to the data set validation the Bureau prescribes.

Monthly Submission and Transfer

11. Perform monthly submission and transfer of applicable validated data sets to the BBHHF.

APS Healthcare will modify the frequency of the transfer of applicable data sets to the Bureau as directed by BBHHF. Currently, all data transfers on a workday daily basis to BBHHF, however, with the need for the development and application of extensive validation of incoming data from BBHHF-funded organizations, the identification, and reconciliation of invalid data with submitters will require time.

Expansion of Service Data Reporting

b. BBHHF awards funding to numerous community based organizations for the purposes of maintaining service capacity or for provision of peer services. These programs are grant funded and are not provided in a clinical or treatment setting. This optional service differs from item a as described above in that this expands the service data reporting to BBHHF funded entities that do not provide either clearly identifiable services or to clearly identifiable individuals.

Once exercised, APS-WV will work diligently with the Bureau for Behavioral Health and Health Facilities on this Optional Service, which is the reporting of specialized data, distinct to programs to which BBHHF awarded funds with the goals of peer services provision and maintaining community-based service capacity.

Develop Data Collection System

1. Develop a data collection system to gather information regarding service data.

These organizations have unique reporting requirements in that they do not provide clearly identifiable services to clearly identifiable individuals. The CSDR therefore may not be an appropriate mechanism to use for such reporting. Upon execution of this optional service, BBHHF and APS-WV will identify the means by which to report and secure specifications to ensure the Bureau's information needs are met. Subsequent to that activity, the specified reporting system's development and implementation of by APS-WV will allow for the collection of the information required from this funded group.

Collection Information through a Web-based Portal

2. Collect the required information through a web-based portal.

The unique reporting requirements among the BBHHF funds-awarded organizations are diverse, thus the specifications for each data set may call for the reporting of distinct data sets. The rapidity by which APS-WV can gather the specifications of each program's reporting requirements, then complete the mapping of common data elements for a web portal with general data entry for all programs and specialized web pages for the collection of unique data among the programs, drives the timeline for implementing the portal. Once exercised, APS will dedicate local and corporate resources to expedite the development efforts for this optional service.

Stay Current with Federal Behavioral Health Report Changes

3. Utilize guidance as it is released to stay current with Federal Behavioral Health Report changes and to update and modify the data collection system to meet the applicable requirements.

APS-WV will remain up-to-date with Federal Behavioral Health Reporting guidance and identify needed reporting changes to this optional service's expanded, unique-to-program, web portal's service/activity reporting program.

Standardized Data Validation Measures

4. Developing and/or incorporating standardized data validation measures, which are subject to annual review and modification to maintain consistency with all applicable federal and state requirements. Vendor should describe their methods for soliciting and reconciling necessary changes from providers to ensure data accuracy.

While likely the validation rules developed during our work regarding the BBHHF Mandatory Services section of the CRFP will not suffice, this optional service will call for additional collaboration between the Bureau and APS-WV to establish a standardized set of data validation rules for the required unique reporting by this group of organizations. Annually, together, we will conduct a complete review of the validation rules to determine if any federal are cause for rule changes.

Initial Training and Ongoing Technical Assistance

5. Provide initial training and on-going technical assistance for BBHHF providers regarding the system to ensure data is accurately being reported, validated, and submitted to the system and to troubleshoot any issues providers experience with reporting data to the system.

APS-WV will provide initial and as needed trainings to the BBHHF-funded entities with regard to the BBHHF data expectations of their specific data set and data validation rules. Additionally, technical assistance by phone and email will be provided when requested. Our commitment to providing responsive, meaningful customer service to these organizations is firm.

Produce Monthly Service Level Reports

6. Produce, on a monthly basis, service level reports regarding each provider on a county, regional, and statewide level.

In the agreed upon format with the agreed upon information and data derived through a collaborative effort with the Bureau of Behavioral Health and Health Facilities, APS-WV will generate monthly service-level reports of each provider on a county, regional and statewide basis.

Opportunity for Administration through Utilization management

c. BBHHF awards funding for the provision of Behavioral Health Community Support Services for the citizens of the state of West Virginia. Currently these agreements are administered through utilization of grant agreements but due to the nature of the services the opportunity exists to administer through utilization management and claims processing.

Familiar with the Bureau-awarded funding to organizations for the provision Community Support Service, historically administered through grant agreements, APS-WV recognizes the said services could be individually defined and incorporated in its existing utilization management system.

Incorporate Community Support Services into Existing UM System

1. Incorporate community support services into an existing utilization management system.

APS-WV will incorporate the Support Services in its existing utilization management system. The ease of this incorporation is dependent upon the information/data required and complexity of each service's prior authorization criteria. Thus, APS-WV looks forward to working with the BBHHF to secure service definitions, utilization management criteria, and service limitations and/or restrictions. Once established, the needed data to make authorization decisions will be identifiable and the gathering of specifications for incorporation into the APS System will be approved, with requirements, development, QA testing, end-user testing and implementation scheduled and occurring.

Utilize Community Support Services Criteria

2. Utilizes the following Community Support Services criteria for eligibility of participants, to be determined at admission and/or at service delivery:

   a. Individuals who are West Virginia residents; and
   b. Individuals who have no other form of third party payer for the services they receive; and
   c. Individuals who are receiving services deemed medically or clinically necessary.

APS-WV will make the determination of an individual's eligibility to participate in the community support services program based on the aforementioned criteria at the time of each provider submission of a request for prior authorization of a support service. With the understanding that all eligible participants must be West Virginia residents, have no other form of third party payer for the services they receive and are receiving services which are medically or clinically necessary.

Use Established BBHHF Definitions

3. Utilize established BBHHF definitions according to applicable policies and standards.

APS-WV will use the BBHHF established community support service definitions according to applicable BBHHF policies and standards in the utilization management processes and system.

Work Collaboratively with BBHHF

4. Work collaboratively with the BBHHF and to perform functions necessary to support compliance with state and federal requirements.

APS-WV will work in collaboration with the Bureau for Behavioral Health and Health Facilities to perform the necessary functions that support compliance with both state and federal requirements. By remaining abreast of both Federal guidance and requirements and our State laws and stipulations, BBHHF and APS-WV will ensure conformity with governance.

Validate Consumer's Eligibility

5. Validate consumer's eligibility and process information through a common systems assessment with a unique identifier attributed to indigent care eligibility. This assessment should utilize the currently accepted International Statistical Classification of Diseases and Related Health Problems (ICD) Codes.

Using a common assessment among BBHHF providers and the BBHHF assigned unique member identifier attributed to indigent care eligibility, APS-WV will make the determination of an individual's eligibility to participate in the community support services program based on the aforementioned criteria at the time of each provider submission of a request for prior authorization of a support service.

The assessment will include the use of the current International Statistical Classification of Diseases and Related Health Problems (ICD) codes, however at this time the common system assessment is utilizing the DSM 5, sanctioned by the Bureau for Medical Services, for behavioral health services. APS will work with BMS and BBHHF to incorporate the ICD-10 in the system.

Consumer Satisfaction Surveys

d. To ensure the BBHHF is providing services that are high-quality and person-centered, the BBHHF administers several consumer satisfaction surveys that are completed by consumers receiving behavioral health services within the state. Currently, three (3) nationally recognized surveys are being used: the Mental Health Statistics Improvement Program Consumer Survey (MHSIP), the Youth Services Survey (YSS), and the Youth Services Survey for Families (YSS-F). Vendor should describe their plan to implement, administer, and report results from consumer satisfaction surveys for all behavioral health services within the state. This plan should address the following items:

Methodology

1. Vendor's methodology to administer the three (3) consumer surveys mentioned above. This methodology should include Vendor's plan for sampling a representative group of consumers, disseminating the survey, achieving acceptable response rates, and validating and cleaning survey response results. This methodology will be subject to annual review and

modification to maintain consistency with any applicable federal and state requirements, as well as common survey research methods and practices.

On behalf of the Bureau for Behavioral Health and Health Facilities, APS-WV conducted the youth satisfaction surveying over the past contract periods. Each survey year, APS used the Bureau's prescribed YSS and the YSS-Family surveys. The 2014-2015 Youth Survey Report may be found in the Exhibits Binder, Exhibit 48.

With regard to possible upcoming consumer satisfaction surveys, APS-WV will obtain the Bureau's approval of the final survey methodology. APS-WV understands the Bureau wants a representative sample of the State's behavioral health consumers. Thus, we suggest using age groups as defined by the prescribed Surveys, regions of the state, and intensity of services authorized as the factors by which to stratify the population. The compilation of the unduplicated counts of the persons with a behavioral health service authorization in the aforementioned categories will provide the population numbers and persons from which to draw a sample. Figure 13 shows these possible population groups. The sample size for groups in Figure 13 should provide a confidence level of 90% for each subset with a sampling error of 10%. At the age, region, or intensity level, compiling the results allows for a higher confidence level (95%) and lower sample size (5%).

Figure 13 Possible Population Stratification and Sample Sizes

AGE: ADULTS	High Intensity Services	Moderate Intensity Services	Low Intensity Services
Region 1			
Region 2			
Region 3			
Region 4			

AGE: 13-17 YEARS	High Intensity Services	Moderate Intensity Services	Low Intensity Services
Region 1			
Region 2			
Region 3			
Region 4			

AGE: < 13 YRS FAMILY	High Intensity Services	Moderate Intensity Services	Low Intensity Services
Region 1			
Region 2			
Region 3			
Region 4			

APS-WV follows a standard methodology to conduct surveys:

- APS-WV conducts random selection from each group (Adult, Region 1, High Intensity Services| Adult, Region 1, Moderate Intensity Services|, and so forth) in the number calculated as a representative sample of the group.
- APS-WV obtains addresses and phone numbers through the APS System and/or the State fiscal agent's eligibility records.

- Conduct telephonic and USPS mail surveying (with an addressed and stamped envelope included for the respondent to return the survey to APS-WV).

Additionally, APS-WV will conduct face-to-face surveying on a convenience-sampling basis such as prior to a focus group of persons with behavioral health disorder, consumer educational session by our APS Community Affairs staff, etc. APS will maintain the segregation of these convenience samples from the representative sample surveys.

APS Healthcare will compile the three Surveys' results as required to meet the Bureau's consumer satisfaction reporting needs. When received, a review of each survey for the identification of indecipherable responses, (e.g., the circled response is between two responses, thus the reviewer cannot determine which response was intended) or disallowed responses to survey items (writing in a response of 4.5 when the allowed responses are 1, 2, 3, 4, or 5). When found, APS-WV excludes these specific item responses and includes other elements as possible. One staff member then keys the survey responses, using a primary key both in the database and on the hardcopy, followed by a different staff member who conducts a quality check to ensure the hardcopy survey responses match the keyed responses, with correction of identified errors.

APS then compiles the survey results in the required way for completion of the data requested in the Summary Profile of Client Evaluation of Care (Table 11) of the Block Grant Report, which includes:

- Client perception of Care:
  - Access
  - Participation in Treatment
  - Cultural Sensitivity
  - Satisfaction
  - Outcomes
- Additional information contained in the report includes:
  - Percentage of Consumers linked to physical health services
  - Percentage of Children in family-like arrangements
  - Percentage of Children in residential care

APS-WV prepares an additional summary of the YSS-F Results of Social Connectedness, Arrests, School Attendance/Absences, and Suspensions/Expulsions as requested by the Bureau.

Support BBHHF Preparation of the Community Mental Health Services Block Grant

9. Use of survey results to meet the needs of BBHHF in preparation of the Community Mental Health Services Block Grant in accordance with any and all federal reporting changes in relation to the above mentioned reports and the ability to incorporate changes into the existing system.

APS-WV will compile the three Surveys' results as needed to meet the Bureau's consumer satisfaction reporting required of the Community Mental Health Services Block Grant and in accordance with federal reporting changes in relation to consumer satisfaction surveying. APS will incorporate identified changes needed into the existing surveying model.

Vendor Response

Utilization Management Vendor Determination

A. Healthcare practitioners who furnish healthcare services or items for which payment may be made (in whole or in part) by the Agency have certain obligations that must be met. These obligations are to ensure that services or items are provided economically only when and to the extent they are medically necessary, of a quality that meets professionally recognized standards of healthcare, and supported by the appropriate documentation of medical necessity and quality. The UM Vendor's determination for medical necessity is considered conclusive for Medicaid payment purposes.

APS-WV understands that our determination for medical necessity is conclusive for Medicaid payment purposes, and for this reason provides exceptional quality assurance efforts to ensure those determinations are reliable, timely, and appropriate.

Peer to Peer Review

B. Establish procedures to implement and perform a proper peer-to-peer review for the denial/reduction of a service or item that did not meet the Agency's medical necessity requirements. This peer-to-peer review allows the ordering provider and the physician reviewer to discuss why the requested service did not meet medical necessity requirements.

There are subtle differences between peer-to-peer requirements in the Behavioral Health and Medical Utilization Management programs, and for this reason, we discuss them independently.

Behavioral Health Services.

APS-WV understands the requirements for the Peer–to-peer review between the behavioral health provider physicians and the APS Physician Consultant (Reviewer). During the denial process or a reduction in service, providers have the opportunity to elect to have a peer-to-peer discussion. The provider has seven (7) days to elect to exercise the peer-to-peer request. APS-WV would like the opportunity to review this timeline with the Bureau. Following the peer review, the request may be authorized based upon the discussion or denied due to lack of medical necessity. For many years, cases eligible for peer-to-peer discussions are those involving adolescents under the age of twenty-one (21). In the event the Bureau wishes to require peer-to-peer reviews for all age groups, APS will comply with this mandate.

APS will record the outcome of the Peer-to-Peer decision in the APS System within one business day of receipt. If a denial decision is rendered, applicable denial notices will be sent to all parties that include identification of criteria not met during the review. Exercising the option of the peer review does not remove the provider and member's option for further appeals if a denial is issued. Providers may proceed to request a Level II reconsideration review and Members may request a Fair Hearing if the reconsideration is unsuccessful.

Medical Services

Providers have the opportunity to elect a peer to peer when the initial APS Physician Consultant has reviewed the case information and determined medical necessity is not present or a reduction in service

is appropriate. APS-WV will notify Providers of the initial physician's conclusion; providers will also receive notification of their option to hold a peer to peer. This notification will be conveyed verbally and electronically requesting the provider respond in writing their desire to have a peer review or lack of intent to have one. APS-WV staff will notify the provider and send the peer-to-peer request form on same day the physician review makes the denial decision. Currently, providers have seven (7) calendar days to acknowledge the peer-to-peer request. APS-WV would like to collaborate with the Agency to review response timelines related to peer review requests.

UM staff will document the Peer-to-Peer decisions in the APS System within one business day of receipt. APS-WV will also notify Providers verbally of the outcome. The peer-to-peer decision will be included in the denial notifications to all parties in addition to the criteria not met during the initial review.

APS-WV staff will proactively notify the Agency when our reviewers or others suspect fraud, waste, or abuse. We will notify a designated representative from the Bureau for Medical Services and any other applicable Bureaus (e.g., Bureau for Children and Families for custody children) within one business day of identifying a concern. APS-WV will also provide notification of fraud, waste, and abuse when the health, safety, or welfare of an individual is at risk within one business day (24 hours) to the Bureau. APS staff will receive training on recognizing these issues and maintain formal procedures for reporting.

Fraud, Waste, and Abuse Protection

C. Ensure the utilization review policies and procedures include procedures to identify potential cases of fraud, waste, and abuse proactively, including notification to the Agency about potential cases. The Vendor shall also include the identification of fraud, waste, and abuse in staff training.

APS-WV supports the ongoing effort to safeguard the Agency's program against unnecessary and inappropriate use of services and to ensure appropriate patient care. We are dedicated to detecting, avoiding, preventing, and mitigating Fraud and Abuse. Through education, communication, and application, our Compliance Plan achieves these ends and is a resource guide that describes the following:

- Overview of the processes in place to minimize or eliminate those concerns
- Individual roles and responsibilities in understanding and addressing Fraud and Abuse
- Controls KEPRO/APS has in place for the prevention and detection of potential or suspected abuse and fraud by KEPRO/Aps employees, subcontractors and providers and enrollees.

The Compliance Plan is kept in an electronic file that is accessible and is required reading for all employees. The Compliance Plan is a living document and will continue to evolve based on system improvements, changing organizational structure, government requirements, and in response to revisions to KEPRO corporate policy. APS-WV utilization review policies and procedures include procedures to identify potential cases of fraud, waste, and abuse proactively, including Agency notification about potential cases.

Notification of Fraud, Waste, and Abuse

D. Provide notification of fraud, waste, and abuse when the health, safety, or welfare of an individual is at risk directly to the Agency within twenty four (24) hours of identification of potential cases.

Maintaining an open line of communication between the vendor and the Agency is critical to the successful implementation and operation of the compliance program.

- Suspected fraud, waste and abuse reports are investigated internally immediately by the vendor to determine their authenticity.
- APS will report suspected fraud, waste, and abuse when the health, safety, or welfare of an individual is at risk directly to the Agency within twenty-four (24) hours of identification of potential cases.
- APS will cooperate with all fraud, waste, and abuse investigation efforts by State and Federal offices.
- APS will provide a quarterly summary report of suspected fraud, abuse and/or misuse, as outlines in Appendix 3, The Agency – Specific Reporting Requirements; R15.

III. Staffing Requirements

A. Sufficient Resources

A. The Vendor should have sufficient physical, technological, and financial resources to conduct UM services that can address the unique needs of members while assuring services are provided in the most economical manner in order to meet the requirements of this CRFP. The Vendor should provide sufficient administrative and organizational staff to implement the provisions and requirements of the contract and for fulfillment of the contractual obligations.

Vendor Response

APS-WV maintains a full complement of staff with the appropriate and relevant clinical licensure, experience, and training to perform all scope of activities for the current contract and the next contract period. Our unequalled record of performance substantiates the adequacy of our physical, technological, and financial resources to meet contract requirements—meeting the unique needs of members with transparent, efficient, and economical review processes. The acquisition of APS Healthcare by KEPRO, a premier Quality Improvement Organization and national utilization management vendor for the Department of Defense and Medicaid agencies created a robust organization with the experience and expertise to meet the future needs of the Department with the same member-centered, exemplary customer service the Department expects.

B. Staffing & Key Personnel

B. The Vendor should provide sufficient staff to perform the required tasks within performance standards. At a minimum, the Vendor must employ the following key personnel by Operational Start Date: a) Project Manager; b) Deputy Project Director or Chief Operations Officer; c) Medical Director d) Dental Director e) Education Manager; and f) Information Systems Manager.

Vendor Response

APS-WV provides sufficient staff to perform all contract tasks within performance standards, and will have the required key personnel on staff as of the operational start date:

- **Project Manager: Jennifer W. Britton, PhD, is designated as the Project Manager across all programs. Julie Wright, Implementation Manager, will serve as Project Manager for the Implementation (shown in the Implementation Organization Chart in Appendix 2).**
- **Deputy Project Director or Chief Operations Officer: Helen Snyder, MA, LPC, LCSW is designated as the Deputy Project Director.**
- **Medical Director: Norman Montalto, MD. is the Medical Director.**
- **Dental Director (modified in the Q&A document to be a Dental Consultant): Dr. Chris Taylor, DDS, is the Dental Consultant.**
- **Education Manager: Caroline Duckworth, MSW, LCSW, is designated as the Education Manager.**
- **Information Systems Manager: Rebecca Jamnick is designated as the Information Systems Manager.**

C. Personnel Changes

C. The Vendor should notify the Agency in writing of any key staff resignations, dismissals, or personnel changes in accordance with current federal and state policy guidelines of the occurrence. Should any key position become vacant, the Vendor must notify the Agency immediately and provide information on the replacement in accordance with current federal and state policy guidelines. The Agency shall have the right to participate in the selection process and approve or disapprove the hiring of any key staff positions.

1. The Agency reserves the right to approve or disapprove Vendor's key personnel, or to require the removal or reassignment of any personnel found by Medicaid to be unwilling or unable to perform the terms of the contract.

Vendor Response

APS-WV understands this requirement and agrees to comply with it.

D. Training & Experience

D. The Vendor should ensure that all staff has the training, education, experience, and orientation to conduct activities under the contract resulting from the CRFP. At a minimum, the Vendor shall:

1. **Ensure that all physician reviewers meet qualifications required in state and federal regulations.**
2. **Provide all key personnel and other supervisory staff with project management training.**
3. **Provide staff with intensive training on procedures, medical necessity criteria, and the Agency policies.**
4. **Ensure that staff is knowledgeable of West Virginia Medicaid and other State healthcare programs, and related federal and State laws and regulations.**
5. **Ensure that all staff has a current professional licensure in the State of West Virginia. Exceptions can only be approved by the Agency**

Vendor Response

Hiring and Credentialing

As our resumes and job descriptions in Exhibit 1 and 2 indicate, APS-WV conducts an exhaustive evaluation process prior to onboarding a candidate to ensure that licensure is appropriate (West Virginia, unrestricted), that education and training meet requirements, and that background checks are according to APS-WV and KEPRO policy. This process ensures that:

- **Staff and Physician Reviewers have appropriate and current licensure, and Board Certifications.**
- **Required years of experience in specific specialties as indicated by Job Descriptions.**

Training Approach

Our training program ensures staff receives current information on policies and procedures and remains updated on issues that affect performance. This information includes new federal and state initiatives as well as information regarding the routine flow of information among APS, the Department and other contracted partners. We will conduct a Program Expansion seminar for all current employees that highlight proposed changes in operations or procedures under the West Virginia programs. This training

is in addition to regularly scheduled staff meetings/briefings, annual training sessions on topics such as HIPAA-Compliance and certification, and the written communications and updates that occur each time there is a change in workflow or desk level procedures.

APS-WV ensures cohesive operations by providing all new employees with a comprehensive, multi-faceted training program. The goal of our initial staff training is to ensure all staff members have the tools and sufficient knowledge to deliver required program services effectively. New staff members will receive an initial orientation to APS-WV and the Bureaus' programs, detailed information on requirements and targeted advanced training depending on job assignments within the program. Advanced training includes competency demonstration via role-play, testing, or skill observation. APS-WV bases proficiency testing a combination of testing criteria to measure immediate results for each individual participant. We use content validation of knowledge, skills, and abilities based on field-testing and research studies/analysis of testing materials and reports. The following paragraphs outline our training program.

Training Program – Phase I

During the first week, staff members are oriented to the company through a series of courses outlining company history and mission. We also use this timeframe to teach staff the clinical philosophy of the company and to introduce many of the clinical policies and procedures. Key areas of focus during the first week of training include:

- Corporate Overview
- Human Resources Orientation
- Business Ethics/Code of Conduct
- Corporate and Office Structure
- Staffing and Responsibilities
- Performance Standards and Measurement
- Time Management
- Quality Management Program
- Confidentiality Guidelines/ HIPAA
- Customer Service Excellence

Training Program – Phase II

After the general orientation, we train staff members in the specific policies and procedures related to their service area and its related systems. This training includes:

- Introduction to the West Virginia Programs and their goals, objectives and program components
  - State and Federal Medicaid and other regulatory requirements
  - CMS Quality Assurances and Sub-Assurances for Waivers
- Review and Referral Protocols
  - Roles, functions and coordination with external entities
  - Project Management
- Call center standards and performance expectations
- Use of the APS System for specific Bureau programs (e.g., Medical, Social Necessity, Behavioral Health, etc.)
- Physician/Provider education, outreach and interface
  - Credentialing and selection of appropriate specialties of Physician Reviewers

- Practical application exercises and assignment of preceptors

We also focus on technical assistance sessions to teach our staff how to coordinate interact and refer to key state organizations and any contracted vendors through the proper channels. We also address the program web site, the APS System, and other important links so that staff understands capabilities and can successfully navigate to important information.

E. Agency Notification of Proposal or Staffing Changes

E. The Vendor should notify the Agency in writing within five (5) work days of any temporary or permanent changes to personnel commitments made in the Vendor's proposal or the Agency approved staffing plan.

Vendor Response

APS-WV agrees, and will notify the Department in writing within five (5) workdays of any staffing change as required by this item.

F. Staff Turnover Rates

F. The Vendor should provide the Agency with its staff "turn-over" rates at the request of the Agency. In the event the Agency determines based on Vendor's performance and/or application of Service Level Agreement (SLA) penalties that the Vendor's staff or staffing levels are not sufficient to properly complete the services specified in the CRFP and the resulting contract, it shall advise the Vendor in writing. The Vendor shall have thirty (30) calendar days to remedy the identified staffing deficiencies.

Vendor Response

We understand this requirement and agree. The Department will notify APS-WV in the event there are concerns with turnover rates, and APS-WV will comply and remedy any staffing deficiencies within 30 days. APS-WV recently completed insourcing work previously conducted by a subcontractor, and therefore welcomed a cohort of new staff members with tenure less than one year. For work that APS-WV previously performed, the overall staff average tenure is 5.9 years. Our turnover is therefore historically very low, and we understand the interest of the Department in avoiding changes in staff. Our proactive recruitment and retention approach is highly successful in preventing avoidable turnover, and we appreciate the Department's interest in this important metric.

G. Staff Availability

G. For administrative purposes, the Vendor should have staff available at their office location during normal business hours. The Vendor's designated office location should be within fifteen (15) miles proximity of the State Agency or Medicaid Bureau located at 350 Capitol Street, Charleston, West Virginia. Normal business hours are defined as 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding State observed holidays.

Availability of Staff and Telecommuting

1. The Vendor should maintain a sufficient (as defined by the Agency) percentage of clinical review staff who will perform their job function under the resulting contract in the designated office location. The Vendor should receive the Agency approval in order to allow staff to telecommute. The Agency reserves the right to approve or disapprove the number of staff allowed to telecommute.

Vendor Response

APS-WV maintains a fully staffed office to meet contract requirements and deliver exceptional customer service at our integrated Call Center. We identify office-based and field-based staff in Table 1; the management team expects office-based staff to be present in the office unless exceptional circumstances intervene. We understand that the Department reserves the right to approve or disapprove telecommuting staff.

APS-WV maintains its office at 100 Capitol Street, Charleston, West Virginia, with normal business hours between 8:00 AM and 5:00 PM, Monday through Friday, excluding State observed holidays. Staff is available at the location during these hours.

H. Changes to Vendor Location

H. The Agency must prior approve any changes to the Vendor office location or when any of the Vendor contractual obligations will be performed at a different site other than the designated office location.

Vendor Response

APS-WV understands this requirement and agrees. The Executive Director is responsible to notify the Department in advance in the event of a change in location for any function, and will provide ample notice to ensure the Department can review our plans and make an appropriate decision.

I. Availability for Meetings

I. The Vendor should make its staff available to meet with the Agency staff on a schedule, as agreed to by the Agency and the Vendor, to review reports and all other obligations under the resulting contract as requested by the Agency. The Vendor should meet in person or by telephone at the request of the Agency, at least monthly, and as required by the Agency, to discuss the status of the resulting contract, Vendor performance, benefits to the Agency, necessary revisions, reviews, reports, and planning.

Vendor Response

The main office of APS-WV is within walking distance of the Department's offices, providing expedited access to staff members for meeting as required by this item. APS-WV agrees that staff will be available on a schedule as we agree with the Department, in person or by telephone monthly and as requested.

J. Liquidated Damages – Key Personnel Vacancies

J. The Agency may assess liquidated damages in the amount of $100 per workday for failure to fill key personnel vacancies within sixty (60) days of a vacancy.

Vendor Response

APS-WV understands the Agency may assess liquidated damages for failure to fill key personnel vacancies within sixty (60) days of a vacancy. We agree to this requirement. With an average of tenure of over 13 years for key personnel on the existing and previous contracts, previous contract performance demonstrates our ability to meet this requirement with no assessment of liquidated damages.

K. Liquidated Damages – Agency Notification

K. The Agency may assess liquidated damages in the amount of $100 per workday for failure to notify the Agency in writing within five (5) work days of any temporary and permanent changes to personnel commitments made in the Vendor's proposal or the Agency approved staffing plan.

Vendor Response

APS-WV understands that the Agency may assess liquidated damages for failure to notify the Agency concerning temporary or permanent changes to personnel. We agree to this requirement. A long-term vendor, APS-WV maintains a fully staffed project roster to meet contract requirements with no assessment of liquidated damages over the past 15 years.

IV. Systems Requirements

Throughout our proposal we have described our specific approach to provide UM/PA services to the state of West Virginia in accordance with Federal and State regulations. We will summarize that approach in the following sections.

A. Management Information System Objectives

Vendor Response

Our systems support compliance with state and federal requirements at multiple levels in the process. The foundation of our approach is an efficient system configured for individual program requirements. We designed the APS System to support the specific policies and approved medical necessity criteria for the review areas specified in the RFP, policy, and regulations. Specific fields are mandated and validated in the applications to ensure that the information needed to authorize the appropriate service, duration, amount and the most cost effective item, are contained in the request. Providers are alerted through error messages if they attempt to submit a request that does not contain all mandatory fields. Error messages to the submitting provider are designed to indicate unit limits and member benefit limitations. Programming in the application is designed to alert the APS reviewer to areas not meeting policy requirements and/or criteria checks. These exceptions are displayed as pend reasons that guide the reviewer to areas of policy that require special attention when the review criteria are applied to the authorization request. This approach provides consistency to the review with respect to service limits, areas of possible service duplication, possible service combination edits, and diagnostic or other restrictions applicable to specific services. On a daily basis, we bundle the authorizations and submit them electronically to the MMIS to ensure that records are synchronized and the provider can submit a claim. APS receives a response file back from the MMIS that tells us if the record we submitted has been accepted; if not, we research and update the rejected record and resubmit it. The MMIS results also go back to the provider – if the reason for the rejection is connected to the provider, APS works with the provider to correct it so it can be resubmitted.

The APS web-based system has a secure provider portal that permits registered providers and their designated users to request prior authorization for services. Organizations must register with APS in order to utilize the system. Each provider organization must be an enrolled West Virginia Medicaid provider to be approved to utilize the system. Provider access to various review areas is governed by a provider grid. For recognition as a referring provider, the provider must be an active WV Medicaid enrolled physician or practitioner permitted to write an order for the specific service; to be a service provider, the provider must be actively enrolled permitted by WV policy to perform the specific service. The provider creating the record in the APS System is referred to as the requesting provider. Requesting providers have access to records they create; the service provider has access to the prior authorization and member information necessary to schedule and perform the service. Requesting providers log into the system using their user names and secure passwords and can then create requests, faxes, or mails a request to APS-WV for entry in the system.

APS' rules operate by identifying the time frame (start and end dates) for the request and then testing the recipient eligibility files for various conditions. The rules engine is sophisticated enough to account for a requested time frame that actually spans multiple valid eligibility segments, something that could not be

done in APS' previous system. The rules can be as specific as they need to be. The rules can check eligibility at the service type level, again when the specific procedure code or service is entered and run each time a change is made to the request to ensure that the proper response (Error or Warning) is given as quickly as possible to the person doing the data entry. The eligibility rules run for all requests for Prior Authorization regardless of source – Provider Portal, fax, or phone. The eligibility rules also run for requests for Prior Authorization that would otherwise be auto-approved by the Rules Driven Auto Approval (RDAA) engine and reject the request back to the provider. Once the submission is accepted a unique tracking number is assigned to the case for permanent reference.

B. Data Exchange

Vendor Response

The APS System manages coverage limits, restrictions and combination edits through a series of rules and specific programming within the application. These validations and edits are based on the Medicaid Policy Manual and the specific chapter(s) relevant to the program. APS has been interfacing with Medicaid Management Information systems for over 25 years on a daily basis. With each contract and interface, we implement a list of "edits" which are mandated by the interface and file exchange policies to help ensure that every request for an authorization will successfully process. In order to do so efficiently and effectively APS must clearly understand the purpose and use of EVERY data field in the files.

APS-WV will only accept prior authorization requests from providers enrolled in the WV Medicaid program. APS-WV, using the provider file received from the Bureau's MMIS vendor, will verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, APS-WV will contact the provider within one working day and notify them that we cannot process the request until we establish their participation status in the program. Additionally, enrolled providers must register with APS-WV to gain access to the APS System. A referring provider grid and a servicing provider grid determine provider status with respect to requesting specific services. These grids identify the provider types that may refer WV Medicaid members for specific services and the providers who may perform specific services. APS-WV's review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payer such as Medicare may be responsible for the services requested. If we identify an alternative payer, APS-WV will notify the provider through messaging on the request.

The provider gets back a notification that the request been approved, and APS gives the provider an authorization number (in some cases the claims entity provides number). On a daily basis, we bundle the authorizations and submit them electronically to the MMIS to ensure that records are synchronized and the provider can submit a claim. These can be transmitted in a 278 format at the request of the Agency. APS receives a response file back from the MMIS that tells us if the record we submitted has been accepted; if not, we research and update the rejected record and resubmit it. The MMIS results also go back to the provider – if the reason for the rejection is connected to the provider, APS works with the provider to correct it so it can be resubmitted.

C. Secure Web-based Prior Authorization System

Vendor Response

The APS-WV proprietary prior authorization system and its fully integrated provider web portal combine state of the art technology and a flexible, easy to configure business rules engine that allows us to easily customize the applications directly to meet Agency and provider needs.

The Provider Portal includes the ability for providers to:

- Submit requests for authorization
- Attach documents, faxes, or other forms to the request
- Complete review specific forms ("Smart" forms)
- Review the results of the request
- Communicate electronically with KEPRO staff (including the clinical reviewer)
- Manage and track requests for authorization

The Provider Portal is driven by a robust rules engine that requires only the necessary fields be filled out and information be provided based on the requirements of the review. Where specific information is required, the rules engine checks the data to insure completeness of the request. Provided that the Agency can supply current member and provider eligibility information on a timely basis, the Web-based system can check eligibility to prevent unnecessary requests, and can also check for duplicate or overlapping requests for service from the same or different providers, thus minimizing the amount of re-work of a request a provider typically sees in other, less sophisticated systems.

Eligibility checking in the system is managed by an extremely robust rule-based management module that allows for changes to made, tested and deployed in a matter of minutes rather than days. The rule-base engine can look at and test for specific eligibility criteria at the point the request for service authorization is created and provide feedback to the person entering the request both through the Provider Portal and through the internal clinical review client. This means that regardless of the data entry source of the request – provider or APS-WV staff – the same rules apply and will stop entry of requests for members that are not eligible for those services. These rules are checked at the time the request for service authorization is submitted and again at the time the clinical reviewer authorizes the request, insuring that no changes have been made to the request that would cause it to fail eligibility checks at the MMIS.

Eligibility (and all other data files transferred between APS-WV and its partners) files are exchanged by either push or pull methodology to / from shared data sites using SFTP protocol, web services call, or HTTPS access. All methods agreed upon with the Agency are acceptable.

Rules operate by identifying the time frame (start and end dates) for the request and then testing the member eligibility files for various conditions. The rules engine is sophisticated enough to account for a requested time frame that actually spans multiple valid eligibility segments. The rules can be as specific as they need to be. The rules can check eligibility at the service type level, again when the specific Procedure Code or service is entered and run each time a change is made to the request to insure that the proper response (Error or Warning) is given as quickly as possible to the person doing the data entry.

The eligibility rules run for all requests for Prior Authorization regardless of source – Provider Portal, fax, or phone. The eligibility rules also run for requests for Prior Authorization that could otherwise be auto-approved by the RDAA engine and reject the request back to the provider. The ability to provide auto-approval is available to the agency if desired and subject to discussions of the circumstances and conditions under which the Agency might desire and approve such an approach.

Authorization for Medicaid Services for dually eligible Medicare patients due to the denial / exhaustion of Medicare or other third party benefits would be handled through the rules engine as well. Rules would identify dually eligible Medicare A and B members that also have Medicaid coverage and provide a message back to the user (provider or Provider Service Representative) that a copy of the notice of denial or exhaustion of benefits from Medicare or other third party is required to process the request. The provider can use the Provider Portal to attach a copy of the documentation to the request, or fax a copy to APS-WV. The prerequisite for these processes to be handled automatically through rules is that APS-WV must have, as part of the member eligibility data files, the information regarding Medicare or TPL coverage.

These features guarantee that provider requests are complete and valid – before they are submitted to APS-WV. These efficiencies help to minimize the burden and expenses of providers.

We currently use web-based "smart forms" in several of our Medicaid contracts to insure that required review specific information is collected and available for the clinical and analytic staff to be able to review and report on. The smart forms are completely customizable and easily changed. Deployment of the smart forms can be determined by service type, services (procedure codes) requested, reported diagnosis codes, member eligibility and / or provider parameters. The smart forms can also be configured to provide "scoring" if required. Smart form scores can be used to determine appropriateness of auto-approval for the request or acuity of the member relevant to the request.

Access to the web-based prior authorization system and contents of requests is role based and strictly prohibits access to any data or information the user is not allowed to view. There must be a direct connection between the user and the request to be able to view / update and PII or PHI.

Access accounts for provider usage of the web-based prior authorization system can be distributed in many ways and will be discussed with the Agency during the implementation period. A key part of the method implemented is the use of a randomly generated PIN for each provider account. The implementation discussion with the Agency will include coming to a decision on the method of communicating the PIN to the provider via a secure method. Each implementation of PIN distribution methods has been unique. Each Agency has a preferred method and we will comply with the decisions reached during implementation.

Once provider access is established, the provider can access the historic requests and any data, analytics or reports that are configured to support the specific provider based on the access parameters for that user. Training for both provider and Agency can be provided in several ways. APS-WV can provide on-site seminars, web-conferences, and training materials tailored to the audience – be they Agency or provider type specific tools.

The systems utilized by APS-WV were developed using HIPAA regulations as the baseline for systems architecture. Our systems will meet and in many cases exceed all applicable HIPAA regulations.

One of the most comprehensive areas addressed by HIPAA is the layout of standard healthcare transactions. Not all of the transaction sets apply to the services we supply to our clients. One transaction set that does apply is the X.12 278 transaction for the electronic processing of referrals and authorizations. Medical's systems provide the functionality to accept and respond to a 278 transaction as well as create a case in the web-based prior authorization system. The ability to accept a 278 could potentially be required by certain provider types and exceptions to the requirement may be instituted by the agency based on provider type. The rules engine can enforce or the business rules decided upon by the Agency. As with any request for review regardless of source, a unique tracking number (case ID)is always assigned to a request. And available to the provider / requester.

In addition to receipt and processing of electronic requests through X.12 278 transactions, another aspect of integration with systems in the future is the need to integrate with regional or statewide Health Information Exchanges (HIX). Although this requirement is for a future component and Medical has no current connections to a HIX, our extensive experience with integration of systems and data exchanges should provide the Agency with knowledge that KEPRO can and will comply whenever HIX is ready for such integration.

We understand that the Agency has to be assured that data used in the contract is secure and available for contract operations, the database supports the timely access for ad hoc reporting and that the Agency has secure access to the data. The security aspects of HIPAA were put in place to help covered entities meet a portion of the privacy regulations by providing environments that control access to healthcare systems. The following database protections are in place. Based on the security standards KEPRO has have found our systems to be compliant in the following areas:

- Log-In Security - HIPAA security requires the use of secure User IDs and the use of passwords. Taking this requirement a step further, our systems not only require unique user IDs and passwords, they also prompt users to periodically change their password as well as mask the password as it is keyed in the system.
- Access Control - HIPAA requires one of the following: Context Based Access, Role Based Access, or User Based Access. Our systems use both User Based and Role Based Access. User Based Access is part of the login security component. The Role Based Access gives individual users access relevant to their role in the organization.
- Audit Trail - HIPAA requires the use of an audit trail to identify who accesses protected health information. These systems track who changed the patient record, the date and time the record was modified, and the specific information changed.
- Automatic Log-Off – Our systems automatically log users off the system after a client-defined time of inactivity is exceeded. Please note however that the web-based prior authorization system automatically saves data frequently so that very little – if any – information is lost in the event of an automatic log off. That data is available when the user logs back into the system.

We have had interfaces with Medicaid Management Information systems for over 20 years on a daily basis. With each contract and interface, we implement a list of "edits" which are mandated by the interface and file exchange policies to help insure that every request for an authorization will successfully process. We place the edits on the front-end of the process before providers and clinical reviewers submit

their cases into the system. When the prior authorization response file is received back from the MMIS system, the authorization information is imported into our integrated system so that the authorization information is immediately available to the provider. In the event an error is return from the MMIS system, a task is created in the system for the staff to review and correct the problem and subsequently re-send and update the request for authorization if appropriate.

After establishing the prior authorization process and collecting baseline data, KEPRO can activate rules-driven algorithms with the approval of the Agency to process authorization requests automatically based on clinical and regulatory requirements. The RDAA process can also offer an incentive for providers who closely comply with the review process. Claims data can be monitored at the provider level as a safeguard against abuse of the system and as a method to streamline the review process. Experienced clinical reviewers handle cases that are complex and do not meet rules-driven guidelines.

The combination of review and validation processes can be highly customized to the state's requirements – both contractual and regulatory – with custom configurations at both program and information system levels. We will discuss the specific methodologies that are most appropriate for the Agency's programs during the Implementation phase. In collaboration with the Agency, we will develop a program appropriate for your specific circumstances and goals, and which is configured to meet evolving circumstances and objectives.

D. Database Creation and Maintenance

Vendor Response

APS has extensive experience in interfacing with MMIS systems. APS will automate and schedule the import of data from MMIS that includes provider, recipient, and prior authorization in batch file mode. APS understands that Medicare Part A and Part B eligibility as well as TPL information will be included and used by APS in the determination of the need for a Behavioral Health authorization. It is understood and accepted by APS that file layouts may change in the future and that APS will work with the Fiscal Agent to implement the changes.

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

Sample data can be extracted from the database either through the web-based reporting portal or through programmatic extracts depending on the volume and purpose of the extract. We agree to the requirement to give the agency access to our databases for monitoring of the UM program.

E. Other System Requirements

Vendor Response

Our systems provide secure facsimile, scanning, secure internet mail, and provide the Agency online access to the Vendor databases, reports, and other information related to the program at no cost to the Agency.

The provider can use the Provider Portal to attach a copy of the documentation to the request, or fax a copy to APS. There is no limit as to the type of document or image that can be attached to a request, although there is a file size limit applied to those attachments. It is worth noting that all attached documents are actually stored in the database itself rather than in a folder and referenced by the database. This distinction makes the chance of losing an image or document less likely that if they are stored separately.

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

Our experience with managing application and system security spans over twenty-five years of support a multitude of federal, state, local, and private healthcare contracts. APS-WV parent KEPRO has installed and utilized site-to-site Virtual Private Network (VPN) connections to exchange data with our customers, as well as a backup for our Multiprotocol Label Switching (MPLS) Wide Area Network (WAN) connection between our offices.

We agree to:

- Have the capacity to access and generate all data and reports needed for this program. We will maintain a sufficient number of qualified MIS and technical staff to continue operation of the Vendor's system, provide prompt, ongoing system support, and accurate data access to the Agency and its authorized agents and service providers.
- Develop and/or acquire any software required by the agency within 90 days of the final written approval and signoff of the Agency
- Provide accessibility through an enhanced internet security communications system and an adequate number of phone and fax lines to interface with the Medicaid Fiscal Agent, MMIS, the Agency, and providers. Accessibility should be centralized, with no change in internet address, telephone, or facsimile numbers for the duration of the resulting contract period.

F. System Modifications

Vendor Response

KEPRO asserts and confirms that any required changes or modifications to KEPRO systems related to access to or file exchanges with existing agency systems will not require modifications to agency systems. All changes and upgrades will be scheduled to run between 10PM and 6AM EST with notice to the Agency within 12 hours of scheduled maintenance. These communications will be provided by a single point of contact.

Application Services staff has an extensive history involving the development of applications that have been used to support a variety of government contracts including:

- State Medicaid programs including both Florida and Virginia Medicaid
- Department of Defense (TRICARE)

- Health Resources and Services Administration (HRSA)

In the course of implementing state-wide Medicaid contracts in the States of West Virginia, Maine, Florida, Virginia, South Carolina, New Hampshire, Minnesota, and Wyoming, KEPRO's policy has always been to adapt to the systems with which interactions are required by making modifications to its own systems and never requiring a change our partners systems.

Careful consideration and clear policies are required to accomplish required changes in an efficient and effective manner. The following sections describe those policies and methodologies in detail. All applications developed in house are built and tested across multiple platforms. KEPRO has established a multi-tiered environment for application development, testing, and release.

V. Reporting Requirements

A. Written Reports

A. The Vendor should provide the Agency with written reports that are clear, concise, and useful for the audience for whom they are intended. The reports shall be composed in a manner consistent with the Agency specifications and with the Vendor's stated criteria. All reports should be provided in electronic formats compatible with software applications in use by the Agency (i.e., MS WORD, Excel, SQL, Crystal, COGNOS, and others as appropriate) as well as in hard copy, as specified by the Agency. All reports should be made available to relevant the Agency staff via web portal. Where required, the Vendor should provide supporting documents such as report appendices.

Vendor Response

APS-WV provides reports to DHHR that meet the requirements of this section and will continue to do so in the next contract period.

B. Deliverable Dates

B. The Vendor must provide reports due on or before the fifteenth (15'~) work day of the month following the report period, unless otherwise stated in this CRFP or agreed to in writing by the Agency.

Vendor Response

APS-WV will submit reports on or before the 15th business day of the month following the reporting period, unless other CRFP requirements or written specifications from DHHR provide different direction.

C. Meeting Applicable State and Federal Requirements

C. Reports defined and approved by the Agency to be generated by the Vendor should meet all applicable state and federal reporting requirements. The needs of the Agency and other appropriate agencies for planning, monitoring, and evaluation should be taken into account when developing report formats and compiling data. Reports to be generated should be agreed upon during the contract Implementation Phase and should include but not be limited to those listed below and in Appendix 3.

1. Monthly Administrative Project Summary to include operational priorities, outstanding issues, staffing, volume, review volume, phone activity, and Vendor calendar of events.
2. Monthly Certification, Continued Stay Workload, and Timeliness Summary per Review Type.
3. Monthly Retrospective Workload and Timeliness Summary per Review Type.
4. Monthly Reconsideration, Outcome, and Timeliness Summary per Review Type.
5. Monthly Approval, Approved Less Than Requested, and Denial Rates per Review Type and Provider Type.
6. Monthly Physician Referral Rates by Reason per Review Type and Provider Type.
7. Monthly Average Days Certified by Principal Diagnosis by Age and Provider Type; and Quarterly Report of All Activity Relating to Provider non-compliance.

Vendor Response

APS-WV has experienced reporting staff and sufficient resources to meet the requirements of this item, which we understand and accept.

D. Annual Report

D. The Vendor should provide an in-depth analysis of each review responsibility in one (1) aggregate state fiscal year (July- June) annual report. Each annual report should be accompanied by the raw data on a CD ROM, in a format agreed to by the Agency. At a minimum, each report should include:

1. A narrative executive summary of all Utilization/Prior Authorization Program activity;
2. Vendor accomplishments;
3. Operational priorities;
4. Significant organizational changes/staffing issues;
5. Provider seminars;
6. Provider concerns;
7. Quarterly and cumulative patterns and trends;
8. Estimated savings, if applicable;
9. Assessment of the impact of the UM/PA program by each individual provider type including summary of authorization requests and outcomes;
10. Policy and/or criteria recommendations that improve the utilization of Medicaid services, improve the quality of services, and/or reduce the cost of Medicaid services;
11. Outstanding issues;
12. Remaining challenges; and
13. Cumulative summary of all reports/contract deliverables including a description of how the Vendor met required timeframes.

Vendor Response

APS-WV agrees to provide an annual report for each state fiscal year that meets the requirements of this section.

E. Ad Hoc Reports

E. The Vendor should provide ad hoc reports on an as-needed basis. The Vendor should be prepared to process up to a minimum of 100 ad hoc reports annually. This is an estimate and subject to change based on management and legislative priorities. All ad hoc reports are to be provided at no additional charge to the Agency.

Vendor Response

APS-WV will provide ad hoc reports as requested by DHHR, up to 100 ad hoc reports annually. We understand that estimate is subject to change. We will provide these ad hoc reports at no charge to DHHR.

F. Acceptance of Reports

F. Any report that is not accurate will be considered unacceptable and the Vendor will have 3 business days to produce an accurate report after the Agency requests a corrected report. The Agency may assess liquidated damages for each business day the corrected report has not been submitted or is resubmitted with unacceptable information, retroactive to the corrected report due date.

Vendor Response

APS-WV understands that any report that is not accurate will be considered unacceptable. We will have three (3) business days to produce an accurate report after DHHR requests a corrected report. We understand that DHHR may assess liquidated damages for each business day APS-WV does not submit the

corrected report or resubmits the report with unacceptable information, retroactive to the corrected report due date.

VI. Quality Improvement and Quality Control

A. Quality Improvement Program

Vendor Response

1. APS shares and is dedicated to the Agency's goal of ensuring that program members receive the highest quality healthcare and, to that end, APS has a robust, comprehensive quality improvement program that supports the four goals in this Section. At APS-WV, Quality Improvement is not relegated to a single department or committee, but rather is part of a corporate culture emphasizes continuous quality improvement across all programs. APS sets expectations for all staff that quality is a shared responsibility and holds staff accountable for individual roles. A culture that espouses quality as everyone's responsibility is better positioned to achieve significant and sustained improvement. 2. The general structure of the APS – West Virginia Quality Improvement Program consists of a Quality Improvement Manager who oversees the Quality Improvement activities within each program. This QI Manager is responsible for scheduling and leading the activities of the local WV Internal Quality Improvement Committee. The local internal Quality Improvement Committee membership consists of a representative from each of the programs as identified by the specifications of this RFP. The APS QI program is a Continuous Quality Improvement Program; accountability is exercised through timely communication. Monthly reports are generated for the various QI parameters, standards, and performance goals identified for each of the program areas. Quality improvement activities, including interventions and audit results, are reported to the local APS-WV executive leadership, to the corporate KEPRO Quality Improvement Committee as well as to the Agency.

   a. The APS quality of care review process, as detailed in the Quality Improvement Plan, is in accordance with local and national healthcare standards. Quality of Care reviews are conducted for each of the programs, using specifications found in this RFP and per Agency policy. APS, as the incumbent, has had and will continue to administer a post utilization review program to measure performance against the standards specific to each program; and plans of remediation will be implemented to improve performance when standards are not met.

   b. Quality of care issues are identified during first level reviews for each type review by ensuring that review staff receive training in the use of appropriate standardized review criteria (example, InterQual) or other criteria approved by the Agency. Surveillance of quality of care issues is accomplished through regular monitoring and a reporting mechanism that allows for the identification of deficiencies or failure to meet performance standards. This process is overseen by the Quality Improvement Manager.

   c. The Quality Improvement Plan includes specifications for a five (5) percent sample of all authorizations and reviews performed in each of the programs as specified in this RFP. APS is prepared to complete this size representative sample, unless otherwise instructed in writing by the Agency.

   d. When Quality of Care problems are identified, the Quality Improvement Plan specifies each instance will be reviewed and confirmed by a physician in the same specialty area as the treating physician. Quality of Care issues are identified in the monthly QI report, along with remediation action taken.

e. It is a goal of APS to identify aberrant providers and practices. This is done by profiling providers across numerous measures and weighting outliers. During the process of UM and Prior Auth activities, when aberrant practices are identified, this is documented and reported to the Program Manager and Quality Improvement Manager. The Quality Improvement Manager oversees the development of an appropriate intervention to the identified aberrant practice and implements a plan for monitoring interventions.

f. In addition to reporting aberrant practices to the Program Manager and Quality Improvement Manager (as stated in e. above); the Quality Improvement Manager is responsible to communicate problems and interventions to the APS-WV executive leadership, Local Internal Quality Improvement Committee, corporate KEPRO Quality Improvement Committee and to DHHR by means of the monthly report of quality improvement activities.

2. APS is fully prepared to provide the Agency a monthly report of quality improvement activities, including interventions and results, by the fifth (5th) workday of the month following the report period.

B. Internal Quality Control

Vendor Response

1. APS looks forward to continuing to provide Internal Quality Control services to the Agency. As in the past, APS is prepared to be responsible for establishing and maintaining internal quality controls for the responsibilities of this contract, and understands that an approved plan should become effective no later than thirty (30) days following award of this contract. APS will continue its activities of including Internal Quality Control information in the orientation of new staff as well as in the ongoing training of employees. APS internal quality control includes the monitoring of all activities identified in the QI plan, and allows for the modification of the plan based on identification of additional areas of concern. Inter-rater reliability is addressed for each of the programs, based on the unique features and requirements of the program.

2. APS has a robust internal quality control program, and is fully prepared to meet all of the requirements as specified in a, 1 through 7.

3. APS will provide monthly reports to the Agency, no later than the 5th workday of the following month, which will include the findings of the Internal quality control reviews including a status report for all CAS's initiated during the month as well as those still outstanding from previous months.

VII. Records Retention and Access

A. Preserving Documentation

A. The Vendor should preserve and make available its records (all documentation regardless of review determination) for a period of five (5) years from the date of final payment under this contract, and for such period, if any, as it is required by applicable statute or by any other paragraph of this contract.

Vendor Response

APS-WV has a fifteen-year record of achievement preserving documentation from our contracts with the Department. With existing offices just blocks from the Department, we maintain and can make available all documentation from the date of final payment under this, and the forthcoming, contract. We understand that we will make documentation available regardless of the review determination for a period of five (5) years and for any period required by the contract or applicable statute.

B. Contract Termination – Retention of Records

B. If the contract is completely or partially terminated, the records relating to the work terminated should be preserved and made available for a period of five (5) years from the date of any resulting final settlement.

Vendor Response

APS-WV understands that if the Department completely or partially terminates the contract, APS-WV will preserve documentation relating to that work for a period of five years (5) from the date of final settlement. We also understand that this requirement is distinct from that of Item (C) in this section.

C. Records Relating to Appeals and Other Actions

C. Records which relate to appeals, litigation or the settlement of claims arising out of the performance of this agreement as to which exception has been taken by the West Virginia State Auditor, General Accounting Office (GAO), Department of Health and Human Services (DHHS), or any of their duly authorized representatives, should be retained by the Vendor until disposal of such appeals, litigations, claims or exceptions.

Vendor Response

Not withstanding other requirements of the RFP or resulting contract, APS-WV understands and will retain records relating to appeals, litigation, or settlement of claims related to the performance of the contract to which the West Virginia State Auditor, General Accounting Office, Department of Health and Human Services, or any of their duly authorized representatives takes exception. This requirement will continue until the resolution and disposal of these appeals, litigation, claims, or exceptions.

D. Terms for Access to Records

D. The Vendor should agree to the following terms for access to records relating to the contract

1. All medical records should be retained for a minimum of one (1) year at the Vendor's location. All other medical records should be made available and retrievable within three (3) work days for review at the request of the Agency, unless a shorter time period is specified in writing.

2. Unless the Agency specifies in writing a shorter period of time, the Vendor should preserve and make available all pertinent books, documents, papers, and records of the Vendor involving transactions related to the contract for a period of five (5) years from the date of final payment under this contract.
3. The Vendor should keep and make available records involving matters in litigation for five (5) years following the termination of litigation, including all appeals.
4. The Vendor should agree that authorized federal, State, and the Agency representatives should have access to and the right to examine the items listed above during the contract period and during the five (5)-year post contract period or until resolution. During the contract period, the access to these items will be provided at the Vendor's facility at all reasonable times at no cost to the Agency.
5. The Vendor should accept full responsibility for record retention in accordance with state and federal regulations.
6. The Vendor should provide the Agency with a detailed plan for record retention upon implementation of the operations. Any changes or updates must be approved through the Agency.

Vendor Response

APS-WV understands and agrees to the terms for access to records relating to the contract.

VIII. Miscellaneous Operation Rules

A. Adverse Weather Plan

A. Adverse Weather Plan

The Vendor shall have a written plan for providing Utilization/Prior Authorization Services for members who need critical medical care during adverse weather conditions. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, hurricane, tropical storms, flooding, tornado warnings, and heavy snowfall. The Vendor is to submit a final completed plan to the Agency for approval no later than two (2) weeks prior to the Operational Start Date and thereafter upon the Agency request. The Vendor shall not begin operations without an approved Adverse Weather Plan.

Vendor Response

APS-WV has a comprehensive business continuation plan that allows for the delivery of necessary services during adverse weather conditions or various disasters. Business continuation is the process of taking the necessary actions to resume business operation after a disaster has struck. Modifications that may be necessary can range from establishing communication services and secure electronic prior authorization review activities off-site (home-based) to having to find another physical location (temporary, long term or permanent,) acquiring any necessary office furniture and office supplies because the original office has had major damage or been destroyed. APS-WV will submit a final completed Adverse Weather Plan to the Agency for approval no later than two (2) weeks prior to the Operational Start Date.

B. Post-Service Authorization Requests

B. Post-Service Authorization Requests

Vendor Response

During previous contract periods, APS-WV worked with the Bureau for Medical Services to develop the following approved policy related to post-service authorizations.

Retrospective Review Submission Policy

- In general, providers have 10 business days from the date of admission/first date of service to submit a prior authorization request;
- There are EXCEPTIONS to this policy (e.g. DME Policy Chapter indicates equipment/supplies CANNOT be place before prior authorization is obtained). In these instances the provider must obtain prior authorization before service is rendered;
- After the 10-business day period has elapsed from the selected service start date prior authorization is NOT available as a selection and retrospective review must be selected. The Retrospective Review Policy will be applied to requests submitted after this period and any request not meeting policy will be administratively closed and will NOT be medically reviewed.
- For any Medicaid member retrospective review is allowed when:

- Retroactive Medicaid- requests may be submitted for services rendered previously if Medicaid coverage is backdated to include the date of the service;
- TPL- an EOB or certificate of non-coverage must be submitted with the request in instances where the service is denied by the primary payer for a Medicaid covered service;
- In instances where the APS system is inaccessible, (this would be announced to all providers) or the provider has approved leniency from BMS due to a systems issue (e.g. computer system failure, fire etc.).

APS will review this policy within thirty (30) calendar days of the operational start date of the new contract to ensure the Bureau does not wish to make any changes to the current policy.

C. Service Denials

C. Service Denials

Vendor Response

APS-WV will comply with WV Medicaid policies and procedures relating to service denials. Requests submitted for WV Medicaid members may be categorized into two different denial types: policy denials and clinical denials. Policy denials are those in which service requests do not adhere to state and or federal requirements, or meet exclusionary conditions identified for the service requested. Clinical denials occur when medical necessity is not demonstrated for the service following clinical review by care managers and a minimum of one APS Physician consultant. The denial decision will be documented in the APS System on the same business day as the denial received.

Denial letters will be attached in the APS System and/or mailed to the provider and members on the next business day following receipt of the denial decision. APS-WV currently mails all denial letters to members; providers are notified via secure email notification. APS-WV will discuss routes of distribution with the Agency and comply with their direction. Costs associated with mailings will be the responsibility of APS-WV. Denial letters will contain information on how to request an appeal of the denial. In addition, members will receive information on their appeal options with a form to request a fair hearing at the State level.

APS-WV has developed denial letter templates for both policy denials and clinical denials. Approval of each will be attained from the Agency; operations will not begin until letters have been reviewed and approved with any updates or modifications requested by the agency. Approval from the Agency will occur at least thirty (30) calendar days before the Operational Start Date. Requests and documentation that are incomplete will not be considered denials for reporting purposes and providers will have a period to submit the documentation necessary to review the request clinically. Requests for which documentation is not submitted within three business days will be closed and may be reinitiated by the provider when complete documentation is available.

D. Denial Reasons

D. Denial Reasons

1. Service requests may be denied for one (1) or more of the following reasons:
a. The member is not eligible for services on the date of service;
b. The member does not have a medical need that required services;

c. The medical service for which service is requested is not a Covered Medical service;
d. The service requested is for an out-of-network provider and did not meet policy criteria;
e. The medical service for which service is requested is covered under another program;
f. The request was for post-service authorization and was not received timely or did not meet established criteria;
g. The service was not requested within an appropriate timeframe;
h. Additional documentation was requested and was not received within an appropriate timeframe;
i. The member refuses the appropriate mode of service; or
j. The member's medical need does not require an ambulance level of transportation. Vendor is to refer the member to appropriate resources, such as local transportation providers/broker in their area.

Vendor Response

APS-WV understands reviewers may deny requests for one or more of the medical necessity, coverage, and policy reasons listed in D.1 a-j. We clearly articulate these reasons in our adverse determination notices and provide relevant and appropriate information about reconsiderations and Fair Hearings to ensure that members and providers can exercise their rights after denial of requests.

E. Timelines

E. Timelines

1. Routine Services

The Vendor should process Utilization/Prior Authorization requests for all requests within two (2) business days after receipt of the request.

Vendor Response

APS-WV will complete Utilization/Prior Authorization Requests as required.

F. Suspected Fraud, Abuse, and Misuse

F. Suspected Fraud, Abuse, and Misuse

Vendor Response

APS-WV is dedicated to the integrity of West Virginia's health and social services programs, and is vigilant in identifying and reporting suspected fraud to the appropriate agencies. APS will cooperate with all fraud, waste and misuse investigation efforts by State and Federal offices, including the Office of Inspector General (OIG.) APS will also report suspected fraud, abuse, or misuse by members or vendor staff including any applicable subcontractor staff to the identified Bureaus designated contact.

Bureau for Medical Services

APS-WV will continue to promote effective and appropriate utilization of West Virginia Medicaid services. We will accomplish this support through ongoing communication, technical assistance/training for providers along with reinforcement of the West Virginia Medicaid manual. A few providers continue to

experience difficulty with adherence to regulations; in these instances, APS-WV has and will continue to report suspected fraud to the Bureau's Office of Program Integrity (OPI).

Bureau for Behavioral Health and Health Care Facilities (BBHHF)

APS-WV reports Instances of suspected fraud or inappropriate utilization of BBHHF funding to the Bureau for Behavioral Health and Health Facilities' Office of Compliance and Monitoring.

Bureau for Children and Families (BCF)

APS-WV will continue to report any instances on known or suspected provider fraud of any kind to the BCF Office of Finance and Administration (BCF OF&A).

APS-WV staff not only has access to provider's clinical information but also have face-to-face contact with members and families on a regular basis. Due to the nature of our work, if an APS employee becomes aware of an incident or suspected incident of abuse and/or neglect of an individual (child or adult) receiving services from the Department, a report to the Department's Abuse and Neglect Hotline is required. APS WV has policies and procedures regarding identifying and reporting abuse/neglect in the community or an institution for all staff regardless of if they are mandated reporters. Training in this area has been incorporated into new staff orientation so it occurs prior to contact with members and families.

G. Provider Policies and Procedures

G. Provider Policies and Procedures

Vendor Response

1. Provider Requirements

The vendor is to ensure that providers are in compliance with the following requirements:

a. all enrolled providers should abide by state and local laws. Within the purview of the contract scope APS-WV will review provider's clinical services and practices to determine if they meet the standards and regulations determined by each Bureau.
b. All providers should have current valid license to practice in the state of West Virginia

When completing provider reviews APS WV will review all provider personnel charts of those employees whose functions require a license to perform in WV.

2. Provider Compliance

The vendor is to develop and implement a plan for monitoring providers' compliance with all applicable local, state and federal laws and regulations. The vendor is to ensure that providers comply with terms of their contracts and all provider related requirements of the vendor, and complaint resolution requirements. The Vendor is to verify that all providers comply with applicable Medicaid policies and procedures, including financial requirements and enrollment policies. The Vendor is to submit a final completed plan to the Agency for approval no later than 30 calendar days prior to the operational start date. The Vendor should not begin operations without an approved provider monitoring plan.

Upon completion of each provider review, APS will conduct a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, APS will make available to the provider a draft exit report and a Plan of Correction to be completed by the provider. If potential disallowances are

identified, the provider will have 30 calendar days from receipt of the draft exit report to send comments back to APS WV. After the 30-day comment period has ended, BMS will be given the comments and the draft exit report and issue a final report to the provider's Executive Director. The final report will reflect the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of services. A cover letter from BMS to the provider's Executive Director will outline the following options to effect repayment:

(1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

(2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or

(3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

If the provider disagrees with the final report, the provider may request a document/desk review by a bureau within 30 days of receipt of the final report pursuant to the procedures in Common Chapter 800 (A), General Administration of the West Virginia Medicaid Provider Manual. The provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed, and set forth in detail the items in contention.

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

    a. Statistical reporting of services,
    b. Analysis of complaints
    c. Provider licensure, professional record, experience and training

The vendor's provider monitoring plan should include written procedures for ensuring that an appropriate corrective action is taken a provider is out of compliance with federal or state laws or regulations. The vendor shall report monthly to the Agency on monitoring activities, monitoring findings, corrective actions taken, and improvements made by the provider.

Monitoring activities may include statistical reporting, complaint analysis and credentialing/personnel chart reviews. Depending on the situation, staff may employ other methods. When there is a negative finding, a corrective action plan is composed with steps to remediate the situation and a timeline for each area identified. APS-WV will review and report on the status of the corrective action plans at appropriate identified intervals. A report regarding all monitoring activities, findings, corrective actions taken and improvements made by the provider will be presented monthly to the contractor.

H. Stakeholder Satisfaction Surveys

H. Stakeholder Satisfaction Surveys

The Vendor's proposal should describe in detail the Vendor's approach to, and experience with, customer satisfaction surveys, various methods of measuring customer satisfaction and its plan for surveying specific populations such as members with disabilities, family members of members, facilities, and providers.

Annually, the Vendor should conduct a stakeholder satisfaction survey regarding the UM program. The purpose of the survey is to verify the availability, appropriateness and timeliness of the trips provided and the manner in which the Vendor's staff and the provider's staff interacted with members. The initial twelve (12) month period is to be the first (1") twelve (12) months during which Vendor delivers 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 prior authorized service;
2. Vendor and provider staff courtesy;
3. Vendor and provider assistance, when required;
4. Overall Vendor and provider behavior;
5. Vendor and provider service performance;
6. Condition, comfort and convenience of the provider facility; and
7. Punctuality of service by Vendor and provider.

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.

Vendor Response

APS-WV routinely conducts surveys and focus groups to collect information about the experience and perspectives of members, providers, and other stakeholders, and uses the information collected to improve the quality, flexibility, and responsiveness of our utilization management and other services.

Experience with Conducting Surveys

APS-WV and our parent KEPRO have years of experience surveying care management participants in multiple program types that include utilization management, case management, and disease management. KEPRO understands how valuable the accurate collection of member feedback can be to improved outcomes.

KEPRO annually collects participants enrolled in the our Health Programs, scrubs this information for duplicate records by household, address and phone number, and typically utilizes a phone-based survey administration methodology to administer the survey after the completion of the performance period. KEPRO has the ability to customize the survey inclusion criteria by examples including:

- **Have a case with "Open" status and "Full" level of care at any time during the period of 2014 – 2015.**
- **Completed a minimum of one "successful" call.**
- **Completed a "Duals Needs Assessment."**
- **18 years or older.**

KEPRO implements survey adjustment methods that are standard to control for sampling error and response rate considerations. KEPRO considers sampling error to be the extent to which the results differ from what would be obtained if every eligible participant could be surveyed. KEPRO includes estimates of sampling error based upon your sample size. KEPRO also considers historical response rates for participants when building the sample. As a general practice, KEPRO profiles the complete survey response group for categories that include:

- Staff
- Age
- Gender
- Satisfaction with overall quality of program
- Recommendation of program to others
- Overall experience with KEPRO

KEPRO question design is focused on ensuring a valid "n" and category responses. For all questions, KEPRO reports the "n," or the number of respondents who chose to answer the question. KEPRO understands this number may be lower than the total number of respondents who completed the survey because respondents either chose not to answer the question or selected "Not applicable." The Category Responses section provides the percentage of respondents who selected each response option. KEPRO provides summary scores for each measure that facilitate comparisons. The summary score groups the most positive response options, depending on the design of the question, (Always or Usually; Very Satisfied or Satisfied; Yes; 8 - 10). In addition to a summary score KEPRO also provides a response distribution component and provides a graphical presentation of the number of respondents who selected each response option for the questions scaled "Always" to "Never," "Very Satisfied" to "Very Dissatisfied," "Yes" and "No," as well as "1" through "10." This type of response is in Figure 14.

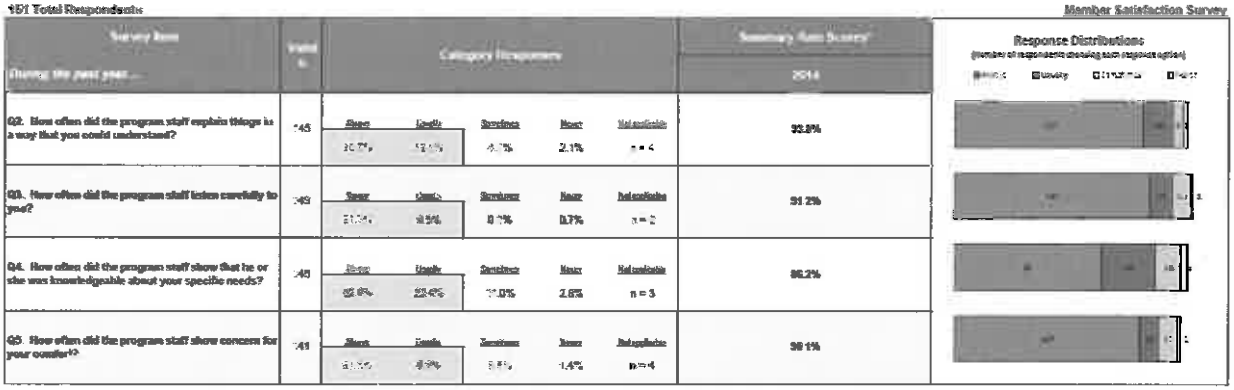


Figure 14 Example of Reporting Survey Results

The survey also consists of questions that include open-ended answers, which gave respondents the opportunity to express what they like best about the program and what they would recommend to improve the program. The report from the survey summarizes results and presents the findings by each individual question (attribute). The following topics are covered by the survey:

- Satisfaction with Program Staff

- Written Materials
- Overall Satisfaction and Recommendation
- Ratings

Lastly, KEPRO conducts correlation analysis that dissects the relationship between the individual questions included in a plan's survey tool and the overall satisfaction attributes can assist a plan in identifying those attributes that are most predictive of overall satisfaction for eligible participants.

For example, a correlation analysis can be run to test the relationship that care management survey attributes have with the responses to each of the following rating questions:

- From 1-10, how would you rate your overall experience with KEPRO staff?
- From 1-10, thinking about all aspects of the program, how would you rate your experience overall?

The correlation analyses conducted determines which attributes are more significantly associated with care satisfaction among survey respondents. The strength of the correlation is given by the correlation coefficient. A correlation coefficient of '1' is a perfect positive relationship and a coefficient of '0' is no relationship. As the correlation coefficient increases, so does the strength of the relationship. Those attributes that have the highest correlations are considered the most predictive of overall satisfaction. An example of our correlation analysis is in both Figure 15 and Figure 16:

Rating of Experience with Health Coach (Q17)

Q#	Attribute	Correlation Coefficient
Q20	From 1-10, thinking about all aspects of the program, how would you rate your experience overall?	0.739
Q13	How satisfied are you with the overall quality of the program?	0.725
Q18	From 1-10, how well do you think the program helped you to manage your health and care?	0.716
Q19	From 1-10, how well do you think the program helped you to improve your health and everyday living?	0.685

Rating of Experience with Program (Q20)

Q#	Attribute	Correlation Coefficient
Q19	From 1-10, how well do you think the program helped you to improve your health and everyday living?	0.818
Q18	From 1-10, how well do you think the program helped you to manage your health and care?	0.813
Q13	How satisfied are you with the overall quality of the program?	0.746
Q17	From 1-10, how would you rate your overall experience with your health coach?	0.739

Figure 15 Example of Reporting Correlation Coefficients for Surveys

151 Total Respondents — **Member Satisfaction Survey**

Survey Item	Correlation Coefficient**	Summary Rate Score*
Satisfaction with Program Staff		
Q2. How often did the program staff explain things in a way that you could understand?	0.644	93.8%
Q3. How often did the program staff listen carefully to you?	0.605	91.2%
Q4. How often did the program staff show that he or she was knowledgeable about your specific needs?	0.472	86.2%
Q5. How often did the program staff show concern for your comfort?	0.536	90.1%
Q6. How often did the program staff spend enough time with you?	0.553	90.5%
Q7. How often was the program staff as helpful as you thought he or she should have been?	0.626	91.4%
Q8. How often did you learn something new from the program that helped you better manage your health?	0.478	86.7%
Q9. How satisfied are you with the ability of your health coach to help you access the care you needed?	0.589	94.2%
Written Materials		
Q11. How often did the materials you receive provide information that was useful to you?	0.376	86.2%
Q12. How often did the materials you receive provide information that was easy to understand?	0.401	87.7%
Overall Satisfaction		
Q13. How satisfied are you with the overall quality of the program?	0.725	93.4%
Ratings		
Q18. From 1-10, how well do you think the program helped you to manage your health and care?	0.716	76.4%
Q19. From 1-10, how well do you think the program helped you to improve your health and everyday living?	0.685	69.5%
Q20. From 1-10, thinking about all aspects of the program, how would you rate your experience overall?	0.739	79.4%

Figure 16 Reporting for Survey Items

I. In-House Call Center

I. In-House Call Center

Vendor Response

Costs Associated with the Call Center

APS-WV understands that we will be responsible for all costs associated with the Call Center. APS-WV uses an integrated approach to delivering Call Center Services in our Charleston, WV office and these services are currently operational. This approach includes a full-time Operator during business hours, and coverage for the telephone as a backup to ensure that individuals calling our offices receive prompt service from informed representatives. Staff in each Department is responsible to handle calls relative to their

responsibilities; this approach helps to ensure that, for example, providers who need assistance with information about specific programs, or who need assistance with the APS System, reach APS-WV staff members who understand their needs and can respond appropriately during the call.

Telephone Access

APS-WV has a statewide toll-free number to support the Utilization Management and Prior Authorization Service program. Providers currently use this number to request service authorizations. APS-WV answers calls with a live operator during business hours Monday-Friday, 8:00 AM – 5:00 PM. The Call Center will be closed on New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. The Call Center will be open on these state holidays:

- 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)
- Primary or General Election days
- Other officially declared holidays

Calls during other times connect to a voice mail system, and APS-WV provides a message with information in English and Spanish about hours of operation, with a request for individuals to call back. APS-WV can accommodate callers who are deaf, hard-of-hearing, blind, and/or speech-disabled through assistive technology and services. We will release this number to DHHR or another Vendor on contract termination.

Language Requirements

APS-WV employs English-speaking staff, and provides language services for callers who do not speak English. We allow family members to provide interpretive services if they are over the age of 18.

Customer Care

APS-WV maintains an exemplary customer-service culture and our Call Center exchanges are examples of this approach. Our training ensures that we consistently interact with members, providers, and other callers with respect, providing prompt and courteous responses. Call Center staff greets callers courteously and identify themselves by name.

Data Analysis

APS-WV currently conducts data analysis on Call Center as well as system performance for prior authorization and utilization management activities. Our approach ensures we consistently meet timeframes for prior authorization as well as maintaining adequate staffing. We will promptly provide documentation of compliance to DHHR at the Department's request.

Sufficient Resources

APS-WV maintained adequate resources over the life of prior contracting periods and will continue to do so in the next contract period. The APS-WV system operates in the context of a national PA/UM contractor, with sophisticated and redundant systems to ensure continuity of operations. We maintain a manual backup system for use in the event that the web-based portal is not operational, and will notify the Department in the event the telephone system is inoperative or switched to backup systems.

Call Center Approach for Transportation

The vendor will utilize and train specific representatives to handle prior authorization requests for non-emergency ambulance transportation, retrospective requests for emergency ground and air transportation, and specific inquiries about transportation authorizations. Calls will be initially screened and routed to ensure the call is managed appropriately by a trained transportation representative or clinical staff.

Requests for non-emergency ambulance transportation may be requested via direct data entry (DDE) or via fax. Direct Data Entry will be encouraged to maximize timeliness of response. Phone requests will be entered in emergent cases but not for routine NEMT requests. Data elements approved by the Bureau for Medical Services will be required at the time of the prior authorization request. Data elements will include: member Medicaid information (for purposes of confirming eligibility), member demographics (pre-filled in DDE application when member is selected), enrolled service provider (pre-filled in DDE application when provider is selected) and pertinent information related to the trip.

- Required information related to the trip will include (but is not limited to):
- Member mobility information (including necessary mobility aids and transfer status);
- Member medical status (e.g. can member sit-up, oxygen and other life-support status etc.)
- Purpose of service/trip;
- Round trip distance;
- Single trip or multiple trips (frequency etc.)

Inquiries regarding the status of requests, provider training, technical assistance requests, and other questions regarding transportation will be directed to the appropriate call center staff or clinical staff. APS will submit a script for agency approval prior to use.

J. Training, Education, and Meetings

J. Training, Education, and Meetings

Vendor Response

APS has consistently provided training, technical assistance, and education to all stakeholders as required by the contract or at the request of the individual provider or stakeholder group. APS will continue to maintain a focus on providing training and training materials on all new processes and updates on system or program changes as they are implemented. The training, education, and technical assistance are provided in a variety of formats: face-to-face training, webinars, on-site provider training; presentations

at conferences and provider group meetings, and through electronic or faxed dissemination of materials and manuals relevant to the various programs and updates. Materials are available on the APS website as well as faxed to providers upon request. Please also see responses regarding training and education in each relevant RFP areas.

Provider Manual

APS currently has Provider Manuals and associated materials approved by the corresponding review type outlining our policies. Contract management has approved these manuals and subsequent changes. A review of the Provider Manuals annually when an update is required. A web link will be e-mailed to each provider annually and anytime there is a change. The current manual is available: http://apshealthcare.com/publicprograms/west_virginia/documents/soc_nec_prov_manual_v2.5.pdf.

New review areas will have provider manuals created in cooperation with the Department and final drafts will be approved by the Department as well.

Provider Training and Education

APS-WV takes pride in our consistently high training evaluations across various programs and Bureaus. We recognize that the success of the state's and our programs is highly dependent on how well-trained and competent the providers are. We plan to continue training providers and other stakeholders as necessary to ensure continued success. We have an established network of venues across West Virginia and capability for web-based trainings as requested by the Bureau. Materials will be made available in an appropriate format, dependent on the audience. All training materials will be submitted to the Bureau for approval prior to dissemination and placement on our website. We will continue publicizing training via an appropriate method, which may include notifications on The APS System, dissemination through email distribution lists or mailings (per the Bureau's requests for the Waiver programs).

Training topics might include the UM Program; requesting prior authorization; use of the APS system; and updated policy/procedures, and may be applicable to all programs. As necessary, training will be made available to providers, members or other stakeholders at convenient and accessible venues.

For example, Figure 17 summarizes providers' staff members participating in APS Healthcare training programs from 2000 through 2015. This chart provides an example of analyzing trends over time to measure the performance of APS-WV's provider education and training. As this chart indicates, participants' satisfaction with APS trainings is indicative of the trainings' pertinence, meaningfulness, and timeliness. Our expectation is to continue this level of participant approval year over year.

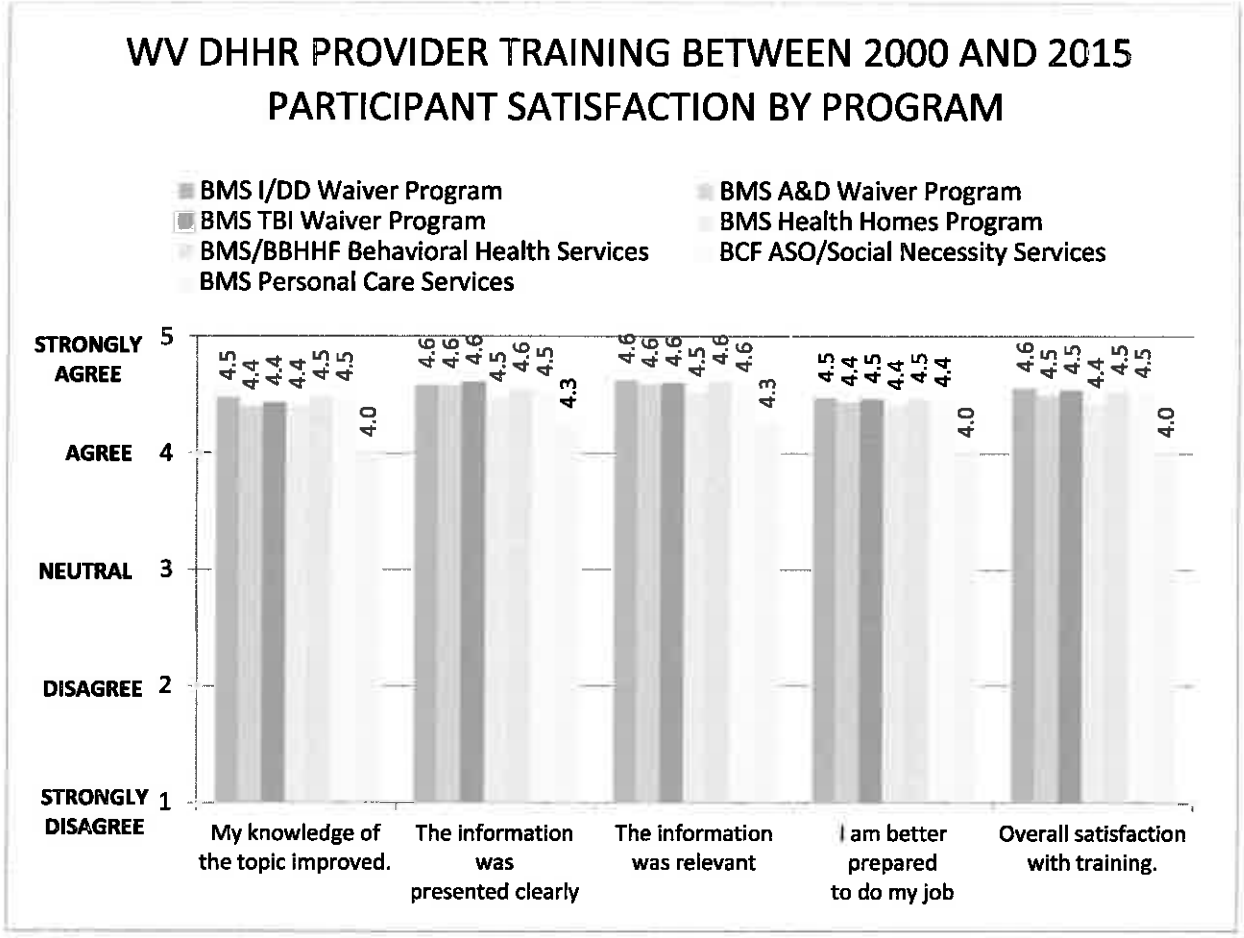


Figure 17 Provider Satisfaction with Training – 2000-2015

Member Outreach and Education Plan

APS intends to continue educating program members regarding the UM Program. Members have the right to understand the services they receive, how to access those services, related processes, and other available services. We will include appropriate in-person training, mailings, documents, etc. in our member outreach plan. We understand the importance of being able to accommodate and communicate with fragile populations or those with disabilities in a culturally and linguistically appropriate method.

Operations Procedures Manual

It is imperative we operate the UM program within the guidelines and expectations of the Bureau. Our Operations Procedures Manual will detail the procedures used in scheduling and delivery of services, and will be made available to the Bureau annually and whenever changes in operating procedures are made.

Meetings

APS hosts and attends any meetings or presentations upon Agency request. APS also conducts a variety of regularly scheduled stakeholder groups and focus groups to obtain information about system needs

and issues. APS participates in Policy Committee meetings and Procedure code work Group meetings and other regularly scheduled Agency meetings as requested by the DHHR Bureaus.

K. Member Complaints

K. Member Complaints

Vendor Response

1. Complaint Policies and Procedures

APS has a solid history of responding to and tracking complaints from providers and members for each of the APS programs. For the past fifteen (15) years, the West Virginia program has managed complaints in a professional manner, providing members and providers a mechanism to file complaints for timely resolution. Each complaint is referred to the Quality Improvement Coordinator (or designee), is documented on a complaint log, and tracked through resolution. APS tracks complaints as a means for identification of quality improvement opportunities.

When a complaint is received, the Quality Improvement Coordinator contacts the program manager of the applicable program to discuss the scope of the complaint and to work toward timely resolution. If the program manager does not have authority to require the needed corrective action, the complaint will be referred to a higher ranking staff person within the organization.

APS agrees to submit a final Complaint Policies and Procedures Manual to the Agency at least thirty (30) calendar days prior to the Operational Start Date for the Agency's review and approval, and to review the complaint policies and procedures every six (6) months. Should is seem that revisions or amendments are necessary, the policy will be amended only with the prior written consent of the Agency.

2. Member Complaint Resolution and Appeal Process

Complaints from members can fall into a number of categories such as:

- Quality of Service from either APS or the service Provider
- Assessments, Communication, Response Time, specific Staff complaints
- Quality of Care from service Provider
- Denial of a requested service authorization

When complaints are received, they are categorized and entered into the complaint-tracking log, given a unique tracking identification number. APS contacts the person making the complaint within one (1) business day of receipt of that complaint, and begins to work toward timely resolution of the complaint, working with all parties involved.

If the complaint involves a service Denial, then APS works with the member following the ASO contract with the agency. APS will continue to follow the criteria established by the Agency and meet the Appeals and Fair Hearings requirements of the new Utilization Management and Prior Authorization Services contract. In accordance with the requirements of the Appeals process, APS shall provide the Agency:

a) Documentation or testimony by a person of appropriate background who is familiar with and able to testify to the specific case being appealed;

b) Records and documentation regarding a denial of a service; those records being maintained and reported as outlined in the referenced sections of this RFP.
c) Comprehensive documentation specific to the particular case, as appropriate based on the nature and scope of the appeal.

APS agrees to submit a final Complaint Policies and Procedures Manual to the Agency at least thirty (30) calendar days prior to the Operational Start Date for the Agency's review and approval.

11. Provider Complaint Resolution and Grievance Process

APS will continue to assure that provider interactions are managed in a professional manner and provide a mechanism for providers to file complaint for timely resolution through the Complaint Resolution and Grievance Process. Each complaint shall be received by the Quality Improvement Coordinator (or designee) and shall be documented on a complaint log, assigned a specific identifying number, and tracked through resolution. APS contacts the provider representative making the complaint within one (1) business day of receipt of that complaint, and begins to work toward timely resolution of the complaint, working with all parties involved.

If additional information from an outside source is needed in order to resolve the complaint, the Quality Improvement Coordinator will investigate the complaint and gather the necessary information. Services of all APS staff will be utilized in order to resolve complaints. All information gathered in the investigation will be documented on the complaint log.

Should the Provider choose to file a grievance against APS, the filing of the grievance will be acknowledged within one (1) business day. The grievance will be entered and tracked in the specified log, given a unique identifying number. All related documentation will be entered and retained in the tracking log. Once a decision is rendered, the Provider has fifteen (15) calendar days to request a review of the decision by APS or the Agency or both. Should the Provider fail to request a review within fifteen (15) calendar days, the Provider's right to request a review shall be waived.

APS agrees to submit a final Complaint Policies and Procedures Manual to the Agency at least thirty (30) calendar days prior to the Operational Start Date for the Agency's review and approval.

L. Additional Services

L. Additional Services

The Vendor should establish and maintain a procedure for providing additional services to comply with externally driven changes to the Agency programs and requirements, including any state or federal laws, rules and regulations. Services provided the Vendor could include assistance with policy development, impact analysis, requirements definition, and testing activities that require substantial subject matter expertise derived from experience in other states, other healthcare organizations, or participation in federal activities. The Vendor is to provide implementation support as requested by the Agency.

Vendor Response

APS-WV has an existing and proven procedure to responding to externally driven changes in requirements for programs we support. During the previous contract periods, APS-WV worked collaboratively with the Department and its Bureaus to:

- Assist with defining requirements in response to state and federal laws, rules, and regulations to ensure that definitions are specific, complete, and accurately reflect the requirements.
- Develop new policy approaches with the Department, conducting data collection and analysis for policy changes and initiatives, and providing subject matter expertise as resources to the Department.
- Configure, test, and implement systems changes to implement new policies and requirements.

Further, as a national specialty company and fully owned subsidiary of the largest QIO, APS-WV can access resources across programs and stakeholders at the state and federal level to assist the Department with its innovative initiatives and goals. Program area experience includes Behavioral Health, I/DD, and medical. We also bring expertise in child/family, adult, and aging populations as well as utilization, case, chronic care, and disease management capabilities. Our analytic capabilities also enable the Department to evaluate its programs with insight data reporting as well as innovative statistics for waiver program budgeting, predictive modeling, and survey methodology.

The APS-WV Executive Director is the point of contact for discussion of additional services. Once notified by the Department concerning the potential for additional services, the Executive Director consults with the appropriate staff and prepares an assessment of the likely impact. She then discusses this assessment with the Department, agreeing on approach, timeframes, and resources to complete the request. By continuing this process, APS-WV can assure the Department and Bureaus the same high quality, efficient, and timely approach to additional services and technical assistance that is a hallmark of our contracts.

M. Contract Close-Out and Turnover Procedures

M. Contract Close-Out and Turnover Procedures

Vendor Response

Contract closeout and turnover procedures are essential to assure an orderly transition of responsibilities between vendors and avoid disruption of service for members and their providers. Through the experience of APS in West Virginia and elsewhere in assuming responsibility from other vendors, we understand and can apply best practices to ensure a smooth changeover through closeout and turnover procedures, rigorous adherence to Department requirements, and a focus on the best interests of members and providers.

WITH EXPERIENCE IMPLEMENTING 16 CHANGE ORDERS AT THE DEPARTMENT'S DIRECTION, APS-WV HAS PROVEN TECHNIQUES AND STRATEGIES TO ADDRESS ADDITIONAL SERVICES

Turnover Plan

1. Turnover Plan

The Vendor is to submit a Turnover Plan to the Agency no later than fourteen (14) calendar days after the date of contract award. The Plan should provide 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 services to members.

The Turnover Plan should include the following:

a. The Vendor's proposed approach to turnover;
b. The tasks and subtasks for turnover;
c. A schedule for turnover;
d. Operational resource requirements;
e. Any training provided; and
f. 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 UM Program.

Vendor Response

APS-WV will develop and submit a Turnover Plan within 14 calendar days of Contract Award. This Plan will describe our overall approach and identify the individuals responsible to administer it if needed to support the process. The timeline for the plan will specify the schedule for tasks and subtasks, assigned responsibilities, operational resources, and training for new vendor staff. Working with the Department and Vendor to document the data structures, content, and timing, we will also transfer review documentation subject to retaining under the terms of this contract, other written materials, Operations and Provider Manuals, and any other material.

Turnover Notification and Period

2. Turnover Notification and Turnover Period

In the event the Agency desires 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 is to 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 may 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 an orderly turnover.

Vendor Response

APS-WV acknowledges the specifications of this section.

Specific Close-Out Requirements

3. Specific Close-Out Requirements

The Vendor is to complete all duties required in the contract with regard to requests for services for dates of services up to and including 11:59 p.m. Eastern Time on the termination date of the contract. These duties should include, but not be limited to, the following:

a. Authorization of services;

b. Successful submission to the Agency of all utilization data;

c. Generation and sending of all required notices to providers and members; and

d. Submission and correction, as necessary, of all reports required by this RFP.

Vendor Response

APS-WV understands and accepts the requirements of this item regarding the timeframe for completion of all contract duties. We recommend that, as part of the Turnover Plan, the new vendor's clinical staff meet with APS-WV to review Waiver member records in the APS System, the status of prior authorizations for selected members, as well as other specifics that are unique to West Virginia. The purpose of this process is to provide a thorough orientation to the vendor and its staff on the needs of specific members and their providers and supports to ensure that members continue receiving services as appropriately authorized.

Agency Access

4. Agency Access

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.

Vendor Response

APS-WV understands this requirement and agrees.

Specific Requirements

5. 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 is to provide, the following information to the Agency:

a. Information including, but not limited to, the number, the review status, and the completion date of all prior authorization services that were requested or authorized by the Vendor up to and including 11:59 p.m. Eastern Time on the termination date of the contract and that have not been transmitted to the Agency for processing.

b. Information on any other deliverables that are pending as of 1159 p.m. Eastern 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 the Agency hearings that have been scheduled or are in process.

APS-WV understands this requirement and agrees.

Response to Questions

6. Vendor Response to Questions

The Vendor is to 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 or 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 the question.

Vendor Response

APS-WV understands this requirement and agrees.

Turnover Meetings

7. 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.

Vendor Response

APS-WV understands this requirement and agrees.

Appendix 2: Implementation Specifications

The following specifications have been determined by the Agency for the Implementation Phase of this project.

Implementation Work Plan

The Vendor's proposal should include an Implementation Work Plan to be maintained throughout the implementation period that includes all tasks required to begin operation of the Utilization Management/Prior Authorization Program successfully. The Work Plan should be sufficiently detailed to satisfy the Agency that the work should be performed in a logical sequence, in a timely manner, and with an efficient use of resources. The Vendor shall submit the final implementation Work Plan electronically and in hard copy to the Agency no later than fourteen (14) calendar days after the date of contract award.

The Implementation Organizational Chart in Figure 18 shows our structure for implementation of the components not currently operational. As this chart reflects, our local and corporate will collaborate to complete the implementation with efficiency and accuracy.

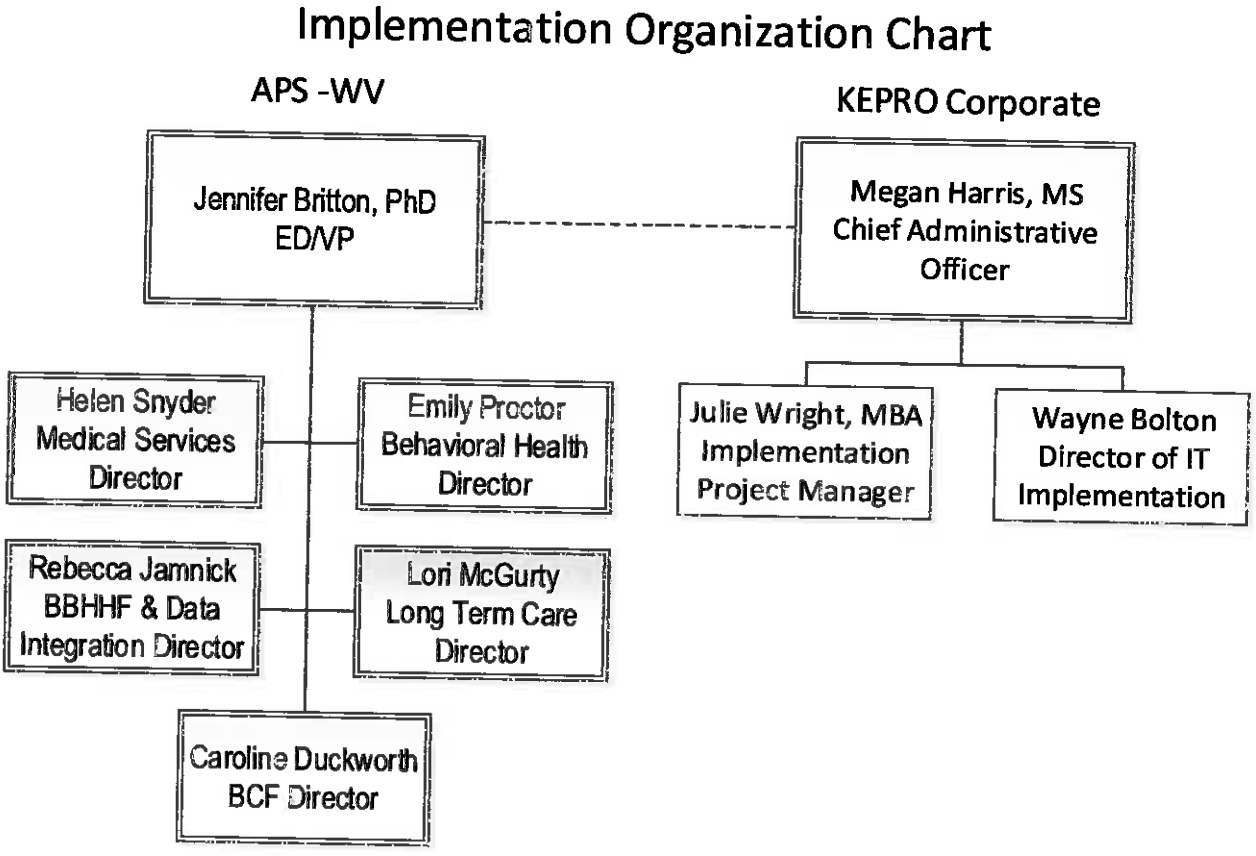


Figure 18 Implementation Organizational Chart

A. Work Plan Tasks

The Work Plan and schedule should include a detailed work plan broken down by tasks and subtasks and a schedule for the performance of each task included in each phase of the contract. The schedule should allow fifteen (15) working days for the Agency approval of each submission or re-submission of each individual deliverable. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined previously in this RFP. This section should cover:

Vendor Response

The draft implementation plan for Information Systems is in Table 12 and encompasses the system requirements to implement prior authorization/utilization management for Transportation and School-based Services (the only components not currently operational) and transition to the 278 Electronic Data Interface (EDI) protocol. Table 13 includes the administrative implementation plan for Transportation Review, and Table 14 includes the administrative and clinical implementation plan for School-based Services. We will review these workplan with the Department upon award, and submit the final Implementation Work Plan electronically and in hardcopy no later than 14 days after contract award.

Table 12 Draft Implementation Plan

Status Indicator	% Complete	Function RFP Section	Key Task	Start Date	Target Completion Date	Responsible Vendor	Lead	Status Update
	100%	**Appendix 2**		**09/04/15**	**11/04/15**			
●	100%		RFP Release Date	09/04/15	09/04/15	DHHR		
●	100%		Mandatory Letter of Intent to Bid Due	09/29/15	09/29/15	APS		
●	100%		Written Questions Due	10/02/15	10/02/15	APS	Vice President- Growth and Development	
●	100%		Answers to Selected Questions Posted	10/23/15	10/23/15	DHHR		
●	100%		RFP Responses Due	11/04/15	11/04/15	APS	Vice President- Growth and Development	
			Milestone: Submit APS Proposal to DHHR	11/04/15	11/04/15			
		Implementation						
	0%		Assign Implementation Director	Contract Award	Contract Award	APS	EVP, Chief Administrative Officer	
	0%		Submit implementation/ work plan to DHHR	Contract Award	+14 Days	APS	Implementation Director	
	0%		DHHR Reviews Implementation plan	Contract Award +14 Days	Submission +15 Days	APS	Implementation Director	
	0%		Approval of Implementation Plan - Not Later Than (NLT)	NLT Submission +29 Days	NLT Submission +29 Days	DHHR		
	0%		Establish weekly face-to-face and conference call schedule with DHHR during implementation phase	Contract Award	+5 Days	APS	Implementation Director	

Status Indicator	% Complete	Function RFP Section	Key Task	Start Date	Target Completion Date	Responsible Vendor	Lead	Status Update
			Update Implementation plan weekly with status updates	Approval of Implementation Plan	Go Live	APS	Implementation Director	
	0%		Milestone: Approval of Implementation Plan		NTL Submission +20 Days			
Security/Privacy								
	0%	**Appendix 2 Section A, B**	Review and update security policies in regards to equipment and data security, storage, and maintenance	Contract Award	+30 Days	APS	VP, IT Application Services	
	0%	**Appendix 2, Section E**	Review and update business continuity plan/DRP	Contract Award	+30 Days	APS	VP, IT Application Services	
	0%	**Appendix 2, Section E**	Finalize APS Site Business Continuity and Contingency Plan, Disaster Recovery Plans.	Contract Award	+30 Days	APS	VP, IT Application Services	
Purchasing/Equipment/Laptops								
	0%		Create & confirm purchase order BOM with Operations	Contract Award	+5 Days	APS	IT	
	0%		Purchase and receive components	Contract Award	+45 Days	APS	IT	
	0%		Receive Inventory, Asset Tag, update CMDB	Receipt of Components	+5 Days	APS	Service Desk Supervisor	
	0%		Desktop / Notebook build and deploy	Receipt of Components	+30 Days	APS	Service Desk Supervisor	
APS System - Transportation/School-based Services/278 EDI								
	0%		Map out Design for input/output for Transportation and School-based Services	Contract Award	+5 Days	APS	IT Configuration	

Status Indicator	% Complete	Function RFP Section	Key Task	Start Date	Target Completion Date	Responsible Vendor	Lead	Status Update
	0%		Map out requirements for 278 EDI	Contract Award	+5 Days		IT Configuration	
	0%		Prioritize Development Needs	Contract Award	+5 Days	APS	IT Implementation	
	0%		Define Business Requirements	Contract Award + 5 Days	+15 Days	APS	IT BA/QA	
	0%		Configuring APS System for Transportation and School-based Services	Contract Award + 15 Days	NLT Sign Off on Requirements + 120 Days	APS	IT Configuration	
			Testing of System - 278 EDI	TBD	+20 Days			
	0%		Testing of System - Transportation/School-based Services	TBD	+20 Days	APS	IT/Operations	
	0%		Systems Testing Passed-Proceed to Production Deployment	Completion of Testing	+ 3 Days	APS	IT Implementation	
	0%		Milestone: All ITS Implementation Tasks are Complete	Contract Award	NLT Sign Off on Requirements + 120 Days			
Operational Preparation/Readiness								
	0%	Appendix 2	Develop Readiness Assessment	Contract Award	Sign Off on Requirements	APS	Implementation Director	
	0%		Perform Readiness Assessment 45 days Prior to Go Live	Go Live '-45 Days	Go Live	APS	Implementation Director	
	0%		Perform Readiness Assessment 30 days Prior to Go Live	Go Live '-30 Days	Go Live	APS	Implementation Director	

Status Indicator	% Complete	Function RFP Section	Key Task	Start Date	Target Completion Date	Responsible Vendor	Lead	Status Update
	0%		Perform Readiness Assessment 15 days Prior to Go Live	Go Live '-15 Days	Go Live	APS	Implementation Director	
	0%		Perform Readiness Assessment 7 days Prior to Go Live	Go Live '-7 Days	Go Live	APS	Implementation Director	
	0%		APS Sign off of Contract Readiness	Go Live '-7 Days	Go Live	APS	Implementation Team	
	0%		Complete Readiness Review Receive Client approval to Implement Services	TBD	TBD	DHHR	DHHR/APS	
	0%		Milestone: Operational Readiness Reviews are Complete (Systems, Staff, Facility, Training)	TBD	TBD			
	0%	GO LIVE	Go Live	TBD	TBD			

LEGEND Status Indicator	
●	Completed
▲	In process
◆	Delayed

Table 13 Implementation Plan for Transportation Review

Task/Subtask	Responsible	Start Date	End Date
Development and Agency Approval of Requirements/Specifications for model		Upon Contract Award	Upon Sign-off
Development and Agency Approval of Forms and Review Criteria		Upon Contract Award	Upon Sign-off
Implementation			
Infrastructure *Acquisition of office space, furniture, and telecommunications, computer including Software and installation of utilities*	Corporate Facilities J. Wright	Upon Contract Award	Within 90 days of Contract Award
Purchase of Equipment/Software for New Employees	Corporate IT W. Bolton	Upon Contract Award	Within 90 days of Contract Award
IT Development			
Modification of Existing Applications/Software Development	Corporate IT	Upon Sign-off of Requirements/Specifications for Model	Within 120 days of Sign-off
Staffing *Hiring and training of central office staff, in-house Call Center staff, and all other Vendor staff required to implement approved model*	Human Resources APS-WV Management Team	Upon Sign-off of Requirements/Specifications for Model	Within 90 days of sign-off
Clinical Staffing *Recruitment and contracting of physician reviewers for transportation services*	Medical Director	Upon Sign-off of Requirements/Specifications for Model	Within 90 days of sign-off
Recruitment and contracting of nurse reviewers for transportation	Human Resources APS-WV Management Team H. Snyder	Upon Sign-off of Requirements/Specifications for Model	Within 90 days of sign-off
Recruitment and contracting of Trainer Consultant reviewers for school-based services	Human Resources APS-WV Management Team	Upon Sign-off of Requirements/Specifications for Model	Within 90 days of sign-off

Task/Subtask	Responsible	Start Date	End Date
	C. Duckworth E. Proctor		
Testing and Readiness *Testing of daily operational requirements, including, but not limited to, in-house Call Center, to ensure that all components are functioning adequately prior to the Agency's Readiness Review*	J. Wright W. Bolton	Upon System Completion	Within 30 days of system completion
Infrastructure	Britton	Upon System Completion	Within 30 days of system completion
Readiness of systems for existing scope of work	Corporate IT W. Bolton	Upon System Completion	Within 30 days of system completion
Readiness of IT systems for new scope (Transportation/School-based Care)	Corporate IT	Upon System Completion	Within 30 days of system completion
Outreach and Communication Member and provider education	J. Britton H. Snyder C. Duckworth E. Proctor R. Jamnick	Upon System Completion	By scheduled system utilization/implementation date
Member Education		Upon System Completion	By scheduled system utilization/implementation date
Member Guide to Ambulance Transportation Requirements		Upon System Completion	By scheduled system utilization/implementation date
Member FAQ/Update		Upon System Completion	By scheduled system utilization/implementation date
Provider Education		Upon System Completion	By scheduled system utilization/implementation date

Task/Subtask	Responsible	Start Date	End Date
Provider Guide to Ambulance Transportation Requirements/School-Based Health Review Requirements		Upon System Completion	By scheduled system utilization/implementation date
Provider FAQ/Update		Upon System Completion	By scheduled system utilization/implementation date
Provider Webinars		Upon System Completion	By scheduled system utilization/implementation date
Reporting *Development of required reports for Ambulance Transportation and School-Based Health Services*	J. Britton H. Snyder C. Duckworth E. Proctor R. Jamnick C. Hayes	Upon System Completion	By scheduled system utilization/implementation date

Table 14 Administrative/Clinical Implementation Plan for School-based Services

Area	Subtasks	Responsible Party	Approximate Time Frames
Advertising and Recruitment of staff	Job Descriptions Job Postings Interviews Hiring	KEPRO HR WV Program Director	30-60 days
Staff Orientation and Training	Corporate WV Program	KEPRO HR APS-WV Team	30-90 days
Equipment Procurement	Office and computers	KEPRO IT KEPRO Operations	30 days
WV IT Programming	Create Databases	APS WV IT	30 days

Area	Subtasks	Responsible Party	Approximate Time Frames
	◦ Training ◦ Technical Assistance ◦ Review Tools	WV Program Director	30 days 90-120 days
Policy Development	UM Guidelines Provider Manual Review Tools Review Policy and Procedure	WV Program Director and staff BMS	90-120 days
Provider Enrollment and Registration	Notifications Agencies ID's Provider Contacts Secure E-mails established	WV Program Director WV Administrative Staff	90 days
Provider Training	Overview of RFP Retrospective Review Process UM Guidelines Service Documentation Review Tools	WV Program Director and staff BMS	90-120 ys

Assumptions or Constraints

Any assumptions or constraints identified by the Vendor, both in developing the work plan and in completing the work plan.

Vendor Response

Assumptions include timely response for approval of materials submitted. With the limited nature of implementation to accomplish, APS-WV only identifies constraints to implementation of systems to support prior authorization of transportation and school-based services: go-live for development of new systems will be complete within 180 days of Department sign-off on requirements.

Person Weeks of Effort

Person-weeks of effort for each task or subtask, showing the Vendor's personnel and the Agency personnel efforts separately.

Vendor Response

As the Department understands, the amount of time to implement the program by December 1, 2015 defines the available person-weeks for both APS-WV and DHHR. Our approach is greatly simplified, given this short time, by the fact that more than 90% of the requirements exist in the current contract. The estimate of person weeks we summarize below reflects *only development of new tasks and requirements.* For this reason, the estimate is significantly lower than possible for any other company. This level of effort is in Table 15, which also notes staffing involved in the Work Plan tasks. Our assumptions about the amount of time required includes allowing at least 15 days for Department review of materials and deliverables, as well as preparation and conduct of Readiness Review activities.

Table 15 Person-Weeks of Effort - Implementation

Implementation Activity	APS-WV	DHHR
I. Infrastructure APS-WV & Corporate Management – HR, Facilities, Purchasing, etc. Assumptions: Six Staff members/1 Week each	6	N/A
II. Staffing APS-WV Management Team; Corporate HR & Finance - APS-WV/KEPRO – 4 Staff /2 weeks each; DHHR – Manager to approve staffing plan if required	8	1
III. Clinical Staffing APS-WV Management Team; Corporate HR & Finance - APS-WV/KEPRO – 4 Staff /2 weeks each; DHHR – Manager to approve staffing plan if required	8	1
IV. Testing/Readiness APS-WV/KEPRO – 6 staff /4 weeks each; DHHR – 5 staff /1 week each	24	5
V. Member & Provider Education Assumptions: APS-WV – 2 Staff members/1 week each; DHHR – 1 Manager to approve materials	2	1
VI. Deliverables Assumptions: APS-WV: 7 Staff /2 weeks each; DHHR – 4 Staff to approve formats/2 weeks each	14	8

Network Diagram

A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.

Vendor Response

We show the Network Diagram in Figure 19, which reflects the critical path for Readiness Review and the Operational Start Date, which based on the current contract period, would be December 1, 2015 for continuation of current scope of work elements.

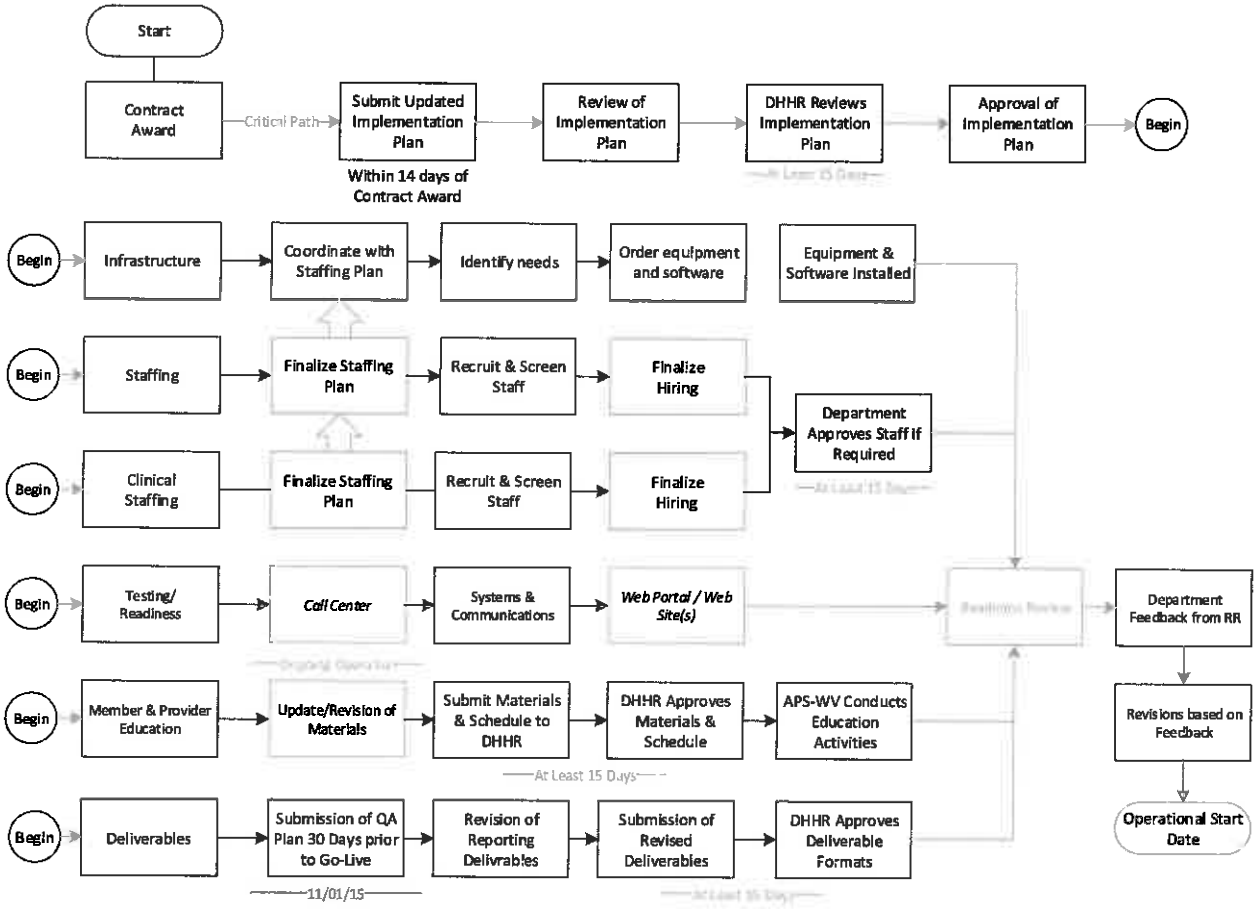


Figure 19 Network Diagram

Addressing Problems and Issues

A discussion of how the work plan provides for handling of potential and actual problems.

Vendor Response

As the organizational charts show in Attachment A, Section 3, APS-WV assigns all aspects of the Scope of Work to a specific, highly experienced member of the Management Team. The Work Plan similarly links specific team members to implementation activities within APS-WV and at the corporate level. An

advantage of the APS-WV solution is that our corporate colleagues bring their own significant and relevant experience to the scope of work – in medical review, information technology, and implementation.

Schedule of Deliverables

A schedule for all deliverables allowing a minimum of fifteen (15) days review time by the Agency.

Vendor Response

We show the schedule for deliverable submission during the Implementation in Table 16.

Table 16 Schedule of Deliverables

Deliverable	Submission
Implementation Plan	14 Days from Contract Award*
Quality Assurance Plan	30 Days before Go-Live*
Reporting Formats	45 Days before Go-Live
Policies and Procedures	45 Days before Go-Live
Business Continuity & Disaster Recovery Plan	30 Days before Go-Live
Weekly Implementation Report	Monday of each week for the previous week

* Timeframes are mandatory

B. Work Plan Schedule

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

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

1. Acquisition of office space, furniture, and telecommunications, computer including Software and installation of utilities;
2. Hiring and training of central office staff, in-house Call Center staff, and all other Vendor staff;
3. Recruitment and contracting of providers/reviewers;
4. Testing of daily operational requirements, including, but not limited to, in-house Call Center, to ensure that all components are functioning adequately prior to the Agency's Readiness Review;
5. Member and provider education
6. Development of required deliverables, including, but not limited to, reports, Operations Procedure Manual, Provider Manual, eligibility file requirement, utilization data submission procedures, Quality Assurance Plan (as described in this appendix), and Business Continuity and Disaster Recovery Plan (as described in this Appendix).

Vendor Response

In Table 17 we show the work plan schedule for tasks referenced in this section.

Table 17 Overall Work Plan

WBS	Task/Subtask	Responsible	Start Date	End Date
100	Implementation		Contract Award	Go Live
101	Infrastructure *Acquisition of office space, furniture, and telecommunications, computer including Software and installation of utilities*	Corporate Facilities J. Wright	Contract Award	Go Live
101.1	Purchase of Equipment/Software for New Employees	Corporate IT W. Bolton	Contract Award	Go Live
102	Staffing *Hiring and training of central office staff, in-house Call Center staff, and all other Vendor staff*	Human Resources APS-WV Management Team	Contract Award	Go Live – 15 days
102.1	Central Office Staff: Hiring Complete	J. Britton	Contract Award	
102.2	Call Center Staff: Hiring Complete*	J. Britton	Contract Award	
102.3	Other Staff: Administrative Staff Complete	J. Britton	Contract Award	
103	Clinical Staffing *Recruitment and contracting of providers/reviewers*	J. Britton C. Duckworth R. Jamnick L. McGurty E. Procter H. Snyder	Contract Award	Go Live – 15 days
103.1	Reviewers	C. Duckworth R. Jamnick L. McGurty E. Procter H. Snyder	Contract Award	Go Live – 15 days
103.2	Physician Advisors (Providers)	Medical Director	Contract Award	Go Live – 15 days
104	Testing and Readiness *Testing of daily operational requirements, including, but not limited to, in-house Call Center, to ensure that all components are functioning adequately prior to the Agency's Readiness Review*	J. Wright W. Bolton	Contract Award	Go Live
104.1	Infrastructure	Britton	Contract Award	Go Live
104.1.1	Readiness of systems for existing scope of work	Corporate IT W. Bolton	Contract Award	Go Live
104.1.2	Readiness of systems for new scope (Transportation/School-based Care)	Corporate IT W. Bolton	Up to 120 Days from Sign-off on Specifications**	
104.2	Staffing	C. Duckworth R. Jamnick	Contract Award	

WBS	Task/Subtask	Responsible	Start Date	End Date
104.3	Clinical Staffing	L. McGurty E. Procter H. Snyder	Contract Award	Go Live - 15
104.4	Outreach and Communication		Contract Award	Go Live – 15
104.5	Deliverables		Contract Award	Go Live - 30
105	Outreach and Communication Member and provider education	C. Duckworth R. Jamnick L. McGurty E. Procter H. Snyder	Contract Award	30 Days before Go-Live
105.1	Member Education			
105.1.1	Member Guide			
105.1.2	Member FAQ/Update			
105.2	Provider Education			
105.2.1	Provider Guide			
105.2.2	Provider FAQ/Update			
105.2.3	Provider Webinars			
106	Deliverables *Development of required deliverables, including, but not limited to, reports, Operations Procedure Manual, Provider Manual, eligibility file requirement, utilization data submission procedures, Quality Assurance Plan (as described in this appendix), and Business Continuity and Disaster Recovery Plan*	J. Britton C. Duckworth C. Hayes R. Jamnick L. McGurty E. Procter H. Snyder	Contract Award	30 Days before Go-Live
106.1	Reporting Deliverables			
106.2	Operations Policies and Procedures			
106.3	Provider Manual/Guide			
106.4	File Exchange Formats and Protocols			
106.5	Prior Authorization Submission			
106.6	Quality Assurance Plan	C. Hayes		
106.7	Business Continuity and Disaster Recovery Plan	Corporate IT		
200	Operations		**Go Live**	**11/30/17**
201	Infrastructure	C. Duckworth C. Hayes R. Jamnick L. McGurty E. Procter H. Snyder	Go Live	11/30/17
202	Staffing			
203	Clinical Staffing			
204	Testing & Readiness	Depending on Area for Implementation	TBD	TBD
205	Outreach and Communication	C. Duckworth C.Hayes R. Jamnick L. McGurty E. Procter H. Snyder		11/30/17
206	Deliverables			
206.1	Reporting Deliverables			
206.2	Operations Policies and Procedures			
206.2	Provider Manual/Guide			
206.3	File Exchange Formats and Protocols			

WBS	Task/Subtask	Responsible	Start Date	End Date
206.4	Prior Authorization Submission		12/1/15	
206.5	Quality Assurance Plan	C. Hayes		
206.6	Business Continuity and Disaster Recovery Plan	Corporate IT		
300	Turnover of Operations		TBD	TBD
301	Submission of Turnover Plan	J. Britton	TBD	TBD
302	Identification of Lead Personnel	J. Britton	TBD	TBD
303	Approval of Turnover Plan	Department	15 Business Days after Receipt	
304	Transition of Operations	Corporate and APS-WV	TBD	TBD

***Using the APS-WV Integrated Call Center Model**

****Depending on the complexity of the implementation**

C. Quality Assurance Plan

At least thirty (30) calendar days prior to the Operational Start Date, the Vendor is to submit a final Quality Assurance Plan to the Agency for its review and approval. The Quality Assurance Plan should include at least the following:

1. The Vendor's procedures for certification that all services are properly authorized;
2. The Vendor's plan to develop safeguards against fraud or abuse by providers,
3. members and Vendor staff and fulfill the Agency reporting requirements regarding such activity;
4. The Vendor's agreement to indemnify the Agency against any causes of actions or claims of payment brought by providers or members;
5. The Vendor's plan to ensure that providers meet standards for qualifications and training; complaint resolution; and other requirements specified by the Agency.

The Vendor should not begin operations without the Agency-approved Quality Assurance Plan. The Agency reserves the right to make quality assurance reviews on services provided by the Vendor under the contract anonymously and without advance notice.

Vendor Response

APS-WV will submit our Quality Assurance Plan, which will address the components required by this section, at least 30 calendar days prior to the Operational Start Date. We understand that the Department may make the readiness review anonymously and without advance notice. In this context, as shown in our response to Section A and B in Appendix 2, our Implementation Plan includes parameters for Readiness Review to ensure that the Department and APS-WV have the same basic expectations for the timeframe of Readiness Review.

D. Operational Readiness Review

Approximately 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 for implementation. The Vendor is to receive written Agency approval of all submission and demonstration requirements prior to the Operational Start Date.

Vendor Response

APS-WV welcomes a Readiness Review approximately two (2) weeks prior to the Operational Start Date. Our location at 100 Capitol Street makes it possible for the Department to conduct this review at its convenience. With the majority of the scope of work currently in Operational Status, Readiness Review can appropriately focus on new tasks.

E. Remediation & Start-Up

The Vendor is to 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 that corrections have been made. Two (2) weeks prior to the scheduled Operational Start Date, the Vendor is to begin taking calls for requests for services that are scheduled to be provided on or after the scheduled Operation Start Date.

Vendor Response

The most significant benefit to continued contracting with APS-WV is our readiness to transition to the next contract period seamlessly – eliminating the risk to individuals who depend on Medicaid and State-funded services for safe and healthy community tenure. This benefit relates in particular to the ability of APS-WV to accept calls for services requested for delivery on or after the scheduled Operation Start Date—including calls for Transportation Prior Authorization and School-based Services, *the only services new to APS-WV*. The current experienced management team has responsibility for these new services and plans for their development and implementation on a timely basis.

Business Continuity and Disaster Recovery Plan

The Vendor's proposal should include a Business Continuity and Disaster Recovery Plan that details the steps the Vendor should take to enable the Vendor to continue to meet all requirements of the contract in the event of a failure of the Agency's or the Vendor's data, communication or technical support systems. The plan should include a process for back-up of the Vendor's data systems, phones, and electronic media records in an appropriate location that is protected against fire, theft or disaster. The Vendor should ensure that its back-up system minimizes the potential for loss of data.

At least thirty (30) calendar days prior to the Operational Start Date, the Vendor is to submit a final Business Continuity and Disaster Recovery Plan to the Agency for review and approval. The Vendor should not begin operations without the Agency approved Business Continuity and Disaster Recovery Plan. The Vendor is to review and update the Business Continuity Plan and Disaster Recovery Plan at least annually.

Vendor Response

KEPRO actively ensures business continuity in the event of a natural or manmade disaster. Immediately following contract award, KEPRO will update our current COOP to integrate all subcontractor systems and supports to address all aspects of program operation.

The KEPRO Contingency and Business Continuity Plan (CBCP) prepares KEPRO for and addresses the elements necessary to ensure continuity of service to critical business systems during various emergencies. Our CBCP establishes procedures to recover business systems following a disruption. KEPRO established the following objectives for this plan:

- Maximize the effectiveness of contingency operations through an established plan that consists of the following phases:
  - **Notification/Activation phase** to detect and assess damage and to activate the plan.
  - **Recovery phase** to restore temporary business systems and recover damage done to the original facilities.
  - **Reconstitution phase** to restore business process capabilities to normal operations.
- Identify the activities, resources, and procedures needed to carry out business processing requirements during prolonged interruptions to normal operations.
- Assign responsibilities to designated KEPRO personnel and provide guidance for recovering business operations during prolonged interruptions to normal operations.
- Ensure coordination with other staff participating in the contingency planning strategies.
- Ensure coordination with external points of contact and vendors who participate in contingency planning strategies.

KEPRO's co-location facility, IPR International, provides a cold site for Disaster Recovery and Business Continuity. The IPR site, located in Reading, PA, is a Tier III, SSAE16 SOC II and Safe Harbor compliant facility. KEPRO maintains rack space and network server and infrastructure equipment that replicate our production environment that we will use in the event of a catastrophic disaster at our facility in Harrisburg.

KEPRO activates the CBCP immediately after determining that a disaster has occurred, ensuring we are operational within 12 hours of activation; and operations are sustainable until resolution of the disaster situation restoration of normal conditions. When disruption of normal operations occurs, KEPRO promptly communicates with the Department and verifies:

- Key points of contact.
- Temporary work locations.
- Means of communication available under the circumstances.
- Essential work products expected to continue performance by priority.

We will use all available resources and tools to continue contracted functions to the maximum extent possible under disaster circumstances.

Appendix 3: The Agency-Specific Reporting Requirements

APS-WV acknowledges and accepts the requirements of Appendix 3.

Appendix 5: Implementation Deliverables, Milestones, and Start-Up Cost Payments

APS-WV acknowledges and accepts the requirements of this section.

Section Four, Subsection 4.2

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

Vendor Response

We assert and confirm that any required changes or modifications to APS-WV systems related to access to or file exchanges with existing agency systems will not require modifications to agency systems.

Application Services staff has an extensive history involving the development of applications that have been used to support a variety of government contracts including:

- State Medicaid programs including both Florida and Virginia Medicaid
- Department of Defense (TRICARE)
- Health Resources and Services Administration (HRSA)

In the course of implementing state-wide Medicaid contracts in the States of West Virginia, Maine, Florida, Virginia, South Carolina, New Hampshire, Minnesota, and Wyoming, our policy has always been to adapt to the systems with which interactions are required by making modifications to its own systems and never requiring a change our partners systems.

Careful consideration and clear policies are required to accomplish required changes in an efficient and effective manner. The following sections describe those policies and methodologies in detail. All applications developed in house are built and tested across multiple platforms. We have established a multi-tiered environment for application development, testing, and release.

Project Management Experience

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

- Develop, implement and oversee the Project Management Methodology / Framework
- Enable the success of project managers by encouraging the use of repeatable governance and project management processes and tools with established standards and measurement criteria
- Establish and promote "best practices" and the use of standard project management tools that will aid in gaining efficiencies and achieving cost savings
- Monitor the Project Portfolio to ensure that projects are prioritized and aligned with strategic objectives
- Promote the use of project management tools and provide guidance in their use.
- Help optimize staff and other assets across projects
- Identify risks and potentials issues

- Provide status and recommendations to the IT Steering Committee and Executive Leadership Team

Our project management team works in conjunction with two oversight functions: Change Control Board (CCB) and the Executive Leadership Team (ELT). The CCB was established to provide a forum charged with ensuring that all proposed system changes, both hardware and software-related, are reviewed to determine if they are viable and will not adversely affect operations.

The change management procedure classifies changes as follows:

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

The CCB derives its authority from the ELT. It is the responsibility of the CCB to review each proposed Change Order, considering its real or perceived impact on existing services and operations. The CCB has final recommendation over all issues brought before it for review. The ELT is composed of C-level and other senior management and has corporate-wide authority established to enable successful mediation of conflicts in Application Services' priorities that may not be in the best interest of the entire organization.

The scope of the Senior Management group:

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

In summary, continued use of our systems and implementation of system for new requirements will not require modifications to existing Agency systems. We have a long and successful history of timely modifications to our own systems to meet the needs of our clients, largely due to thoughtful and detailed policies and procedures related to design, development, testing and implementation of applications.

Section Four, Subsection 4.3:

4.3 Vendor should describe their approach and methodology to maintain secure electronic communication of medical and dental claims data with BMS, BCF, and BBHHF and applicable external service providers which have financial, case management, and/or custody responsibilities.

Vendor Response

Any medically necessary service authorizations completed for the Bureau for Children and Families, while not funded via Medicaid, are treated with equal security and follow the same policies and procedures. APS system data will be provided to the Bureaus on their specified secure FTP site. Service request outcomes will be available for external service providers within the secure APS-WV web application.

Communications not encompassed via these two means will be accomplished using secure e-mail, fax, and phone lines.

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

Our experience with managing application and system security spans over twenty-five years of support a multitude of federal, state, local, and private healthcare contracts. APS-WV parent KEPRO has installed and utilized site-to-site Virtual Private Network (VPN) connections to exchange data with our customers, as well as a backup for our Multiprotocol Label Switching (MPLS) Wide Area Network (WAN) connection between our offices. Additionally, KEPRO regularly uses Secure Sockets Layer/Transport Layer Security (SSL/TLS) to protect data transmissions between KEPRO and customers to protect PHI transmissions and to provide secure email connections between sites. KEPRO has been using SFTP to transmit data to the Fiscal Agent associated with our Virginia, South Carolina, Minnesota, Wyoming, and New Hampshire Medicaid contract since 2002.

APS-WV will exchange medical and dental claims files only files with the Bureau for Medical Services (BMS), the Bureau for Children and Families (BCF), the Bureau for Behavioral Health and Health Facilities (BBHHF), and applicable external service providers. SFTP would be the best fit to protect the security of file exchanges across the Internet. KEPRO will coordinate the connection to our SFTP sites and provide unique credentials for each of the Bureaus and involved providers to facilitate the access.

We typically use FileZilla SFTP client for manual SFTP file transfers. If FileZilla is not acceptable, we will work with the respective Bureaus to find another suitable package. APS-WV will manage any changes to our system such as changes to our firewall to allow access to various Bureau's sites if necessary.

We have a solid history of ensuring HIPPA compliance and securing our internet connections, as well as complying with any additional requirements of the clients we serve. KEPRO has multiple contracts with these requirements and adheres to HIPPA laws and regulations by implementing industry standard technologies and processes for the safeguarding of protected information types.

KEPRO focuses on Operational, Management, and Technical controls to ensure our compliance and the examples below show how we can meet HFS's requirements:

- Annual HIPPA-HITECH Compliance training for all employees
- Annual Security and Awareness training for all employees
- Privacy and Compliance officers for contract auditing
- Annual physical site assessments
- Cisco Adaptive Security appliances for firewall and securing our information system boundaries.
- Enterprise application portals configured with 128bit SSL encryption using Active Directory integrated authentication
- Secure File Transfer Protocol used for data transfers between client sites

- Transport layer security setup for email encryption between sites.

In summary, APS-WV recommends the use of SFTP for communication of medical and dental claim data to BMS, BCF, and BBHHF as well as other applicable providers that have financial, case management, and/ or custodial responsibilities.

Section Four, Subsection 4.4

4.4 Vendor should describe their communication plan that will provide feedback for medical and dental claims, which will assist in the statewide administration of the Medicaid Program, Socially Necessary and BBHHF programs, through generation of consumer and service utilization profiles on all the program areas subject to review and utilization management.

Vendor Response

APS-WV will build on its contracting history to continue our record of achievement for quality, accountability, and intersystem communication with BMS, BCF, and BBHHF to continue development and implementation of effective services. Our established communication plan, constructive consultation, a sound utilization management system, and timely reporting of results assisted DHHR with their continued development and management of the high quality, accountable, system for behavioral health and socially necessary services that is a landmark in public programs.

APS-WV currently meets with representatives of the DHHR Bureaus represented in the scope of work every two weeks and on a monthly basis for waiver programs. In addition to the regularly scheduled Contract Management meeting, APS-WV meets with the contract manager or representatives of any Bureau as requested. As BMS retains authority over the Administrative Services Organization (ASO) contract as a whole, APS ensures that BMS is cognizant of all contract activities and will approve all communications in advance. APS-WV also sends monthly reports of utilization activity to participating providers in addition to detailed feedback provided through retroactive reviews. This detailed information is analyzed at the end of each review cycle to provide both provider and system utilization profiling.

BCF and APS-WV will continue to meet monthly for the ASO Support Meeting and with BCF as represented at the Contract Management meeting. This meeting originally started at one time per week to address issues that applied specifically to the Socially Necessary Services program. This group addresses provider and DHHR worker issues, program changes and Federal policy changes that will affect the program's functioning. The group consists of providers, APS-WV staff, DHHR's MMIS, and Bureau staff. The Bureau has representatives from policy, training, licensing, finance, field staff, and regional management. APS-WV currently provides specific data to this group as requested. APS-WV will continue to provide program utilization profiles using data obtained from program deliverables to aid the work of this group.

Communication Plan for Transition and New Contract Period

APS-WV will continue our practice of timely communications to DHHR, the provider community, recipients, and other stakeholders. APS-WV will expand the current communication plan to include feedback on additional areas of utilization management in the current RFP. We will produce utilization profiles from required reports to provide feedback on program areas in the current scope of work.

Specific program areas addressed include Medical inpatient and outpatient services, waiver services, dental services, transportation, nursing facility medical eligibility, behavioral health inpatient and

outpatient services, socially necessary services, and BBHHF services. Through this approach, APS-WV ensures that our activities are transparent and well-understood in the community, greatly facilitating our ability to assist DHHR, providers, and others to promote the quality and efficiency of services to recipients. We summarize our communication plan in Table 18, and will submit this plan to DHHR prior to implementation for review, input, and approval.

Table 18 Summary of Communication Activities

Pre-Implementation Communication	Post-Implementation Communication
Bureau for Medical Services	
◊ Ongoing updates with BMS contract manager regarding readiness and to obtain sign-off on specifications for new scope of work to initiate 90 day implementation phase ◊ Meetings with designated BMS staff to develop specifications for sign-off by Contract Manager ◊ Complete identified tasks in the Readiness Plan and keep Contract Manager apprised of progress ◊ Conduct outreach and educational communications to healthcare community to prepare for changes in medical review, level of care/medical eligibility, and PASRR reviews. ◊ Attend Contract Management meetings as scheduled per existing protocols	◊ Ongoing Contract Management meetings at specified intervals ◊ Participation in meetings with BMS as requested ◊ Participation in committees, work groups, task forces as requested (e.g. Medicaid Redesign) ◊ Provide feedback and continued education to healthcare community on best practices and opportunities for improvement in service delivery and process of medical necessity and eligibility review. ◊ Consultation on topics as requested
Bureau for Children and Families	
◊ Ongoing updates with BMS contract manager and designated BCF contact regarding readiness and to obtain sign-off on specifications for new scope of work to initiate implementation phase ◊ Meetings with designated BCF/FACTS staff to develop specifications for sign-off ◊ Complete identified tasks defined in the Readiness Plan and keep BMS Contract Manager and BCF contact apprised of progress ◊ Attend Contract Management meetings as scheduled per existing protocols	◊ Ongoing Contract Management meetings at specified intervals ◊ Participation in meetings with BCF as requested ◊ Participation in committees, work groups, task forces as requested (e.g. JAD sessions, CON Review, ASO Work Group) ◊ Consultation on topics as requested
Bureau for Behavioral Health and Health Facilities	
◊ Ongoing updates with BMS contract manager and designated BBHHF contact regarding readiness and to obtain sign-off on specifications for new scope of work to initiate 90 day implementation phase	◊ Ongoing Contract Management meetings at specified intervals ◊ Participation in meetings with BBHHF as requested

Pre-Implementation Communication	Post-Implementation Communication
◊ Meetings with designated BBHHF staff to develop specifications for sign-off ◊ Complete identified tasks defined in the Readiness Plan and keep BMS Contract Manager and BBHHF contact apprised of progress ◊ Attend Contract Management meetings as scheduled per existing protocols	◊ Participation in committees, work groups, task forces as requested (e.g. BH Redesign, NOMS) ◊ Consultation on topics as requested
DHHR Contractors	
◊ Regular meetings with the MMIS to review existing interfaces and modify or develop the necessary interfaces to initiate the required scope of work ◊ Meetings with other DHHR Contractors identified as relevant to APS scope of work to develop IT interfaces or other relevant specifications	◊ Meetings as necessary to address issues and facilitate execution of required scope of work
Providers	
◊ Provide orientation, APS System and Milliman training to new providers: - regional training - provider group specific training - webinars ◊ Provide web materials for reference: UM Guidelines, Provider Manual, FAQ responses	◊ Training as necessary on topics identified through the review process - regional training - provider group specific training - webinars ◊ Web materials ◊ Quarterly Newsletter ◊ Provider QI Council
Members	
◊ Consumer and Community Affairs orientation - regional meetings and training ◊ Web materials – Consumer Manual, general information, contact information	◊ Focus groups ◊ Community Presentations ◊ Consumer QI Council ◊ Web materials ◊ Quarterly Newsletter
Other Stakeholders	
◊ Web materials to introduce APS team, provide orientation to medical necessity, medical eligibility, PASRR, SNS review and other ASO functions.	◊ Web materials ◊ Community Presentations ◊ Quarterly Newsletter

An area of special attention in the new contract period will be implementation of utilization management for school based services and transportation services. During the transition period, we will produce special notices and informational materials for providers and stakeholders to ensure knowledge of the process, timeframes, and responsibilities of all parties.

This communication plan illustrates the continued benefit to DHHR from the comprehensive and integrated approach of APS-WV – communications will be coordinated across Bureaus for enhanced quality and clarity of materials and methods, and oversight by BMS, BCF, and BBHHF will be more efficient through a single vendor.

Section Four, Subsection 4.5:

4.5 Vendor should describe their plan to communicate denial notices to the provider, member, and/or member's legal representative, and how they will specify what elements of admission or continued stay criteria were not met and/or documentation needed to verify medical necessity, and include provider1 practitioner reconsideration and the member's right to appeal for state fair hearing.

Vendor Response

Using the APS System, APS-WV communicates denial notices to providers, members, and/or member's legal representatives within one calendar day of the physician decision to deny service. Denials are communicated to the referring and servicing provider through electronic means. The denial notice is attached to the prior authorization request record in the APS System in a format the provider can print or download to the member record. Providers are informed of the reconsideration process and the peer-to-peer (Reconsideration Level I) and Reconsideration (Level II) actions become immediately available in the system for the provider to request Peer-to-Peer review and/or reconsideration. Members receive mailed behavioral health service denial notices. Providers and APS staff coordinates Peer-to-Peer activities.

The member is informed via US mail as required for the medical program. All letters contain the service denied, the reason for denial (criteria that were not met), and BMS policy relevant to the denial. Both the physician and member letters indicate that the physician may request reconsideration. The member letter contains information informing the member of their appeal rights. All denials reference specific policy and/or criteria that were not met, to assist the member and provider in appealing the adverse decision.

We describe the denial process here related to individual programs, with a flowchart in Exhibit 7.

Personal Care: If the applicant/member does not meet medical eligibility or does not meet the criteria for the requested Service Level, APS will provide the applicant/member with a denial letter. This letter which will include: purpose for denial, a copy of the PAS, the applicable Personal Care policy manual section(s), notice of free legal services, a Request for Hearing Form to be completed if the applicant wishes to contest the decision and specific timeframes for filing an appeal. Providers will be notified of denial through our APS system.

Aged and Disabled Waiver: If the applicant/member does not meet medical eligibility, the applicant or member and their legal representative and the referring physician (for applicants) will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial and include a copy of the PAS and ADW policy. The applicant will have 2 weeks to submit supplemental medical information to APS. Information submitted after the 2-week period will not be considered.

If the review of the supplemental information by APS determines the applicant is not medically eligible, the applicant or legal representative and the referring physician will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision, include the applicable ADW policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied),

notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision. Providers are notified of a denial through our APS system.

I/DD Waiver: If the applicant/member does not meet medical eligibility, APS will mail a Notice of Decision letter to the applicant/member and their legal representative. This letter will include an Independent Psychological Evaluation (IPE) or functional assessment results if applicable, reason for the denial, applicable policy, free legal resources and a Request for Medicaid Fair Hearing form. Providers associated with established members are notified through our APS system of a denial.

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

Traumatic Brain Injury Waiver: If it is determined that an applicant/member does not meet medical eligibility, the applicant, the referring physician or neuropsychologist (for applicants), and applicant's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the Potential Denial letter. The applicant will have 2 weeks to submit supplemental medical information to APS.

If the review of the supplemental information by APS determines that there is still no medical eligibility, the applicant and/or their legal representative (if applicable), and the referring physician or neuropsychologist will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the denial , applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision. Providers will be notified of denial through our APS system when available. Until then, they will be sent electronic notice.

Nursing Home: If it is determined that an applicant/member does not meet medical eligibility for Nursing Facility as a result of their Pre-Admission Screening, they and their legal representative will be sent a Notice of Denial letter. This letter will advise the recipient of the reason for the denial, applicable Nursing Facility policy, a copy of the Pre-Admission Screening, notice of resources to provide free legal services and Request for Fair Hearing form to be completed if they wish to contest the decision. Providers will be notified through our APS-PAS system or electronic communication.

SNS Program: APS-WV will continue to follow the ASO Denial Standard Operating Procedure updated and approved by the Bureau for Children and Families ASO Group on 12/4/2014. When a service is denied within the Socially Necessary Services (SNS) program the following individuals receive secure e-mail notification containing the denial documents: the service provider, DHHR worker, DHHR Worker's supervisor, Customer Service Manager, and Regional Program Manager or their designee. The denial document indicates which specific service(s), the start date of the requested service, FACTS Client ID, Consumer ID, the specific reason for the denial and any recommendations to the DHHR. Recipients of service are not voluntary for this program so notice of the denial is not shared with them. Each letter states these directions to the provider, which were approved by BCF regarding member notification and follow up steps:

Attention Providers: This letter serves as notification to you that the internal APS-WV denial has occurred and APS-WV has referred the case to the DHHR worker to follow through with the DHHR Standard Operating Procedure for ASO Denials if he/she wants or needs the service to continue. The DHHR worker has 15 calendar days from the time that APS-WV notifies him/her of denial to pursue and schedule a DHHR Review Committee. If this contact does not occur, the denial stands. It is your responsibility to assure that proper accepted termination of services procedures have been completed with the consumer. If the consumer expresses the desire to appeal the termination of services, please contact the DHHR worker so that he/she may fully apprise the consumer of his/her right to appeal

Section Four, Subsection 4.6:

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

Vendor Response

APS-WV supports compliance with state and federal requirements at multiple levels in the process. The foundation of our approach is an efficient system configured for individual program requirements. We designed the APS System to support the specific policies and approved medical necessity criteria for the review areas specified in the RFP, policy, and regulations. Specific fields are mandated and validated in the applications to ensure that the information needed to authorize the appropriate service, duration, amount and the most cost effective item, are contained in the request. Providers are alerted through error messages if they attempt to submit a request that does not contain all mandatory fields. Error messages to the submitting provider are designed to indicate unit limits and member benefit limitations. Programming in the application is designed to alert the APS Nurse reviewer to areas not meeting policy requirements and/or criteria checks. These exceptions are displayed as pend reasons that guide the reviewer to areas of policy that require special attention when the review criteria are applied to the authorization request. This approach provides consistency to the review with respect to service limits, areas of possible service duplication, possible service combination edits, and diagnostic or other restrictions applicable to specific services.

We provide a second level of assurance through job descriptions and qualifications carefully aligned with clinical and technical requirements of the work performed. Hiring individuals who meet these requirements at the highest level adds a third level of assurance through detailed knowledge of requirements and, just as importantly, knowledge and experience with delivery of quality services. In this way, APS-WV provides a comprehensive approach to ensuring medical necessity of services delivered in the most appropriate service setting.

Section Four, Subsection 4.7

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

Vendor Response

BMS Services. APS-WV Trainer/Consultants implement a retrospective review of provider documentation practices and utilization management processes. With implementation of this scope of work, Trainer/Consultants will now also review service invoices provided by BMS. Each BMS provider will receive at least one review every eighteen-month cycle. Additional reviews may be warranted based on:

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

Based on the above factors the provider will be slated for a desk audit or an on-site review. A random sample is selected based upon the volume and complexity of the service array of the enrolled provider. Consultations with providers will be scheduled at least four to six weeks in advance by the designated Trainer/Consultant (TC). If the provider cannot be immediately reached by telephone, the TC will leave a message for the provider to return a call to the TC's cell phone. If the call is not returned the same day, the TC will attempt to contact the provider daily for three business days. If no return call is received within three business days, the TC will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Trainer/Consultant Team Leader is apprised of the situation. During the phone call to schedule the consultation, the TC outlines the retrospective process and its purposes. The TC confirms the provider's mail and email addresses during this phone call and confirms the contact to which the sample should be sent. The TC then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The TCs maintains confidentiality as per HIPPA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information while the Trainer/Consultants are on-site. These tools are required:

- BH Outpatient Medical Necessity UM Guidelines manual;
- Copies of review instruments;
- APS-WV Interpretive Guidelines (proprietary);
- Copy of each consumer's APS System record with demographic information and summary clinical information.

Once on-site, the TC begins the review by interviewing the primary contact person for the provider. Using the sample printout sent to the provider, a record is selected by the TC for review. The start date, service

category, and service are noted for the most recent authorizations. If there are multiple services for the same period, all documentation referring to that service is reviewed. The member's APS System copy with fields reflecting the consumer's functional deficits and the focus of the service is compared to any information in the record and the service plan for consistency. If there are multiple re-authorizations for the same service, the TC reviews case notes, service plans and any documentation that indicates progress on service objectives and appropriateness of services delivered to the member.

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

This process will be modified for providers utilizing the Medicaid manuals that were recently updated, such as Behavioral Health Clinic and Rehabilitation Services, to require disallowance reviews. These will be incorporated for each behavioral health provider type as their manuals are updated. Clinic and Rehabilitation Providers were notified by BMS in writing on April 16, 2015 that the following reasons will result in a disallowance:

- Credentialing
- CIB (fingerprint check at initial and every three years - can do name-based check for 90 days while waiting on print returns)
- OIG monthly checks
- Degree (diploma and transcripts)
- License verification
- Internal credentialing for services including a policy for services provided while seeking internal credentialing
- Clinical Supervision
- Chart demonstrating the clinical "chain of command"
- Supervisor must have an equal degree, clinical experience, credential, or higher than the supervisee
- 72 hour Authorization forms for Coordinated Care
- Signed Service Plans (physician, physician extender, licensed psychologist, supervised psychologist)
- Legible Records
- Documentation requirements of date, start/stop times, place of service, signature, and credentials
- Duplicate billing

- UP-Coding
- Services not permitted by Tele-health
- ACT team composition and credentials

The process for the completion of disallowance reviews will follow the description in Table 19:

Table 19 Chapter 503.9 REHABILITATION PROVIDER REVIEWS

Monitoring of Rehabilitation Services
"The primary means of monitoring the quality of Rehabilitation services is through provider reviews conducted by OHFLAC and the Contracted Agent as determined by BMS by a defined cycle. The Contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site Rehabilitation provider reviews and/or desk reviews may be conducted by OHFLAC and/or the Contracted Agent in follow up to Incident Management Reports, complaint data, Plan of Corrections, etc. Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the Rehabilitation provider. If potential disallowances are identified, the Rehabilitation provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the Rehabilitation provider and issue a final report to the Rehabilitation Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Rehabilitation Services. A cover letter to the Rehabilitation provider's Executive Director will outline the following options to effectuate repayment: (1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or (2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or (3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments. If the Rehabilitation provider disagrees with the final report, the Rehabilitation provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in Common Chapter 800 (A), General Administration of the West Virginia Medicaid Provider Manual. The Rehabilitation provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention. Continued review cycles may expand the areas for potential disallowances per direction from BMS. For further information on the provider reviews, the VW Clinic and Rehabilitation manuals can be accessed at http:/Ailww.dhhr.wv.oov/bms/Paqes/ProviderManuals.aspx . If you have any questions regarding this process, please contact me at 304-356-4936 or Cynthia.A. Parsons@wv.gov."

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

Socially Necessary Services. After the prior authorization, APS-WV Trainer/Consultants implement a retrospective review of provider documentation practices and utilization management processes. Trainer/Consultants (TC) will review service invoices provided by BCF or continue to review invoices provided directly from the provider and provider credentialing information while on site for the retrospective review. Each SNS provider will receive at least one review every eighteen-month cycle. Additional reviews may be warranted based on:

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

Providers with 10 or more unduplicated consumers authorized for Socially Necessary Services will receive an on-site review. Providers with less than 10 unduplicated consumers will receive a desk audit. A random sample is pulled based upon the volume and complexity of the service array of the enrolled providers. Consultations with SNS providers will be scheduled at least four to six weeks in advance by the designated Trainer/Consultant. If the provider cannot be immediately reached by phone, the TC will leave a message for the provider to return a call to the TC's cell phone. If the call is not returned the same day, the TC will attempt to contact the provider daily for three business days. If no return call is received within three business days, the TC will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Director of Socially Necessary Services should immediately be apprised of the situation. During the phone call to schedule the consultation, the TC outlines the consultation process and its purposes. The TC confirms the provider's mail and email addresses during this phone call and asks to whom the sample should be sent. The TC then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The TCs maintains confidentiality according to HIPAA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. The following tools are required:

- Social Necessity Services UM Guidelines manual
- Copies of review instruments
- APS-WV Interpretive Guidelines
- Copy of each consumer's APS System record with demographic information, current living situation, and service plan summary, presenting problems, level of support questions, guardianship status, and free text field information.

Once on-site, the TC begins the review by interviewing the primary contact person for the agency or the actual SNS provider. This person is queried regarding how referrals are received, what information is received at first contact, how is information gathered for APS System, and whether there are concerns about the referral process. Using the sample printout a record is selected by the TC for review. The start date, service category, and service are noted for the most recent authorizations. If there are multiple services for the same period, all documentation referring to that service is reviewed. The Referral Form is

reviewed for justification of the service, category of service and any information from the DHHR worker that indicates the consumer's deficits and needs as related to the definition of the authorized service being reviewed for the specific period. The consumer's APS Social System copy with fields reflecting the consumer's functional deficits and the focus of the service plan should also be compared to any information in the record and the service plan for consistency. If there are multiple re-authorizations for the same service, the TC reviews case notes, service plans and any documentation that indicates the worker was contacted at the re-authorization period and that progress towards service objectives was addressed and all agreed that the services should continue. Provider personnel charts will also be reviewed to ensure that the proper credentials and requisite background and safety checks such as the OIG list have been completed. A portion of the review report will directly address the results of each personnel chart. If questions or concerns about specific records arise during the consultation, they can be discussed by phone with the Director of Social Necessary Services or an SNS Care Manager.

APS-WV meets with providers at the conclusion of the on-site review. We discuss the most important findings of the review, and assess strengths and areas of improvement for the provider. The TC addresses any provider questions brought up during the entrance meeting or during the review process. After the meeting, the provider completes an Exit Technical Assistance form and returns it to APS-WV. A Consultation Report, which presents results and recommendations for improvement, is distributed electronically to the provider immediately following the exist conference. A consultation Follow-up Technical Assistance call addresses areas for improvement identified through the review process and is made within 10 days of the provider's receipt of report.

Providers who receive less than 80% on a retrospective review will be required to undergo mandatory technical assistance on each individual service scoring under 80% on the BCF approved retrospective review tools. Once the technical assistance is completed, the trainer will conduct a follow up review to determine if the provider has made improvements. The outcomes of these reviews will also be provided to BCF and reviewed with the ASO Group to determine if any further action is required. For all providers scoring 80% or above on a retrospective review, training and technical assistance will be available for the provider but is not mandatory.

BMS Behavioral Health Retro Reviews. Currently we perform retrospective reviews as follows:

APS-WV Trainer/Consultants implement a retrospective review of provider documentation practices and utilization management processes. With implementation of this scope of work, Trainer/Consultants will now also review service invoices provided by BMS. Each BMS provider will receive at least one review every eighteen-month cycle. Additional reviews may be warranted based on:

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

Based on the above factors the provider will be slated for a desk audit or an on-site review. A random sample is selected based upon the volume and complexity of the service array of the enrolled provider. Consultations with providers will be scheduled at least four to six weeks in advance by the designated Trainer/Consultant (TC). If the provider cannot be immediately reached by phone, the TC will leave a

message for the provider to return a call to the TC's cell phone. If the call is not returned the same day, the TC will attempt to contact the provider daily for three business days. If no return call is received within three business days, the TC will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Trainer/Consultant Team Leader is apprised of the situation. During the phone call to schedule the consultation, the TC outlines the retrospective process and its purposes. The TC confirms the provider's mail and email addresses during this phone call and confirms the contact to which the sample should be sent. The TC then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The TCs maintains confidentiality as per HIPPA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information while the Trainer/Consultants are on-site. These tools are required:

- BH Outpatient Medical Necessity UM Guidelines manual;
- Copies of review instruments;
- APS-WV Interpretive Guidelines (proprietary);
- Copy of each consumer's APS System record with demographic information and summary clinical information.

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

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

This process will be modified for providers utilizing the Medicaid manuals that were recently updated, such as Behavioral Health Clinic and Rehabilitation Services, to require disallowance reviews. These will be incorporated for each behavioral health provider type as their manuals are updated. Clinic and Rehabilitation Providers were notified by BMS in writing on April 16, 2015 that the following reasons will result in a disallowance:

- Credentialing

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

The process for the completion of disallowance reviews will follow the description below in Table 20.

Table 20 Chapter 503.9 REHABILITATION PROVIDER REVIEWS

Monitoring of Rehabilitation Services
"The primary means of monitoring the quality of Rehabilitation services is through provider reviews conducted by OHFLAC and the Contracted Agent as determined by BMS by a defined cycle. The Contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site Rehabilitation provider reviews and/or desk reviews may be conducted by OHFLAC and/or the Contracted Agent in follow up to Incident Management Reports, complaint data, Plan of Corrections, etc. Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the Rehabilitation provider. If potential disallowances are identified, the Rehabilitation provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the Rehabilitation provider and issue a final report to the Rehabilitation Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Rehabilitation Services. A cover letter to the Rehabilitation provider's Executive Director will outline the following options to effectuate repayment: (1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or (2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or (3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments. If the Rehabilitation provider disagrees with the final report, the Rehabilitation provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in Common Chapter 800 (A), General Administration of the West Virginia Medicaid Provider Manual. The Rehabilitation provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention. Continued review cycles may expand the areas for potential disallowances per direction from BMS. For further information on the provider reviews, the VW Clinic and Rehabilitation manuals can be accessed at http:/Ailww.dhhr.wv.oov/bms/Paqes/ProviderManuals.aspx . If you have any questions regarding this process, please contact me at 304-356-4936 or Cynthia.A. Parsons@wv.gov."

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

BMS Inpatient Psychiatric Services Under 21 Retro. APS-WV will complete on site retrospective reviews of inpatient psychiatric services for individuals under 21 years of age. At least one time with in an 18 month cycle APS will be on site to review each provider who received an authorization regardless of if it is an instate or out of state provider. A 10% sample will be utilized for each reviewer with a minimum of three charts- whichever is greater. APS' psychiatric nurse will participate in the joint certification reviews conducted with BCF and the WV Department of Education. Certification reports will be given to BMS as well as BCF. The APS staff member will also review corrective action plans when required and make recommendations to the multi-agency certification team regarding the provider's responses. All retrospective tools are currently approved by BCF and BMS. No changes will be made to these retrospective tools without both Bureaus approval.

BMS Psychiatric Residential Treatment Facility (PRTF) Retrospective Review

APS will complete on site reviews of all providers receiving an authorizations for PRTF services at least one time in an 18-month cycle. A 10 10% sample will be utilized for each review or a minimum of three charts- whichever is greater. The retrospective reports consisting of a policy review, clinical review and areas that need to be improved to meet WV's standards will be provided to BCF and BMS within 30 business days of the exit conference.

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

Section Four, Subsection 4.8

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

Vendor Response

APS-WV excels at meeting the analytic and reporting requirements of the Bureaus in our current contract, and will continue this successful record of accomplishment into the next contract period. This approach will consolidate all data analysis and reporting functions within APS-WV to provide DHHR with a single report point of contact. We describe our process to respond to specific reports and invoicing requirements in Reporting. APS-WV presented our approach to retrospective reviews for authorization above.

Data Access Across Bureaus

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

Data Reporting, Trend Analysis, and Profiles

APS-WV will not only provide timely reports and accurate reporting/analysis through reviews but will also provide the same timeliness when adding the additional invoicing and credential checks to the procedure. APS also conducts analysis of activities for inclusion in the annual and other reports. APS-WV also provides analyses on program activity on an annual basis, as we show in Table 21.

Table 21 Summary of Socially Necessary Service Reviews Fiscal Year 2014 – 2015

Number of Providers	A. Clinically Processed	B. Denied	C. Pended (Closed)	D. Pended (Authorized)	E. Auto Authorized	F. Total Authorized (D+E)	G. Auth Rate (F / A)
337	75,053	9	6,183	48,725	15,065	63,790	84.99 %

This table indicates the volume of review activity by type of activity, and dramatically emphasizes the APS-WV approach to timely service reviews and consistent communication with providers to promote authorizations within guidelines.

Section Four, Subsection 4.9

4.9 Vendor should describe their plan for development and implementation of initially pending authorization, which are identified as needing further documentation, during the review process, prior to denying the authorization. This includes, but is not limited to the following:

Vendor should include in their plan, steps to assure that pending notices specify documentation needed in the behavioral, medical, or dental necessity review or socially necessary review and efforts that the vendor will take in collecting specified documentation.

Vendor Response

Socially Necessary Services

APS utilizes a tiered system for the purpose of authorizing services delivered to The Bureau for Children and Families consumers. All data is submitted electronically. Increasing levels of data are required as the complexity of a case increases. Tier One (1) involves a minimal set of data elements. At Tier Two (2), the number of data elements increases. This tier is utilized for more complex case scenarios where the intensity of service may be minimal but the need for continued stay warrants further review. Tier Three (3) is reserved for transitional living services. Information received is automatically entered into the APS Social System, which compares the consumer data to UM criteria. APS-WV promptly makes a confirmation of authorization available to providers for those requests that meet the criteria via the secure APS website. For each eligible consumer for whom the provider has submitted an authorization request, there is an initial amount of each service that is automatically authorized for a particular level of care, if the UM criteria are met.

Cases that do not meet criteria are automatically flagged by the system and deemed "pending" or "pended" for the care manager for electronic and/or telephonic review with the requesting provider or DHHR worker. Providers are notified of "pended" requests via the secure APS website. If extra documentation or information is required, the SNS care manager places the request in review and contacts the provider and /or worker explaining what is needed. The provider and/or DHHR worker are given 10 business days to provide the information. If there is no response, the service request is closed with a note explaining that information was not received and again outlines what information is needed. In the event that a consumer currently in care needs service beyond the initial authorization, providers obtain re-authorization for continuing services using the submission of data at the appropriate Tier based

on the defined UM Guidelines for the service. The authorization/pending process for re-authorization requests functions the same manner as for initial authorization requests. After the review process, one of the following outcomes will occur: authorization, review, closure, or an alternative service is recommended. The service requests are not authorized if the consumer is ineligible for all or specific requested services, maximum allowable number of authorizations has been exhausted and/or the service is being used by inappropriately.

If the DHHR worker wishes to appeal the decision, an APS internal reviewer will analyze the case and data available to determine if there is justification for granting the request. If justification is not found, the request(s) will be denied. Internal reviewers are master's level licensed social workers, counselors or psychologist who do have conflicts and have no prior knowledge of the case being reconsidered. If the DHHR worker desires a second level appeal, the case if forwarded to the DHHR Review Committee consisting of a representative from BCF policy, finance, and field operations. APS then implements the decision of the DHHR Review Committee. APS posts all responses to our secure web site for providers to access and places all the authorizations and rollback information on DHHR's secure site to be loaded into FACTS. APS retrieves the next day's referral file and any DHHR initiated rollbacks, and repeats the cycle.

Medical and Behavioral Health Services

APS has developed a clear method for suspending review of prior authorization requests that require additional documentation in order to complete the review. In the medical program:

a. documentation is reviewed at the time of submission and missing documentation is identified. If the provider uses the provider portal to direct data enter (DDE) a request they are alerted through a variety of means that documentation is needed to complete the review. For those applications that are solely DDE (e.g. ADW, BH) the provider is notified through pend reasons or error messages if submissions do not comply with requirements. For the medical program which allows faxed requests, if the documentation is not received upon fax of the request a "fax back" form is completed that delineates the missing information and faxed to the provider. For DDE requests, electronic and telephonic notification is used as in the other programs.

b. Timelines have been established for the various programs to establish parameters for the timely receipt of documentation. If documentation is not received within specified timeframes, the request is either administratively closed or denied depending on the amount of information initially received. Timelines are 3 business days for the medical program to receive documentation and 10 business days for the behavioral health program. Providers have been notified of these timeframes and the verbal and electronic notifications remind them of these timelines. When the reviewer places a request in the "documentation requested" status, the review timeline is suspended and resumes when the documentation is received. If the documentation is not received within specified timelines, the request is administratively closed. The provider may resubmit the request with the corrected, updated, or additional information using a "copy for new submission" feature.

Long-Term Care Management

I/DD Waiver: Upon receipt of a request for service authorization through our web-based System, the service is automatically placed in a "pend" status. An APS Registration Coordinator (RC) will review and make an initial determination within 2 days of receipt. Should we require additional information, the RC will place the requested service(s) in "documentation requested" status and will include a note outlining

the needed follow-up or documentation. This change of status automatically sends a notification of the update and requested information to the provider. The provider has 10 days to respond with necessary documentation or the request will be administratively closed.

TBI Waiver: Upon receipt of a request for service authorization, the request will automatically be placed in a "pend" status. A TBI Waiver staff will review and make determination within 2 days of receipt. Should we require additional information, the TBI staff will request documentation or follow-up by the provider electronically (email or web-based system, when available). The provider has 5 days to respond with necessary documentation or the request will be administratively closed.

Personal Care: APS-WV receives authorization requests for Personal Care services via our electronic system. If, upon review, we find the request incomplete or that it does not substantiate medical eligibility, we will request documentation from the submitting provider through the system. The provider has 5 days to respond with additional information. If no response, the request will be administratively closed. The provider may submit a new request at any time.

Nursing Facility: We review requests for Nursing Facility approval in the APS-PAS system. If the PAS does not include criteria to establish medical eligibility, we will request additional information through the system. Submitting providers have 5 days to respond, else the PAS will be administratively deactivated. The submitter may submit a new request at any time.

Aged and Disabled Waiver: Only the Service Level Change Request is the process applicable to this section. In the event an Aged and Disabled Waiver member requires/requests an increase in their service level, the ADW provider will submit a request through our APS system. If upon review, we find we cannot approve the request, we will request additional information or follow-up through the system. Providers have 5 days to submit necessary information or the request will be closed.

a. Contacting Practitioners

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

b. Establishing Time Frames

Timelines have been established for the various programs to establish parameters for the timely receipt of documentation. If documentation is not received within specified timeframes, the request is either administratively closed or denied depending on the amount of information initially received. Timelines are 3 business days for the medical program to receive documentation and 10 business days for the behavioral health program. Providers have been notified of these timeframes and the verbal and electronic notifications remind them of these timelines. When the reviewer places a request in the "documentation requested" status, the review timeline is suspended and resumes when the documentation is received. If the documentation is not received within specified timelines, the request is

administratively closed. The provider may resubmit the request with the corrected, updated, or additional information using a "copy for new submission" feature.

Section Four, Subsection 4.10

4.10 Vendor should describe their plan for identifying criteria for denial notices which were deemed not met during the review process and advise the practitioner of the reconsideration process and the member of their right to appeal. Vendor should include in their plan steps to assure that denial notices specify criteria which were deemed "not met" in the behavioral, medical, or dental necessity review or socially necessary review.

Vendor Response

APS-WV will continue to follow the ASO Standard Operating Procedure for Denials from December 2014. Each provider letter outlines the reason for referrals related to the UM Guideline Criteria that was not met. Denial notices sent to providers and members contain the specific policies and/or criteria not met. In the medical program, we generate letters based on specific medical necessity criteria that are not met as well as policy citations when policies are not met (see Exhibit 47 for specific policy criteria most frequently cited in letters). Denial notices are specific to the program or service and behavioral, medical, dental and Waiver denial letters all provide specific information to the provider and member as to why the service was denied. Denial notices specifically inform the practitioner of the reconsideration process and the member of their appeal rights.

Section Four, Subsection 4.11

4.11 Vendor should describe their plan to receive requests via secure electronic media, web-based, telephonic, facsimile, or written request through the mail for all services that require medical necessity, with the understanding that Vendor is to receive web-based requests for all socially necessary services.

Vendor Response

APS-WV currently receives authorization requests for behavioral health outpatient services and socially necessary services from all providers via web-based or EDI submission. APS-WV will retain existing formats for services it already manages and will develop web-based formats through the APS application as well as accepting fax, telephonic or written requests for service authorization that are completed within specified guidelines. Where appropriate to improving the efficiency of the prior authorization request process APS-WV will encourage providers to utilize the APS application and will provide the training and technical assistance necessary for them to make this transition.

Below we have provided additional details on the process for receiving requests for all services that require medical necessity for each Bureau.

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

The APS System is a HIPAA-compliant system that supports BMS' Transformation Grant by:

- Collecting data to help track over- and under-utilization of program-funded services.
- Promoting more rapid adoption of health information technology among providers.
- Integrating data to increase identification of fraud, waste, and abuse.

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

Although APS-WV's current provider types do not submit via fax, telephone or written requests, we are able to accommodate other types of submission modes according to the individual service needs within the expanded provider base (i.e., inpatient psychiatric, partial hospitalization, and PRTF services). Based upon the large group of providers currently submitting electronically, APS-WV suggests consideration be given to maintaining the requirement for electronic submissions for Behavioral Health Outpatient providers; this approach is consistent with current practice and prevents potential disruption to providers. Additionally as we have emphasized throughout Section I, we will encourage providers to make use of Internet access to APS systems to improve efficiency and data quality.

Bureau for Children and Families (BCF)

APS-WV currently receives requests for socially necessary services via the web from all providers. Based upon the large group of providers currently submitting electronically, APS-WV suggests consideration be given to maintaining the requirement for electronic submissions for agency and individual providers but giving consideration to allowing foster parents and biological parents to submit via fax or telephone.

Bureau for Behavioral Health and Health Care Facilities (BBHHF)

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

Section Four, Subsection 4.12

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

Vendor Response

The current APS systems serves as a basic behavioral health assessment that has been standardized by the Department and is utilized by Clinic, Rehabilitation, TCM, psychologists, psychiatrists and BBHHF Contract providers. The APS Social IT System is utilized by providers of socially necessary services. Both applications contain basic demographic information that facilitates tracking individuals in both programs and reporting across the two programs. In the next contract period, APS-WV will work with the Bureau to incorporate medical information into the assessment, which can then be used for initial and on-going assessment in treatment and identification of the appropriateness in level of treatment as relevant. The data requirement for behavioral health providers is tiered to provide comparable demographic and diagnostic information on all recipients of behavioral health services to BBHHF and to provide a more robust data set (which includes information about symptoms, functional impairment, current treatment plan goals and other pertinent data relevant to authorizing behavioral health services) when more intensive services are requested. BBHHF contract providers must submit a larger basic data set for federal reporting, discharge data on all members for NOMS and Substance Abuse Block Grant reporting, and the federal reporting data when the member has a substance abuse diagnosis. BBHHF contract providers also submit basic demographic and diagnostic data (and federal reporting data, if applicable) for BBHHF eligible individuals and individuals with other payer sources (e.g. third party payers).

APS-WV will make the necessary revisions and additions to the Federal Reporting data set to collect information on persons with addictive disorders. The current military data set can be validated by APS or can continue to be sent to BBHHF without validation as is the current practice. APS-WV will also work with BBHHF and BBHHF Contract providers to develop the required data sets for children/adolescents and information to be collected from state hospitals and hospitals and private inpatient facilities that receive diversionary patients from the state hospital when there is no bed availability. Data from BBHHF contract providers, state hospitals, inpatient psychiatric hospitals handling diversions, and other providers of BBHHF services designated by BBHHF, will be collected upon entry in the system, at critical treatment junctures and at intervals designated by BBHHF (e.g. discharge). Data will be utilized to complete specified BBHHF reports.

Section Four, Subsection 4.13

4.13 Vendor should describe their plan to collect and process basic information about persons served under the Clinic and Rehabilitation, Home Health, Hospice, and Private Duty Nursing, Psychology, and other behavioral health specialty manuals including demographic information, diagnosis, medical eligibility for service, level of service need and other basic service information; information to be collected upon initial entry into the system, at regular intervals and at critical treatment junctures.

Vendor Response:

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

Section Four, Subsection 4.14

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

Vendor Response

Basic demographic data is collected for all behavioral health and socially necessary service recipients so that reporting can be done across programs. Medical services, inpatient psychiatric services, PRTF and optional services will collect the same basic demographic data for integrating reporting and recipient tracking across program areas.

As a specific example, for BCF, APS-WV will continue to collect and process the data set previously designed by BCF at the established authorization periods for individuals receiving services through the Socially Necessary Services program. The quarterly and critical juncture lengths of service were established to align with the Adoption and Safe Families Act and BCF's policy for case reviews. For medical and/or behavioral health services paid by BCF for those who are uninsured, other third party insured, or those receiving services not funded by Medicaid at contracted or enrolled facilities, the data set approved by BMS for Medicaid providers will be utilized and collected at the same times including admission, continued stay and critical junctures.

Section Four, Subsection 4.15

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

Vendor Response

APS-WV has an established relationship with the MMIS vendor, the Department's fiscal agent, to access their system to verify member's eligibility status and to check the status of authorizations issued by APS-WV. APS-WV additionally receives Clinic, Rehabilitation, TCM, Psychology, and Psychiatry claims information for analysis and will continue to follow the procedure established by BMS for APS-WV receipt of claims data. APS-WV will expand the claims analysis to include the expanded scope of authorizations. APS-WV will continue to interface with the MMIS vendor to complete required reports and claims analysis and will work with the vendor to establish a method for receipt of claims data on a more frequent basis to accommodate the requirement for quarterly reports on claims.

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

APS-WV will maintain the approved process for receiving and distributing data. APS-WV will meet with the fiscal agent to expand the claims analysis scope of work further to include all medical claims. Through this efficient and accountable system for funding appropriate services can be maintained. Sample reports are included in Exhibit 48.

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

Section Four, Subsection 4.16

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

Vendor Response

Training and technical assistance to the provider community has remained a strength of APS-WV throughout each contract period. We look forward to continuing this record of support into the new contract. Over the 15 years of our contract, we have tried various ways to ensure that every skill/trend and detail was communicated to our providers. In the last contract, the trainer consultant changed the

process to offer smaller trainings at the each individual provider's site. This approach allowed providers to pin point with APS, which staff or departments needed the most support and directly reach them. Trainings done in great groups tended not to get the information passed down to those actually providing the services and less improvement than APS wanted was demonstrated. This change allowed providers to take ownership in the training technical assistance process and we even coordinated with provider's schedules to provide multiple sessions at their site so operations could continue. General regional trainings have still been held when requested by the Department, but we have found more success in using Webinars to reach more people. By using webinars, we can do multiple sessions on various days and times. This allows providers to continue to provide services by distributing staff across the trainings. Attendance also increased because the provider does not have to arrange transportation for staff members. When we do a large webinar, trainer/consultants always offer to come on site to assist providers to implement the new information and/or just to answer questions specific to their agency. Onsite provider trainings have also been altered so that providers can choose a traditional PowerPoint informational training or actually use cases from their agency as examples.

APS-WV will conduct training in each of the two (2) identified BBHHF regions (North – Healthways, Northwood, Valley, United Summit, Appalachian, Potomac Highlands, East Ridge and Westbrook counties; and South – Prestera East and West, Logan-Mingo, Southern Highlands, FMRS, Seneca counties) quarterly on relevant topics approved by BBHHF and identified by providers and APS staff.

Training and technical assistance to the provider community has been a strength of APS-WV throughout each contract period. We look forward to continuing this record of support into the new contract. Our process to develop and deliver technical assistance and training includes the following activities, which we will finalize with the approval of BBHHF:

- *Needs assessment.* APS-WV will work with BBHHF and the provider community to identify training and technical assistance needs at the provider and regional levels. We will also use information from our eligibility verification and data validation processes to identify areas where providers may require technical assistance and/or training. An important aspect of needs assessment is the analysis of data trends and patterns of provider performance that vary from BBHHF requirements. Needs observed among providers will be documented and reviewed with BBHHF, with our recommendations for training and technical assistance services that address the identified needs.
- *Development of training programs to address identified needs.* With approval from BBHHF on provider training needs, APS-WV will develop training materials and programs for the provider community, such as documentation requirements, aspects of medical eligibility for services that can be improved among providers, and the assessment process and results of reports on provider performance. These materials will be submitted to BBHHF in advance for review and approval, and revised after comment from BBHHF as needed.
- *Scheduling of technical assistance and training.* Technical assistance and training opportunities can be delivered at the individual provider level and/or to the provider community as a whole. In this discussion, we address scheduled regional training and technical sessions for providers. APS-WV will continue to provide one-on-one training and technical assistance to BBHHF providers as needed. Regional training sessions will be scheduled so that providers can be notified of the training and agenda, location, and timeframes at least 30 days in advance of the training session.

This information will be distributed directly to providers as well as posted on the APS-WV website. As with training and technical assistance materials, APS-WV will submit the proposed training schedule, locations, and agendas to BBHHF in advance, as part of our collaborative planning and management process.

- *Delivery of technical assistance and training for BBHHF providers.* APS-WV team members will conduct the regional technical assistance/training sessions as proposed. During the training sessions, providers will also be encouraged to identify other topics for future training sessions, as well as request and schedule opportunities for technical assistance at the individual provider or provider group level.
- *Evaluation of technical assistance/training.* As with all training APS-WV has conducted, we carefully evaluate the success of each session through feedback from participants. This information allows us to assess each component and determine its success in meeting the technical assistance/training need identified. Participants will be asked to complete a questionnaire on the session that helps us evaluate the extent to which the:
  - Training format and content provided relevant information.
  - Training format and content provided useful information.
  - Session content could be improved and in what way.
  - Session scheduling could be improved and in what way.
  - Overall, format and content were satisfactory or very satisfactory.
- *Improvement of technical assistance and training programming.* Feedback from the provider community and BBHHF will be used to improve the content and process of developing and delivering these programs.

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

Section Four, Subsection 4.17

4.17 Vendor should describe their plan to provide a web-based reporting portal for prior authorization of Medicaid and non-Medicaid covered services to community behavioral health service providers, and the vendor selected by the agency to manage any of the self-direction programs. This system would permit for expansion and collection of unique data sets for program specific information.

Vendor Response

APS-WV has existing, easily accessible, web-based portals for purposes of reporting an array of information. Providers currently access the APS system applications for programs such as behavioral health, socially necessary, I/DD Waiver, Aged and Disabled Waiver and Personal Care services. The applications has components tailored to the specific program types and perform functions related to prior authorizations, budgetary model modifications, and non-medically necessary services (e.g., socially necessary services). In addition, WV Medicaid Medical and Nursing Home Services are reported through the web-based APS system application.

Non-Medicaid services, such as Charity Care funding governed by the Bureau for Behavioral Health and Health Facilities (BBHHF), also utilizes the APS system for prior authorization reporting. Several additional features provided in this application for BBHHF, including Federal Reporting requirements and the Consumer Service Delivery Report.

APS-WV's applications can be tailored to self-direction programs as desired by the Agency; we welcome the opportunity to identify to expand the existing data set to meet demands of self-direction programs (i.e., the Severe Emotionally Disturbed Waiver and the Substance Use Disorders Waiver). APS-WV's key staff will meet regularly with Bureau representative to identify and formulate delivery options; application specifications will be derived from these planning meetings.

As indicated above, reporting capabilities are well established and may be expanded. APS-WV has a strong history of responsive, accurate, and useful data reporting to assist the Agency and providers. If further reporting options are desired, APS-WV will be glad to meet with Agency representatives to address issues.

Section Four, Subsection 4.18

4.18 Vendor should describe their plan to refer any instances of suspected fraud to the following parties:

a. Medicaid fraud, to the Bureau's Office of Program Integrity (OPI);
b. Instances of suspected fraud in the delivery of BCF socially necessary services, to the BCF Office of Finance and Administration;
c. Instances of fraud related to BBHHF Funded programs, to the BBHHF Office of Compliance and Monitoring.

Vendor Response

APS-WV is dedicated to the integrity of West Virginia's health and social services programs, and is vigilant in identifying and reporting suspected fraud to the appropriate agencies. We understand that instances of suspected fraud will be reported to the Bureau's Office of Quality and Program Integrity; instances of suspected fraud related to socially necessary services will be reported to the BCF Office of Finance and Administration. APS-WV will go beyond the mandatory requirements of this item to help ensure the most effective approach to *preventing* waste, fraud, and abuse. In response to this Item we discuss our detection and education programs.

Bureau for Medical Services

APS-WV will continue to promote effective and appropriate utilization of West Virginia Medicaid services. This support will be accomplished by ongoing communication, technical assistance/training for providers along with reinforcement of the West Virginia Medicaid manual. While best efforts continue, a select few providers have experienced difficulty in maintaining adherence to regulations; in these instances, APS-WV has and will continue to report suspected fraud to the Bureau's Office of Quality and Program Integrity (OQPI).

Bureau for Children and Families (BCF)

APS-WV will continue to report any instances on known or suspected fraud of any kind to the BCF Office of Finance and Administration (BCF OF&A).

Bureau for Behavioral Health and Health Care Facilities (BBHHF)

Instances of suspected fraud or inappropriate utilization of BBHHF funding are reported to the Bureau for Behavioral Health and Health Facilities.

Section Four, Subsection 4.19

4.19 Vendor should describe their grievance process to ensure compliance with the Bureau's fair hearing process. Vendor should also describe their plan to attend, coordinate, and participate and/or represent the department in member prehearings and hearings as requested by or on behalf of a member who disputes their denial of service, with the understanding that:

a. The Vendor is required to provide appropriate staff to attend and testify at the hearing, either in person or telephonically, whichever is required by the Agency;

b. Vendor is to schedule and coordinate the hearings with the State Hearing's officer, member, legal representative and any other agency/individual required;

c. The Vendor is to prepare and distribute the hearing packets and schedule as required by the Agency to all parties involved in the scheduled hearing.

Vendor Response

Waiver Management Programs

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

TBI Waiver: APS has been (and is prepared to continue) providing appropriate staff to attend and testify at prehearing conferences and/or hearings when requested by the Agency. APS will continue to schedule and coordinate applicable hearings with the State Hearing officer, member, legal representative and any other agency/individual required. We will continue to provide hearing packets to applicable parties within designated timelines. If a member has acquired legal services, APS will only communicate with the Bureau and the Bureau's attorneys.

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

Behavioral Health Services: APS-WV understands that fair hearings may occur when requested by members following service denials. Currently, APS-WV receives notification from the Department when a hearing is requested and the date of the hearing. APS-WV gathers all information related to the service request and denial; information is sent to the Department for distribution to all parties. APS understands the Department's intent to modify this process.

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

Socially Necessary Services: This process does not apply to socially necessary services or services funded by BCF proposed in this RFP.

Section Four, Subsection 4.20:

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

Vendor Response

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

InterQual criteria are recommended in review areas where it is available. Medical providers are familiar with InterQual guidelines for determining eligibility for various services, and a number of them have adopted InterQual for internal use because it makes internal QA/QI determinations congruent with external prior authorizations. Additionally, current medical reviewers have extensive experience with InterQual. By continuing to use these criteria for medical review, we significantly reduce the time and cost associated with re-training across the system.

In review areas where there are no applicable InterQual criteria that can be used for review; APS-WV will work in collaboration with the Bureau to establish criteria that meet the medical necessity guidelines outlined in West Virginia Medicaid policy to ensure policy intent is inherent in the selected criteria. When new services are added, APS will research available criteria and make recommendations to the Bureau. We will also confer with BMS regarding possible modifications to current review criteria. Based on BMS approval, APS will revise existing criteria to reflect current medical opinion and practice patterns better.

Though APS-WV supports the use of InterQual criteria, there are certain types of review for which no criteria exist (i.e., dental, orthodontia, chiropractic, speech therapy, etc.) or inadequate criteria exist (i.e., cases requiring follow up imaging post-scan to monitor disease progression, wide surgical excisions, post-positive biopsy). In such cases we will work with provider experts to develop or modify evidence-based review criteria for use by initial clinical reviewers. Use of the modified criteria will prevent delays in review

determinations and reduce case review costs by eliminating the physician review step of the process for some reviews. The modifications that we propose are based on the experience and observations of our clinical staff, physician reviewers, and the APS Medical director. We believe these modifications will enhance the quality, timeliness, effectiveness and cost efficiency for the Medicaid program. These proposed criteria will be submitted to the Bureau in advance for review and approval, and reviewed by APS-WV on an annual basis to identify any need for refinement in responses to program updates. Requirements in several areas of review (e.g. Dental/Orthodontia and Genetic Testing) have specific timelines and requirements for the development, ongoing review and submission of medical necessity criteria. These requirements are specifically discussed in these sections of the RFP.

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

Section Four, Subsection 4.21

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

Vendor Response:

As APS WV has done in the past when retrospective reviewing for BCF, we will first share the standards with applicable staff, gather questions, arrange a meeting schedule and go through all the questions and standards with the Bureau. This is done to ensure that what the Bureau is interpreting a regulation or set of regulations is the same as the vender. Once these parameters are established inner rater activities will be completed for APS staff to ensure that we are reviewing each standard the same. Through this process a set of internal guidelines or interpretive guidelines are created and continually revised to address new situations discovered during review. These situations are also brought to the contractor for final interpretation/direction. The interpretive guidelines are reviewed quarterly at a minimum. If review tools need to be created, APS WV will again meet with the Bureau to determine the exact expectations and/or what outcome measure is being monitored. Tools are always approved by the contractor before implementation.

Section Four, Subsection 4.22:

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

Vendor Response

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

APS-WV, with our instate clinical and programmatic resources, has the expertise available to research peer-reviewed and other topical information, consult with experts in the field locally and nationally, and identify and recommend criteria to the Bureau for review and approval. APS-WV used this approach in the development of Socially Necessary Services criteria, for example. The relevant Department Director is responsible for this process when we identify areas lacking national standard criteria, depending on the nature of the service. Just as important is our ability to communicate and train providers when the Bureau approves new criteria or updates existing criteria. Through our online, regional, and one-on-one training process, APS-WV disseminates requirements throughout the provider community, providing orientation and training for other stakeholders as well. Through this process, we promote high degrees of compliance in the provider community as well as understanding and acceptance among other stakeholders.

Section Four, Subsection 4.23

4.23 Vendor should describe their plan for tracking all information for statistical and reporting purposes which must be performed utilizing Medicaid member ID, Family and Children's Tracking System (FACTS) Client ID, and provider ID numbers, in addition to any Social Security numbers and/or provider FEIN numbers

Vendor Response

Below we provide details on our approach to identify and track information for each Bureau.

Bureau for Medical Services (BMS)

APS-WV uses the Medicaid member number to track information for statistical and reporting purposes. We also use identifiers unique to the individual member to track the member within and between programs in the utilization management system, with this unique identifier. This identifier will allow us to provide unduplicated counts and to improve accuracy of reporting. APS-WV also uses the provider identifier, and where appropriate, the members' Social Security numbers, and/or provider Federal Employer Identification Number (FEIN).

Bureau for Children and Families (BCF)

For reporting and statistical purposes, the Socially Necessary Services program APS-WV uses the FACTS Client ID and Provider ID. As demonstrated by our past performance, APS-WV makes every effort to meet the contractor's need for accurate reporting.

Bureau for Behavioral Health and Health Care Facilities (BBHHF)

APS-WV will use identifiers that are unique to the individual member, such as, but not limited to the Medicaid/BBHHF Consumer ID and/or Molina Claimant Id to track the member within and between programs in the utilization management system. These identifiers will allow us to provide unduplicated counts thus ensuring the accuracy of state and federal reporting.

Section Four, Subsection 4.24

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

Vendor Response

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

The APS System addresses emergency requests in a variety of ways:

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

Section Four, Subsection 4.25

4.25 Vendor should describe their plan for reviewing both in network and out of network services for medical necessity at the closest in network location. This also applies to the services covered by the BCF "special medical card," group residential facilities and Psychiatric Residential Treatment Facilities (PRTF's) located outside the borders of WV, the WV Children's Home and Socially Necessary Services.

Vendor Response

Medical and Behavioral Health Services

Medicaid policy requires that any service provided by an out-of-network provider be prior authorized with the exception of emergency room services, labor and delivery, and, services to foster children at facilities near their placement when prior authorization is not normally required for the service. APS has worked extensively to define and refine this process to ensure that BMS policy is implemented appropriately and that out-of-network services are utilized appropriately. APS has also worked with the enrollment vendor and claims payer, Molina, to ensure that out-of-network providers approved to serve WV members are reimbursed appropriately. We provide a workflow for out-of-network provider review in Exhibit 33. Additionally, any services falling in this category reimbursed by BCF will follow the process for Medicaid's corresponding service area.

Section Four, Subsection 4.26

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

Vendor Response

After the prior authorization, APS-WV Trainer/Consultants implement a retrospective review of provider documentation practices and utilization management processes. Trainer/Consultants (T/C) will review service invoices provided by BCF or continue to review invoices provided directly from the provider and the provider's credentialing information while on site for the retrospective review. Each SNS provider will receive at least one review every eighteen-month cycle. Additional reviews may be warranted based on:

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

Providers with 10 or more unduplicated consumers authorized for Socially Necessary Services will receive an on-site review. Providers with less than 10 unduplicated consumers will receive a desk audit. A random sample is pulled based upon the volume and complexity of the service array of the enrolled providers. Consultations with SNS providers will be scheduled at least four to six weeks in advance by the designated Trainer/Consultant. If the provider cannot be immediately reached by phone the TC will leave a message for the provider to return a call to the TC's cell phone. If the call is not returned the same day, the TC will

attempt to contact the provider daily for three business days. If no return call is received within three business days, the TC will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Director of Socially Necessary Services should immediately be apprised of the situation. During the phone call to schedule the consultation, the TC outlines the consultation process and its purposes. The TC confirms the provider's mail and email addresses during this phone call and asks to whom the sample should be sent. The TC then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The TCs maintains confidentiality according to HIPAA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. The following tools are required:

- Social Necessity Services UM Guidelines manual
- Copies of review instruments
- APS-WV Interpretive Guidelines
- Copy of each consumer's APS record with demographic information, current living situation, and service plan summary, presenting problems, level of support questions, guardianship status and free text field information.

Once on-site, the TC begins the review by interviewing the primary contact person for the agency or the actual SNS provider. This person is queried regarding how referrals are received, what information is received at first contact, how is information gathered for the APS system, and whether there are concerns about the referral process. Using the sample printout a record is selected by the TC for review. The start date, service category, and service are noted for the most recent authorizations. If there are multiple services for the same period, all documentation referring to that service is reviewed. The Referral Form is reviewed for justification of the service, category of service and any information from the DHHR worker that indicates the consumer's deficits and needs as related to the definition of the authorized service being reviewed for the specific period. The consumer's APS Social IT System copy with fields reflecting the consumer's functional deficits and the focus of the service plan should also be compared to any information in the record and the service plan for consistency. If there are multiple re-authorizations for the same service, the TC reviews case notes, service plans, any documentation that indicates the worker was contacted at the re-authorization period, that progress towards service objectives was addressed, and all agreed that the services should continue. Provider personnel charts will also be reviewed to ensure that the proper credentials and requisite background and safety checks such as the OIG list have been completed. A portion of the review report will directly address the results of each personnel chart. If questions or concerns about specific records arise during the consultation, they can be discussed by phone with the Director of Social Necessary Services or an SNS Care Manager.

APS-WV meets with providers at the conclusion of the on-site review. We discuss the most important findings of the review, and assess strengths and areas of improvement for the provider. The TC addresses any provider questions brought up during the entrance meeting or during the review process. After the meeting, the provider completes an Exit Technical Assistance form and returns it to APS-WV. A Consultation Report, which presents results and recommendations for improvement, is distributed

electronically to the provider immediately following the exist conference. A consultation Follow-up Technical Assistance call addresses areas for improvement identified through the review process and is made within 10 days of the provider's receipt of report.

Providers who receive less than 80% on a retrospective review will be required to undergo mandatory technical assistance on each individual service scoring under 80% on the BCF approved retrospective review tools. Once the technical assistance is completed, the trainer will conduct a follow up review to determine if the provider has made improvements. The outcomes of these reviews will also be provided to BCF and reviewed with the ASO Group to determine if any further action is required. For all providers scoring 80% or above on a retrospective review, training and technical assistance will be available for the provider but is not mandatory.

Section Four, Subsection 4.27

4.27 Vendor should describe their plan to provide BCF a schedule of retrospective quality reviews to be conducted on Socially Necessary service providers, with the understanding that BCF shall provide a sampling of invoices to the vendor for claims made for socially necessary services and, that as a part of the retrospective review, the vendor shall review the supporting documentation in the provider records to ensure the services invoiced and paid for have been provided and all reports have been sent to the Bureau.

Vendor Response

APS-WV will provide the monthly consultation review schedule to the BCF OF&A by the last week of the month. OF & A will pull a random sample of provider invoices which will be sent to APS-WV within two business days of receipt of the schedule. This approach will allow the APS-WV Data Analyst to pull a supplemental sample of services and charts in order to meet APS-WV sampling volume requirements.

At the scheduled time, APS-WV will conduct the consultation review utilizing the consultation tools that were previously approved by BCF. Each chart will be assigned a score based upon the established scoring criteria. APS-WV will also compare the service documentation to the BCF OF & A invoices, ensuring that all services invoiced were provided, appropriately documented, and consistent with APS-WV Utilization Management guidelines and BCF service definitions. Invoiced services that do not meet these requirements will be reported to BCF OF & A within five business days of the end of consultation reviews.

During the consultation review, APS-WV will also verify the degree and licensure/certification of the provider staff members whose names were documented in the consumer record by visually inspecting the personnel record or other provider confirmation of staff credentials. Any staff member whose degree and license cannot be immediately verified to conform with the degree and/or licensure requirements for the service will be (within one business day) reported to BCF OF & A. The provider will be informed of this report and will be directed to cease utilizing the staff member for the applicable service code until this matter is resolved by BCF. APS-WV will conduct an Exit Interview with the provider immediately after the conclusion of the consultation review and will present salient findings and issues to the provider at that time. All reports will be reviewed at the ASO Group with BCF staff and plans made for technical assistance and another retro review for those scoring under 80%.

Section Four, Subsection 4.28

4.28 Vendor should describe their plan to provide BMS a schedule of all retrospective quality reviews to be conducted for BMS service providers with the understanding that, as a part of the review process, the vendor shall propose a quality management plan for the BMS services as well as a schedule of the review cycle. This will include all the total quality management services for the Title XIX Intellectual/Developmental Disabilities Waiver (IDDW) and the Traumatic Brain Injury Waiver (TBIW) in order to meet the CMS standards for the program.

Vendor Response

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

APS will review every TBI and I/DD Waiver provider who actively serves (or served) a member during the review period annually. Total quality management will be comprehensively integrated into every aspect of the work we do. We will continually seek to improve the quality of our own services as well as the services provided and offered to program members.

APS has already recommended and been approved on the quality indicators that will be used for the next approved TBI and I/DD Waiver cycle. We will collect and report this information on the Discovery and Remediation Report monthly.

APS builds customer satisfaction into most aspects of the work we do. We request feedback through surveys for functional and eligibility assessments, provider reviews, training, etc. We approach our provider quality reviews through a lens of the desire for total system improvement. We focus on identifying individual and systemic issues that require improvement. We make decisions and recommendations based on facts. We effectively communicate the issues, the plans for improvement and the expectations for the programs. We develop and implement training for providers, members and stakeholders as the needs for such evidence.

1. APS will review every provider every year with an emphasis on the approved CMS quality indicators, policy, and procedures approved by the Bureau. We will provide technical assistance during and after every provider quality review. Providers will be expected to complete and submit a Plan of Correction following their reviews. We will work with the provider until the plan is acceptable/approved. For those providers with a deficiency identified on their Plan of Correction, we will complete a desk or on-site follow-up review. This second review will focus on the provider's implementation of their approved Plan of Correction. APS will report findings of the follow-up review per a plan approved by the Bureau.
2. APS will evaluate data from statewide provider reviews to determine potential areas of improvement.
3. APS will present data to the Quality Improvement Advisory Council (which is comprised of members, providers and other program stakeholders) for their feedback about areas of improvement and potential interventions.

4. APS will recommend to the Bureau any additional training, technical assistance, or policy clarification as necessary for system change.
5. APS will implement the training, technical assistance or policy clarification.
6. APS will evaluate the effectiveness of the intervention upon the next cycle of provider quality reviews.
7. APS will continually implement a cycle of: Assess, advise, plan, implement, evaluate

The BMS program manager will receive a schedule of all behavioral health retrospective reviews and also be provided the follow up plan in addition to a copy of the report regarding the site review.

Section Four, Subsection 4.29

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

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

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

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

d. State the consequences of failure to perform.

e. Provide three (3) references for the subcontractor.

f. Provide a draft of the proposed subcontract.

APS-WV PROVIDES SINGLE VENDOR EFFICIENCY

AND SINGLE VENDOR ACCOUNTABILITY

Joe Dougher,
President and CEO

Vendor Response

APS-WV does not intend to use subcontractors for any administrative functions of the Utilization and Prior Authorization Program. Our ability to make this statement is one of the most significant benefits of the strategic acquisition of APS Healthcare by KEPRO. Founded as a behavioral health company over 20 years ago, APS dynamically expanded its capabilities, leveraging our behavioral health expertise to provide effective, person-centered services for socially necessary, waiver, and chronic care management services. Founded as a Medicare Peer Review Organization over 30 years ago, KEPRO expanded its capabilities in all aspects of medical review, leveraging our quality improvement expertise to provide effective, evidence-based services for medical review and auditing services. Together, we are the premier Quality Improvement Organization (QIO), with the capacity to provide evidence-based services across the spectrum of medical, behavioral, intellectual/developmental disabilities, and state-funded public programs. With efficient, proprietary, and HIPAA-compliant systems, we improve the quality of information at the same time as we reduce administrative burdens on providers and streamline prior authorization and utilization management services. By continuing DHHR's fifteen-year relationship with

APS-WV, the Bureaus assure continuity of services and performance in the context of a local company with *a national presence in all requirements.*

Section Four, Subsection 4.30

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

Vendor Response

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

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

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

Section Four, Subsection 4.31

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

Vendor Response

APS has worked with BMS in a consultative role to make recommendations on policy coverage and to recommend criteria for reviewing services for medical necessity. Annually, BMS reviews new and edited CPT and HCPCS codes to make decisions regarding coverage, changes in coverage (e.g. previously

investigational/experimental procedure is recognized as an accepted practice and could be covered), prior authorization recommendations, and, impact of changes on policy. This process is completed through the Procedure Code Work Group. Once decisions are made regarding coverage, APS makes recommendations regarding criteria for services requiring prior authorization. The Procedure Code Work Group process also evaluates changes in service limits, prior authorization requirements, and practitioners, providers, or specialties approved to perform the service. Additionally, APS serves as a consulting member of the Bureau for Medical Services Policy Committee. This group evaluates and updates BMS policies, including the benefit contained in each manual chapter and the covered services in each chapter.

Through these processes, APS-WV assures that the appropriate services are being prior authorized in the correct amounts and within policy guidelines. This process also serves to ensure that services being authorized are in line with the requirements for claims payment through alignment with the requirements of the claims payer (e.g. CCI edits). This integrated approach ultimately benefits the member by ensuring that services requiring prior authorization are reviewed using sound, nationally accepted guidelines and the provider by increasing the likelihood that claims for authorized services will pay.

APS-WV is proud of the active role it has played in the past fifteen (15) years in researching evidence-based guidelines and established clinical guidelines in order to assist the Bureau in making policy decisions. Clinical standards do change, and APS has assisted, and will continue to assist the Bureau, making recommendations as new information becomes available. Graphic overviews of the workflows are in Exhibit 49 (criteria), Exhibit 50 (Procedure Code Work Group), and Exhibit 51 (BMS Policy Committee).

Section Four, Subsection 4.32

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

Vendor Response

APS has worked extensively with all parties involved in the EPSDT process to develop an approach to ensure children identified with needs not normally covered within the standard Medicaid guidelines can be evaluated and served. APS developed an approved definition for evaluating EPSDT eligibility and has imbedded a workflow process in the system that when enabled allows a provider to make requests for non-covered services, unpriced items, and for services over limits or for combinations of services not normally allowable under policy guidelines. APS has worked to refine the process for all medical and behavioral health services, to interface with Pharmacy services and with the Bureau for Medical Services, the EPSDT program and the Children with Special Health Care Needs Program to develop a protocol for serving children requiring medical foods. The EPSDT program continues to develop and APS will continue to provide the consultation necessary for expansion of the program within its' defined parameters and assure that members with needs identified through the EPSDT process receive services.

Section Four, Subsection 4.33

4.33 Vendor should describe their plan to validate and authorize eligibility for the BBHHF's Indigent Care program for Non-Medicaid individuals receiving Medicaid eligible Behavioral Health services through the State's thirteen (13) Comprehensive Behavioral Health Centers.

Vendor Response

APS-WV will conduct person-level eligibility for Indigent Care determination, based on BBHHF's criteria for participant eligibility:

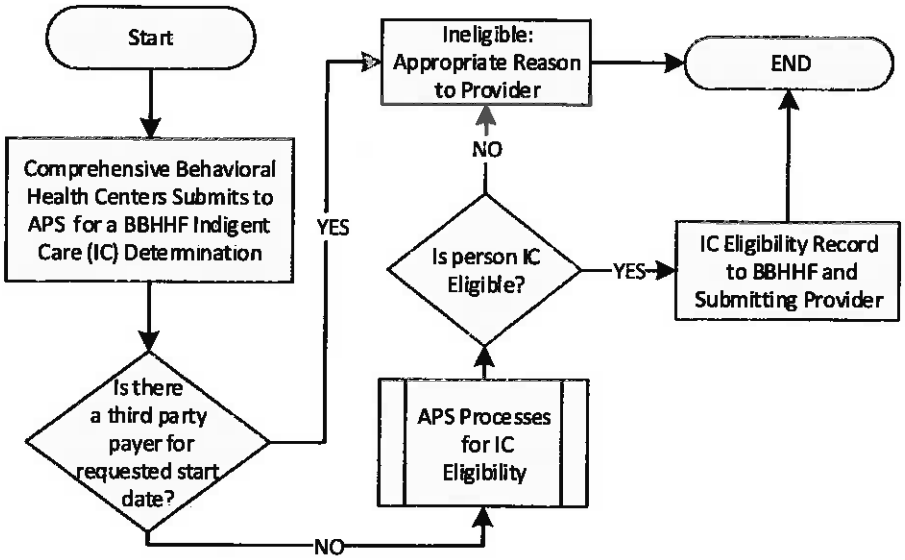
1. **Individuals who are West Virginia residents; and.**
2. **Individuals who are at or below 200% of Federal Poverty Level; and**
3. **Individuals who have no other form of third party payer for the services they receive; and**
4. **Individuals who are receiving services that are deemed medically or clinically necessary; and**
5. **Have an eligible diagnosis consistent with Medicaid criteria; or**
   Have a history of hospitalization for mental health, substance abuse, or developmental disability; or
   Live in a controlled setting such as a group home; or
   Receive supportive residential services; or
   Receive services as required by West Virginia Code Chapter 27, *Mentally Ill Persons;*

or

1. **Are in need of crisis services or**
2. **Are deemed "at risk" of involuntary hospitalization.**

APS-WV will incorporate the eligibility requirements, including that an individual must have *no other form of third party payer* for the needed behavioral health services. Put in practice, an individual with Medicaid coverage at the time of the BBHHF Indigent Care eligibility determination will not gain indigent care benefits due to failing this eligibility requirement, see Figure 20.

Figure 20 BBHHF Indigent Care Participant-Level Eligibility Determination



APS-WV will continue to accept the necessary information from the comprehensive centers for the determination of persons' BBHHF Indigent Care eligibility including the new third party payer verification criteria. Historically, APS Healthcare calculates the household size income limits, which are 200% of the federal poverty level, prepares the BBHHF Financial Eligibility Thresholds document, gains BBHHF's approval, and finally disseminates to the thirteen comprehensive centers' leadership and data contacts. The most current BBHHF Indigent Care (charity care) follows in Table 22.

Table 22 Income Guidelines

Bureau for Behavioral Health and Health Facilities
CHARITY CARE ELIGIBILITY INCOME GUIDELINES
Effective August 15 2014

200% of the 2014 Federal Poverty Guidelines
for the 48 contiguous States & Washington, DC

Family Size (Consumer & Dependents)	Maximum Annual Income	Maximum Monthly Income
1	$23,340	$1,945
2	$31,460	$2,622
3	$39,580	$3,298
4	$47,700	$3,975
5	$55,820	$4,652
6	$63,940	$5,328
7	$72,060	$6,005

Bureau for Behavioral Health and Health Facilities
CHARITY CARE ELIGIBILITY INCOME GUIDELINES
Effective August 15 2014

200% of the 2014 Federal Poverty Guidelines
for the 48 contiguous States & Washington, DC

Family Size (Consumer & Dependents)	Maximum Annual Income	Maximum Monthly Income
8	$80,180	$6,682
9	$88,300	$7,358
10	$96,420	$8,035

For each additional dependent of the consumer add
$8,120 to Annual Income or $677 to Monthly Income

Source: January 22, 2014 Federal Register
(Volume 79, Number 14, Page 3593)

APS-WV will validate each individual's BBHHF Indigent Care eligibility for which a provider submits an indigent care funded request for prior authorization of service using the WV DHHR fiscal agent's daily eligibility full file feed. When found to have Indigent Care coverage for the requested start date of service and no other third party payer, APS-WV will apply the current Medicaid prescribed clinical review applicable to each indigent care-funded request for prior authorization of a Medicaid-like service while adhering to current federal and state guidelines.

Section Four, Subsection 4.34

4.34 Vendor should describe their approach and methodology to collect and process information identical to applicable West Virginia's Medicaid criteria for Non-Medicaid individuals receiving services under the BBHHF's indigent care program. The indigent care program is administered through the State's thirteen (13) Comprehensive Behavioral Health Centers and funds Medicaid eligible Behavioral Health services to non-Medicaid eligible individuals with income up to 200% of the Federal Poverty Level (FPL).

Vendor Response

As the incumbent vendor and since early 2012, APS-WV has managed the utilization of the Bureau's Indigent Care Program for Medicaid-like outpatient behavioral health services while adhering to the applicable West Virginia Medicaid Clinic and Rehabilitation Service requirements for prior authorization, service limits, and medical necessity criteria.

Through its web-based application file transfer capability, the Behavioral Health Services system, APS-WV will continue to serve the Bureau by evaluating each Medicaid outpatient service for which the BBHHF Indigent Care program funds. This system defines the data collection requirements for requests to ensure

that information identical to West Virginia's Medicaid criteria. When a WV Comprehensive Behavioral Health Center makes a request for the prior authorization of an indigent care-funded service, APS-WV will apply the same medical necessity criteria, as well as, service limits and restrictions as it would to an identical Medicaid-funded service request.

With Medicaid-like clinical criteria applied to each indigent care-funded request for prior authorization, some service requests can auto-adjudicate, but most require review by a West Virginia licensed professional to evaluate if the individual meets Medicaid's medical necessity standards for requests for prior authorization of Indigent Care-funded services.

The results of the system process are shared with the requesting Comprehensive Behavioral Health Center via the website and downloadable daily files, which indicate the initial status of each request, for instance, AUTH if authorized, PEND if the request requires review by a clinician, and CLOS if closed for an administrative reason.

Section Four, Subsection 4.35

4.35 The vendor should describe their plan for providing a Certified Brain Injury Specialist to conduct initial assessments and annual assessments for all appropriate members to determine program initial medical eligibility and/or re-eligibility for the Traumatic Brain

Vendor Response

APS currently employs one of the only Certified Brain Injury Specialist Trainers/Proctors in the state of West Virginia. All staff who conduct initial or reevaluation assessments for medical eligibility of the Traumatic Brain Injury Waiver program (Assessment Coordinators) have gone through the coursework and passed the certification test to be a Certified Brain Injury Specialist (CBIS). Should a vacancy for an Assessment Coordinator position arise, APS proposes the position will be filled by a CBIS whenever possible. Because of a shortage of persons statewide who possess both the CBIS and licensure requirements for the position, APS recommends we would hire staff who possess a Registered Nurse, Social Work, Professional Counselor, Rehabilitation Counselor or Psychologist license and required degree and experience. We would have them complete CBIS coursework, training and become certified within 1 year of being employed.

Assessment Coordinators complete the Pre-Admission Screening and Rancho Los Amigos assessments with the member and representative (when applicable) initially and then annually for reevaluation. All TBI Waiver program members have a Case Manager who assists then with program planning. APS will make available the medical eligibility assessments and provide technical assistance as necessary for Case Managers who will work with the member and their supports to develop a Service Plan. In the event that a member chooses not to utilize the services of a Case Manager, APS will work with the member and their supports to recommend a service plan to meet their needs within current state and federal policy guidelines.

Section Four, Subsection 4.36

4.36 The vendor should describe their plan for reviewing initial assessments and evaluations of all Personal Care applicants to determine medical eligibility and service levels in accordance to current state and federal policy guidelines, with the understanding that Level 11 determinations will require review by a Registered Nurse.

Vendor Response

APS proposes a continuation of existing processes and procedures related to the review of Personal Care services for prior authorization. Though this RFP proposes a Registered Nurse is only required for level 2 services, APS refers to the October 25, 2012 memorandum in which the West Virginia Department of Health and Human Resources responded to findings by the Centers for Medicare and Medicaid Services. Based on this correspondence and its findings, we will have a Registered Nurse review all requests for Personal Care, regardless of service level.

Personal Care provider agencies complete an initial or reevaluation request for Personal Care Services. Providers coordinate with physicians or complete the Pre-Admission Screening (PAS) for submission and to request prior authorization through our system. They must enter/submit basic member demographic information and then have the option to either data-enter and attach the original PAS –or- to just attach the original signed PAS into the system and an APS staff will key the assessment. Currently more than 50% of requests are data entered by the provider.

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

Section Four, Subsection 4.37

4.37 The Vendor should describe their plan for implementing agency-requested optional services and/or optional hourly services that are added to the contact through a Change Request (CR) process, with the understanding that the Hourly Rate in effect at the time of a Change Request for Optional Hourly Services will remain in effect for the duration of the delivery order. Optional hourly services are defined as work requested by the Agency and performed by the vendor that is not delineated in this RFP as mandatory or optional.

Vendor Response

APS-WV will implement a Change Request (CR) process for optional hourly services that will provide the framework for requesting, reviewing, approving and monitoring a Change Request from BMS. This will ensure all parties involved have a complete understanding of the request and the agreed requirements. The key elements of the process will include, but not be limited to, the following:

- Submitter's Request:

- Type of CR – enhancement, change, correction
- Project/Program initiative for x
- Goal and/or outcome of change
- Brief description of request (background & SOW)
- Date submitted
- Date required
- Attachments/references where appropriate
- Approval Signature
- Approval Date

- Vendor Project Manager Initial Analysis
  - Preliminary specifications of the project
  - Hour/duration impact
  - Key deliverables and related timelines
  - Other recommendations for consideration
  - Cost impact

- Submitter & Vendor Decision
  - Final discussion meeting for Submitter & Vendor
  - Adjustments to document per discussion
  - Approval signatures on documents

Depending on the type of CR (i.e. IT, clinical, process, program, etc.), the appropriate Project Manager will be assigned. The Quality Coordinator will provide oversight and tracking of deliverables until completion of CR. APS understands that the hourly rate in effect at the time of a Change Request for Optional Hourly Services will remain in effect for the duration of the delivery order. Furthermore, APS acknowledges the optional hourly services are defined as work requested by the Agency and performed by the vendor that is not delineated in the RFP as mandatory or optional.

The plan for implementing Optional Services outlined in the RFP will begin with a meeting(s) of the relevant parties (Bureau staff and APS staff) to review the proposed plan(s) outlined in the RFP and finalize the scope of work (SOW). APS will develop the Implementation Plan to meet the approved SOW. Dependent upon the type Option being exercised (IT, clinical, new program, etc.), the appropriate Project Manager and implementation team will be assigned. As always, specification development is critical to a successful "go live". Specifications will be developed in conjunction with the appropriate Bureau staff with agreement among the parties.

Section Four, Subsection 4.38

4.38 The vendor should describe their approach and methodology for reporting and should also provide examples of reports produced by projects of the type, size and scope described in the RFP. The vendor should describe their plan to manage and operationalize 1915(c) Waiver for Children with Serious Emotional Disturbance (SED) in West Virginia.

Vendor Response

APS–WV excels at meeting the routine and ad hoc reporting requirements of the three Bureaus, doing so throughout our fifteen years with the Department. We pledge to continue this successful record through the provision of timely delivery of accurate routine and ad hoc reports.

Our approach has and will continue to be an intimate one in that our data analytic and reporting staff, dedicated to the WV DHHR contract, is located in our local office to provide a single point of contact for report requests and development. In addition, we can easily acquire the support and assistance from an extensively skilled corporate-based health research team should the need arise.

With the specifications set forth in the required reporting section of the CRFP *[Appendix 3: The Agency - Specific Reporting Requirements]* and dialog with the appropriate Bureau's business owner of each report, APS-WV will firstly assure its understanding of the intended content and desired format of each report. APS will then develop the report, review it with the Bureau to assure we have met expectations and gain the Bureau's approval on the report content and format. Once successful QA testing has occurred, each report will enter production on the indicated schedule. Additionally, report requirements, as well as, desired content and formatting, may benefit from periodic review and revision. Given this consideration, APS-WV recommends an annual review of each required Bureau report with the business owner to assure reports remain meaningful and comprehensive.

APS–WV readily generated and delivered an abundance of frequently requested ad hoc reports for the WV DHHR. The ad hoc reports varied in scope, complexity, and presentation. Regardless of the required effort, APS values the Bureaus' need for information and data, thus addressed each requested ad hoc report with vigor, all the while striving to exceed the requestor's expected delivery time.

Examples of required and ad hoc reports are located in Exhibit 48.

Section Four, Subsection 4.39

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

Vendor Response

In order to ensure we meet all deliverables described in Appendix 3 and performed according to the service level agreements in Appendix 4, the local APS-WV internal quality department will gather all the requirements into one plan. Specifications from the Bureau will be obtained to ensure that reports APS will produce will meet the expectation of the Bureau. We will integrate this plan into the required internal quality control plan required in Attachment A of the RFP. The rigorous "balanced scorecard" approach KEPRO uses is complementary to our strong local approach, providing corporate oversight at the highest levels of the organization. Figure 21 summarizes the structure of this approach.

Figure 21 KEPRO Balanced Scorecard for High Performing Contracts

This process results in a clear and detailed approach to achieving the requirements of the contract and ensures that business units within KEPRO have specific accountability for contract objectives through their realization of organizational goals. With definition of objectives, we then develop performance measures and targets – including for example, timeliness of review, achievement of deliverables and submission of reports. The KEPRO management team translates these performance measures into realistic, detailed 90-day action plans that we link to contract deliverables and completion of assigned task orders. We use the 90-day timeframe for overall action plans at the organization and individual level. In addition, KEPRO establishes and maintains internal quality controls for monitoring, accuracy, productivity, and quality output of all of its team members. Uniformity in practice includes orientation of new employees, ongoing training of employees, defined policies and procedures, development of key process indicators, and monitoring of all activities. In addition, KEPRO has established methods for assuring Inter-Rater Reliability to ensure consistent findings between nurse reviewers and physician reviewers.

The level of monitoring is risk-based. KEPRO conducts risk assessments at the start of a new contract and throughout the contract term to identify high-risk compliance issues and to establish priorities, necessary monitoring activities, procedures/policies, and to determine auditing schedules. KEPRO monitors contract performance through systematic reporting and analysis; interim and annual evaluations; and ad hoc and formal quality improvement (QI) initiatives. Executive and contract management assess the evaluation results and QI initiatives, and implement training programs and corrective actions to address opportunities for improvement. Continuous monitoring of training and corrective actions allows us to provide feedback to the Operations team, ensuring we meet deliverables throughout the contract.

A key strength of the APS-WV solution is the fact that healthcare is KEPRO's business – our only business. This focus brings a depth and continuity to our management, staff, and systems that enable us to meet the Department's requirements and exceed its expectations for quality, performance, and customer service. Our successful experience extends over 30 years of measuring, managing, and improving healthcare at the facility, provider, and consumer levels of care for government clients.

As our Technical Proposal conclusively demonstrates, APS-WV builds on a successful record of achievement. A local Operations team brings proven abilities to respond dynamically to complex requirement changes, completing diverse tasks on time and on budget through skilled staff; rigorous project management; and insightful analysis at the data, provider, and beneficiary levels. Our corporate team provides efficient access to essential services and national expertise in medical review and quality improvement. Together we continue to be the best value solution for the Department of Health and Human Resources, its Bureaus, providers, and West Virginia residents who depend on these services.

Attachment B: Mandatory Specification Checklist

The following mandatory requirements must be met by the Vendor as a part of the submitted proposal. For mandatory requirements that require documentation to be submitted with the Technical Proposal, vendor should include in their response in Attachment B the location of the documentation in their overall proposal. For mandatory requirements that require future conformance or compliance, vendor shall include in their response in Attachment B their agreement to comply or conform to the mandate. Failure on the part of the Vendor to meet any of the mandatory specifications shall result in the disqualification of the proposal. The terms "must," "will," "shall," "minimum," "maximum," or "is/are required" identify a mandatory item or factor. Decisions regarding compliance with any mandatory requirements shall be at the sole discretion of the Purchasing Division.

APS Healthcare West Virginia (APS-WV) provides our response to the Mandatory Specifications as an experienced local Vendor, building on 15 years of successful contract performance for the Department of Health and Human Resources. In the Sections that follow, we confirm our ability to meet these mandatory requirements and provide details of documentation to support our capabilities.

Section Five, Subsection 1

5.1 **This subsection is removed from the solicitation. No response is required.**

Vendor Response

N/A

Section Four, Subsection 5.2

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

Vendor Response

APS-WV confirms that we will be responsible for the requirements of this Section.

APS-WV authorizes services in conformance with current Medicaid program policy coverage and benefit limitations. We configure our data system, CareConnection, to meet the verification and eligibility validation required by the Bureaus for their specific programs. This includes, but is not limited to, validating the member Medicaid or BBHHF eligibility through a daily eligibility feed from the MMIS Vendor, and verifying Managed Care Organization (MCO) enrollment, other insurance coverage, or Third Party Liability.

For services that are the responsibility of the MCO, if the member has MCO enrollment during the requested dates of service, we close the request and notify the requesting provider of the specific MCO covering the member and provider contact information. If we find another primary payer, we notify the provider to submit the request to the primary claims payer. In cases where the primary payer denied payment or indicated non-coverage for a Medicaid member, the provider must attach an EOB or Certificate of Non-Coverage to the request in order for a review to proceed.

Section Four, Subsection 5.3

5.3 Vendor shall provide prior authorization services as outlined in the member's benefit plan and the vendor must respond within a 48 hour time frame for any prior authorization requests. Vendor shall provide a process for reconsideration which takes no longer than 48 hours. Vendor shall issue prior authorizations through direct entry into the prior authorization module of the Medicaid Management information System (MMIS) or through the electronic interface with FACTS and MMIS or other means with approval from the Bureau. Vendor must comply with UM/PA Solution Connectivity Requirements outlined in Attachment 1. Those authorizations that are not directly entered into the MMIS must meet the HIPAA compliant 278 standard format. Vendor must provide verification that they have the capacity to accept all prior authorizations in a web-based format.

Vendor Response

APS-WV confirms that we will comply with the requirements of this Section.

APS – West Virginia verifies the benefit coverage of each member for whom a request is made. When a member has no required coverage for the requested start date of service or no benefit for the requested service, the request is administratively closed. The requesting provider is notified in writing through the web portal of the request closing for payer/benefit ineligibility.

APS-West Virginia will respond to all requests within 48 hours. If additional information is required for the review to proceed, the review timeline is and the status of the request is updated to pending-documentation requested. The provider receives written notification of this new status—including the reviewer requesting the information and the specific information requested. When the provider responds with requested information within the program-specific specified period then the review and the APS timeline for completing the review both resume. When a provider does not submit information, the request is closed administratively. In this instance, the provider may choose to submit again by copying the request for a new submission, update it with the necessary information, and then APS-WV reviews the request.

When a request is denied, the provider may request reconsideration within 60 days of the denial date. Upon receipt of a reconsideration request, APS will have 48 hours to review the request by a physician (specialty match) who did not render the initial denial.

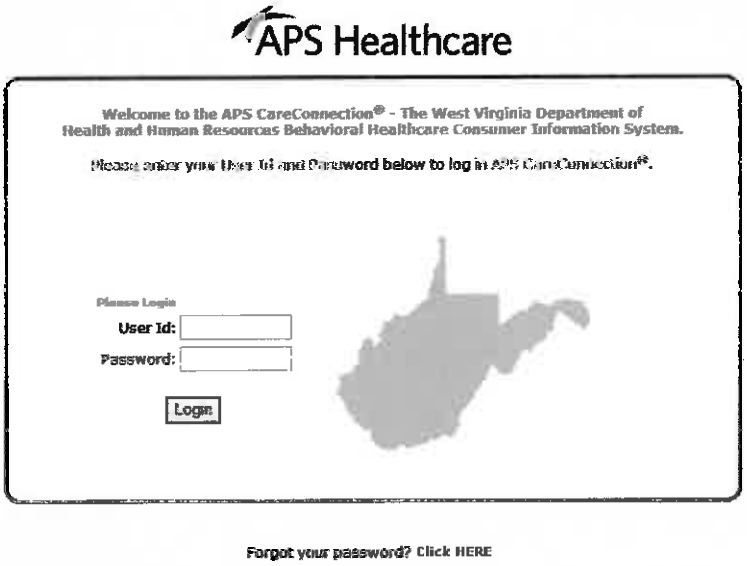
APS-WV will continue to issue prior authorizations through direct data entry into the MMIS module and through an electronic interface with both FACTS and the WV MMIS. APS-WV fully understands it must comply with UM/PA Solution Connectivity Requirements outlined in Attachment 1, which includes our use of the HIPAA compliant 278 standard format electronic interface with the WV MMIS.

The Screenshots in this section verify APS' capacity to accept all requests for prior authorization in a web-based format. The URL for each site is provided.

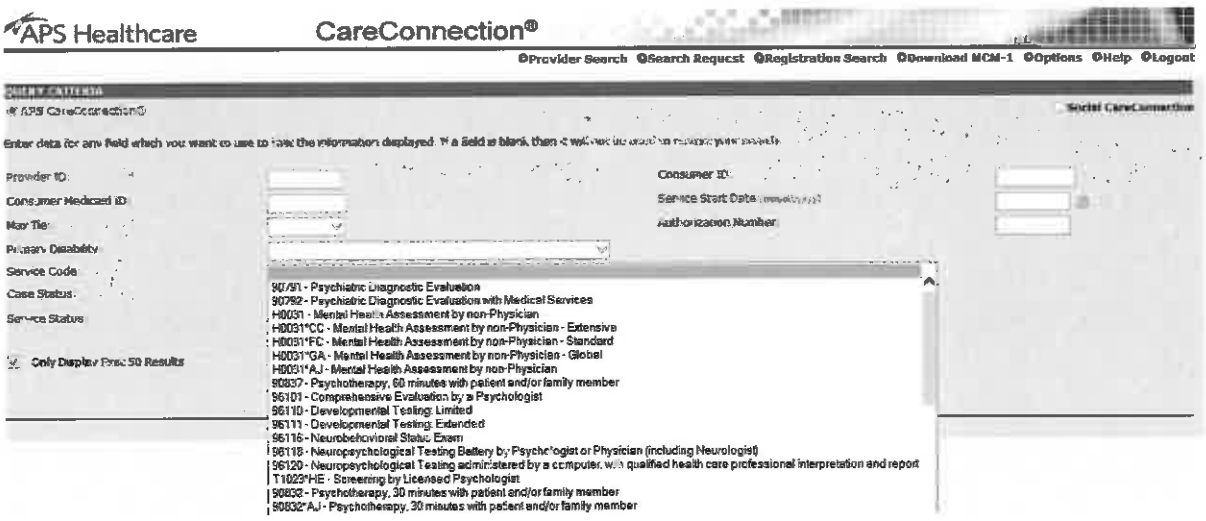
Verification of capacity to accept prior authorizations in a web based format.

Behavioral Health Services

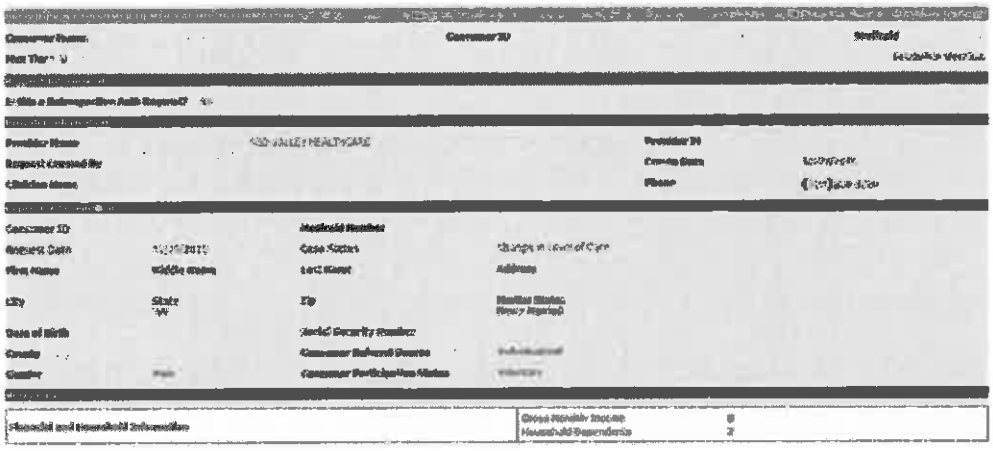
URL: https://careconnectionwv.apshealthcare.com/



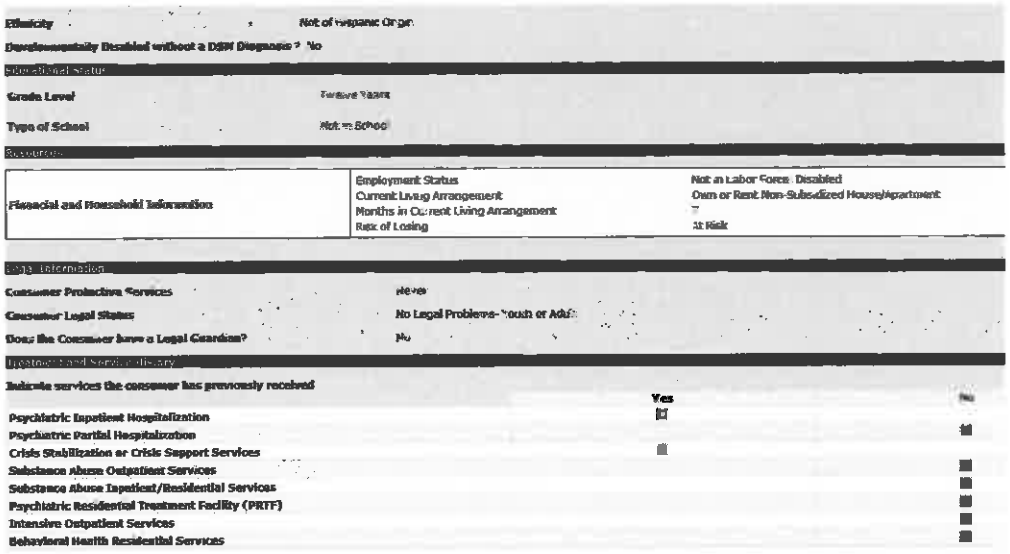
Initial screen with a portion of services in pick list shown:



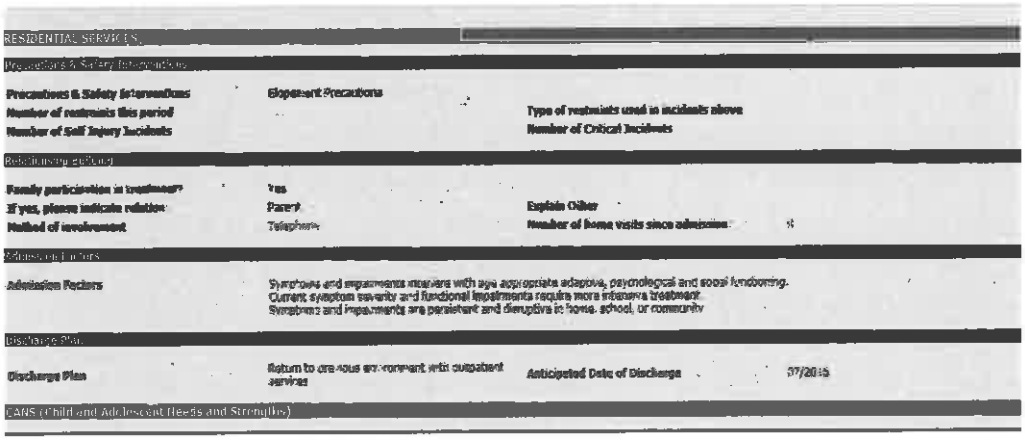
Demographic Information



A portion of BBHHF data collection



Information only required for Children's Residential providers:



RESIDENTIAL SERVICES

Precautions & Safety Interventions

Precautions & Safety Interventions	Elopement Precautions		
Number of restraints this period		Type of restraints used in incidents above	
Number of Self Injury Incidents		Number of Critical Incidents	

Relationship Support

Family participation in treatment?	Yes		
If yes, please indicate relation	Parent	Explain Other	
Method of involvement	Telephone	Number of home visits since admission	8

Admission Factors

Admission Factors	Symptoms and impairments interfere with age appropriate adaptive, psychological and social functioning. Current symptom severity and functional impairments require more intensive treatment. Symptoms and impairments are persistent and disruptive in home, school, or community

Discharge Plan

Discharge Plan	Return to previous environment with outpatient services	Anticipated Date of Discharge	07/2015

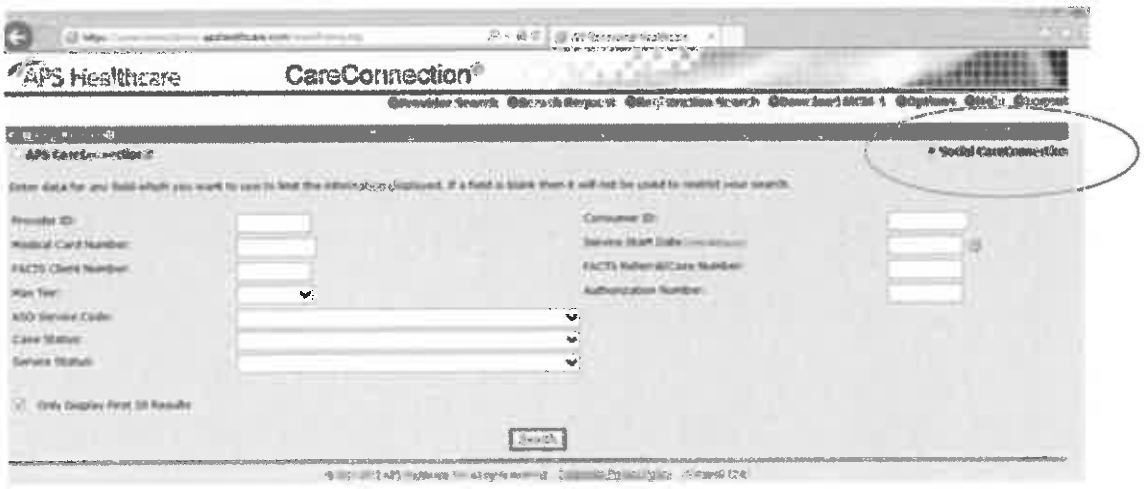
CANS (Child and Adolescent Needs and Strengths)

Socially Necessary Services:

Web Portal is https://careconnectionwv.apshealthcare.com

Logon Screen

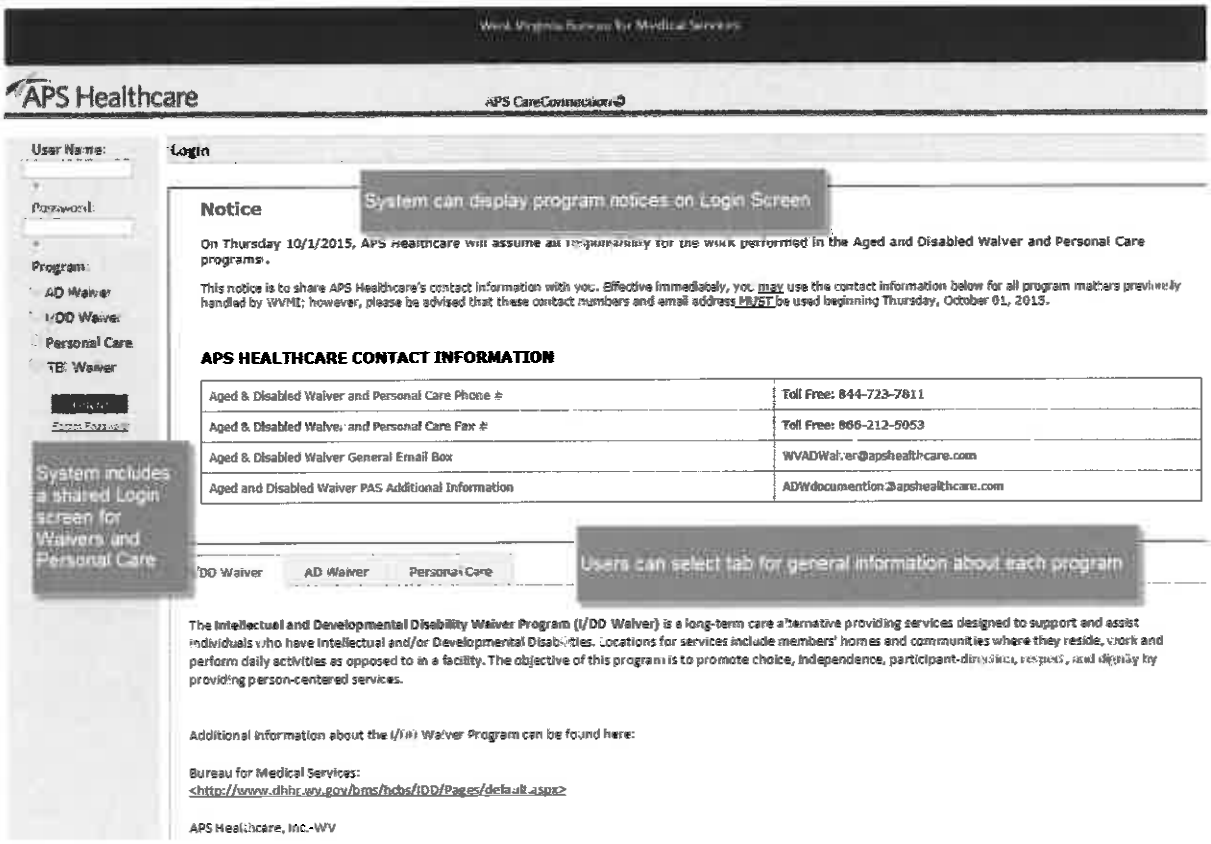
Search Screen

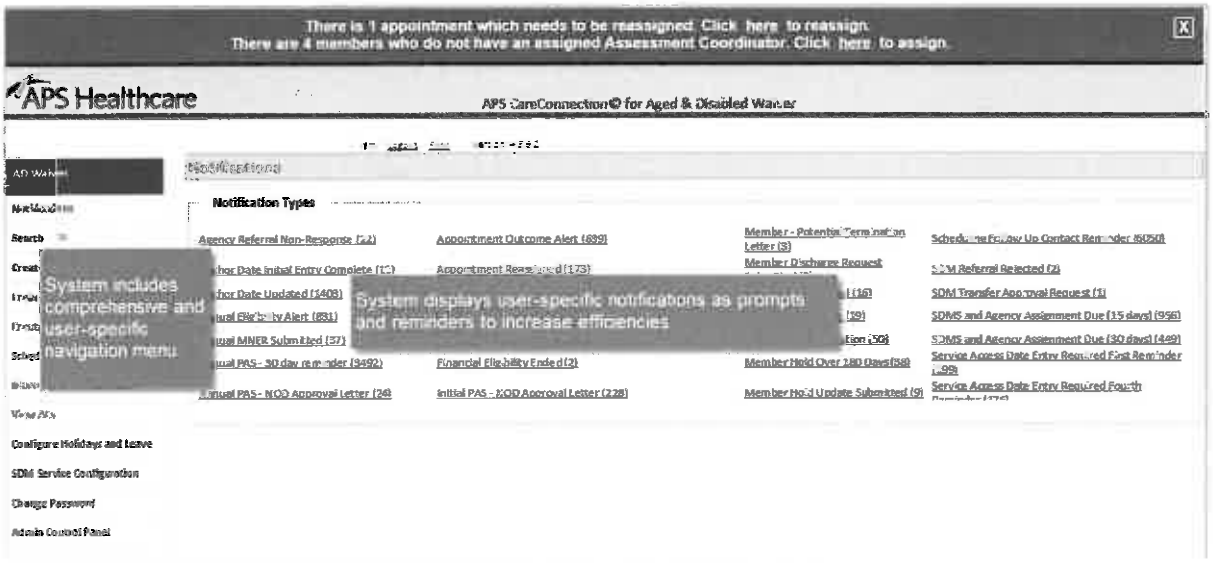


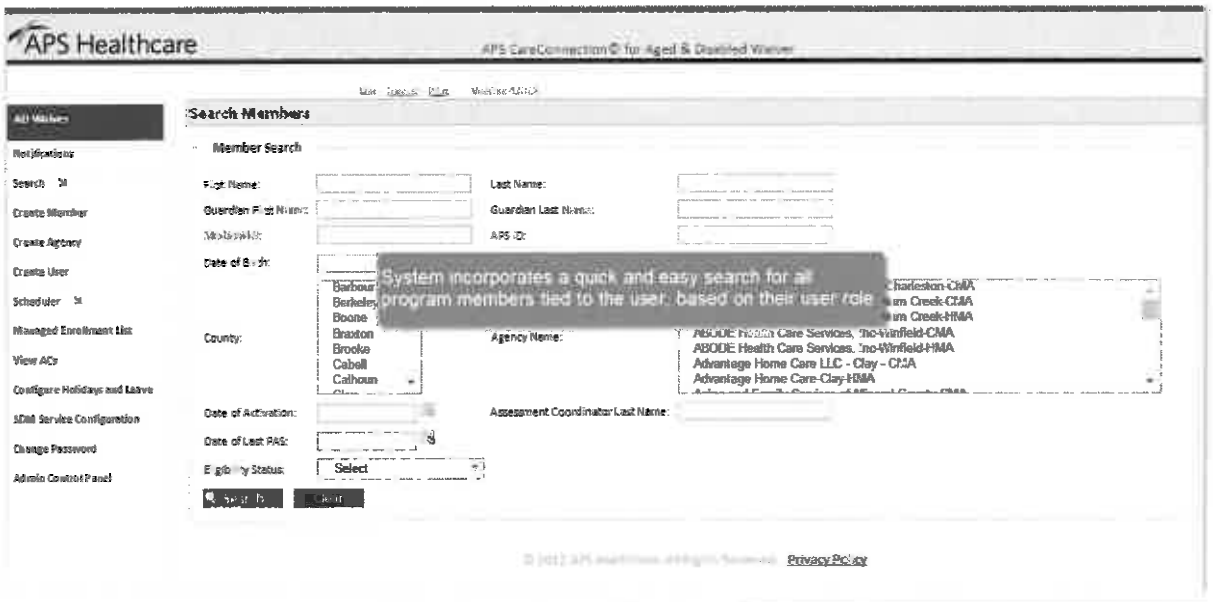
The Current BCF Social Necessity Instructions and Manuals for providers are posted at:
http://apshealthcare.com/publicprograms/west_virginia/WV_Providers_Soc_Nec_Data_Submission_Instruction.htm

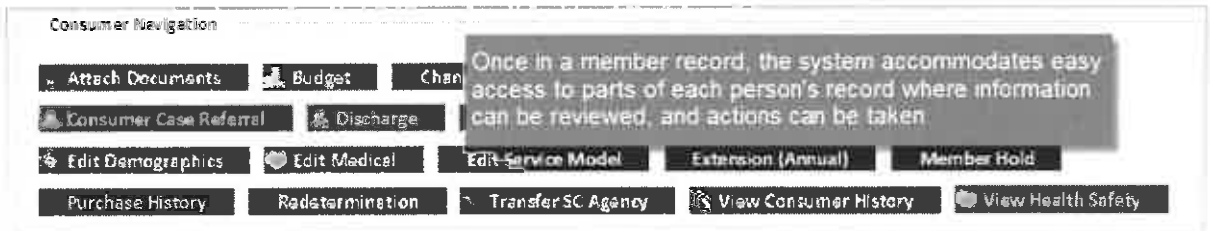
The systems for I/DD Waiver, TBI Waiver and Personal Care are available at the following address: https://mrddwv2.apshealthcare.com/App/Default.aspx.

The overall system shares a common theme across programs, but each program has been designed and tailored to the specific program's policy and procedures. TBI Waiver will be added to this platform.




There is 1 appointment which needs to be reassigned. Click here to reassign.
There are 4 members who do not have an assigned Assessment Coordinator. Click here to assign.
APS Healthcare
APS CareConnection© for Aged & Disabled Waiver
Notification Types
System includes comprehensive and user-specific navigation menu
System displays user-specific notifications as prompts and reminders to increase efficiencies

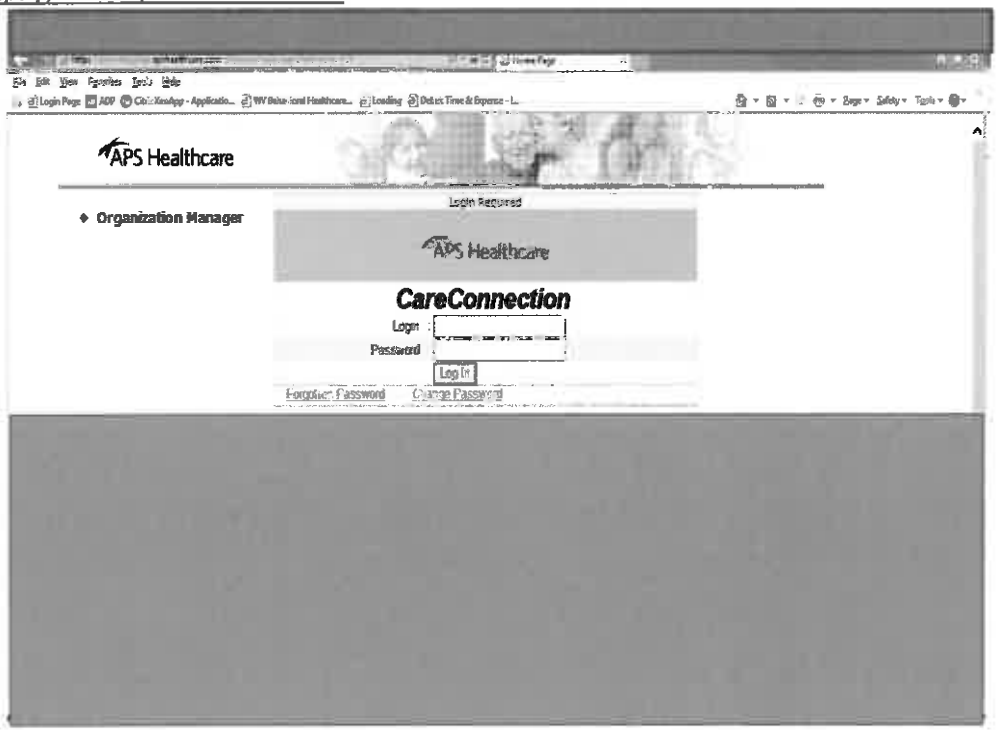

APS Healthcare
Search Members
Member Search
System incorporates a quick and easy search for all program members tied to the user, based on their user role


Consumer Navigation
Attach Documents
Budget
Consumer Case Referral
Discharge
Edit Demographics
Edit Medical
Edit Service Model
Extension (Annual)
Member Hold
Purchase History
Redetermination
Transfer SC Agency
View Consumer History
View Health Safety
Once in a member record, the system accommodates easy access to parts of each person's record where information can be reviewed, and actions can be taken

Medical Services and Health Homes

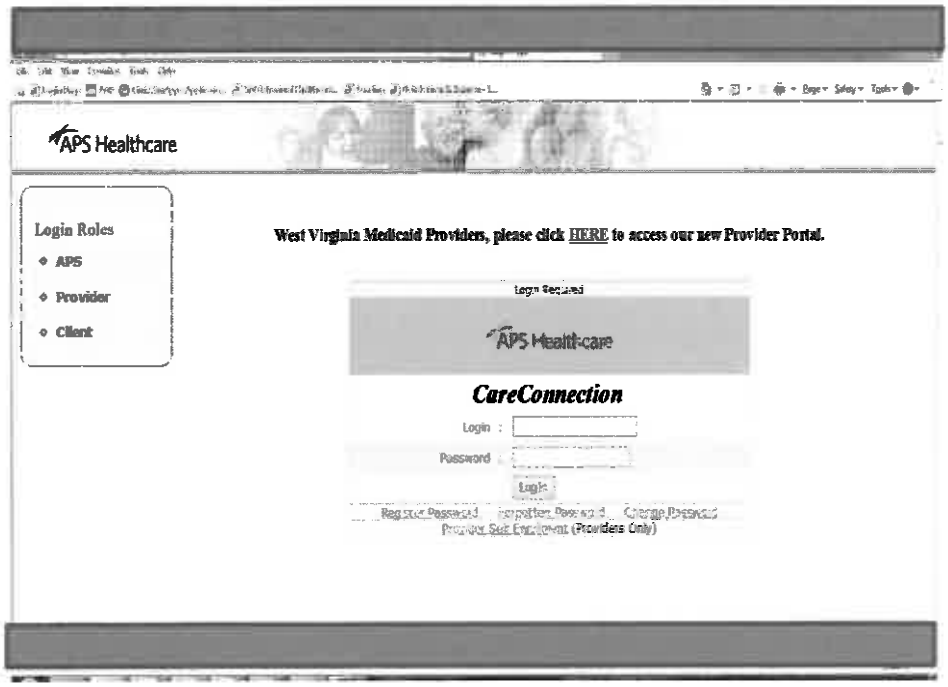
Organization Manager Initial Screen

URL: https://c3wv.apshealthcare.com

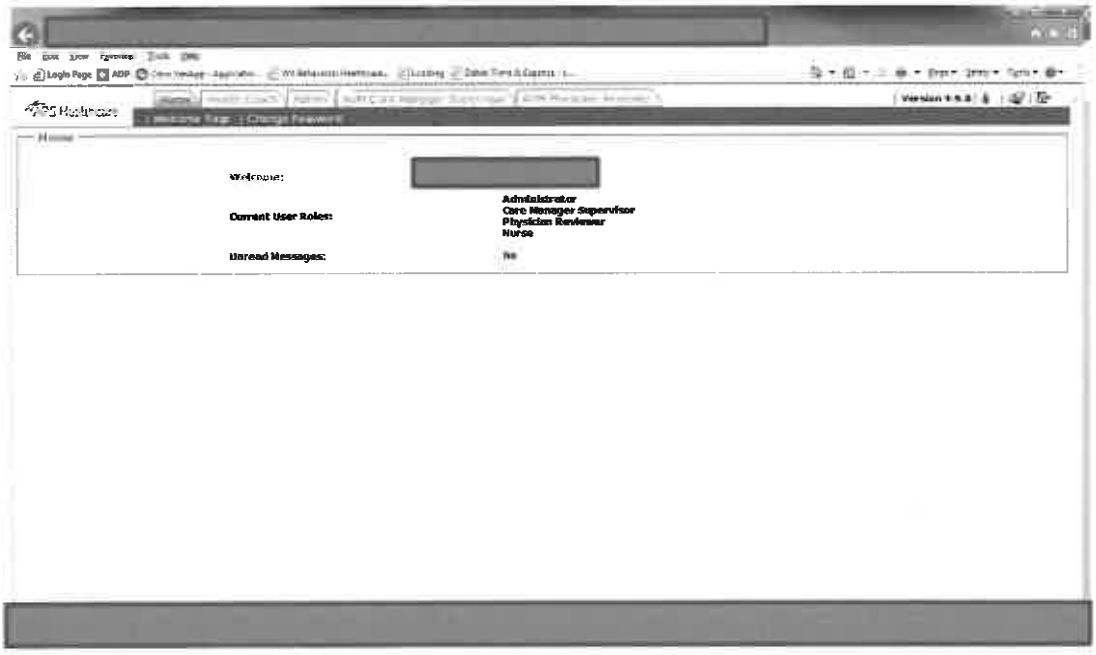


Utilization Management Users Initial Screen:

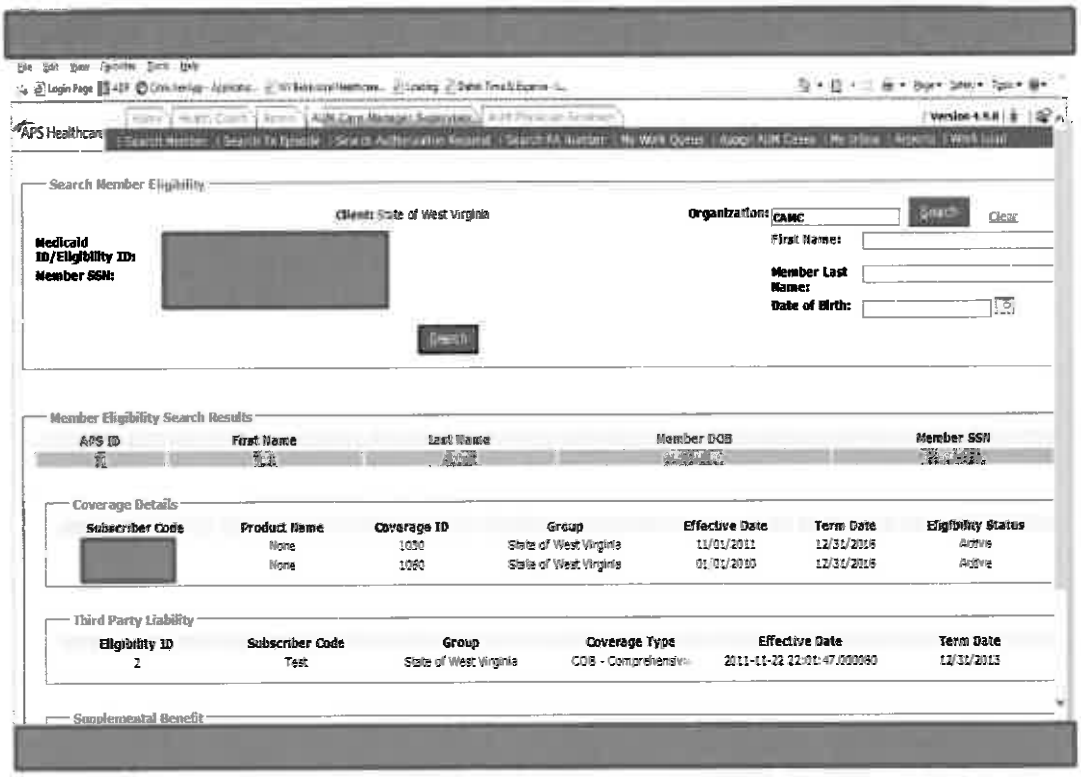
URL: https://providerportal.apshealthcare.com



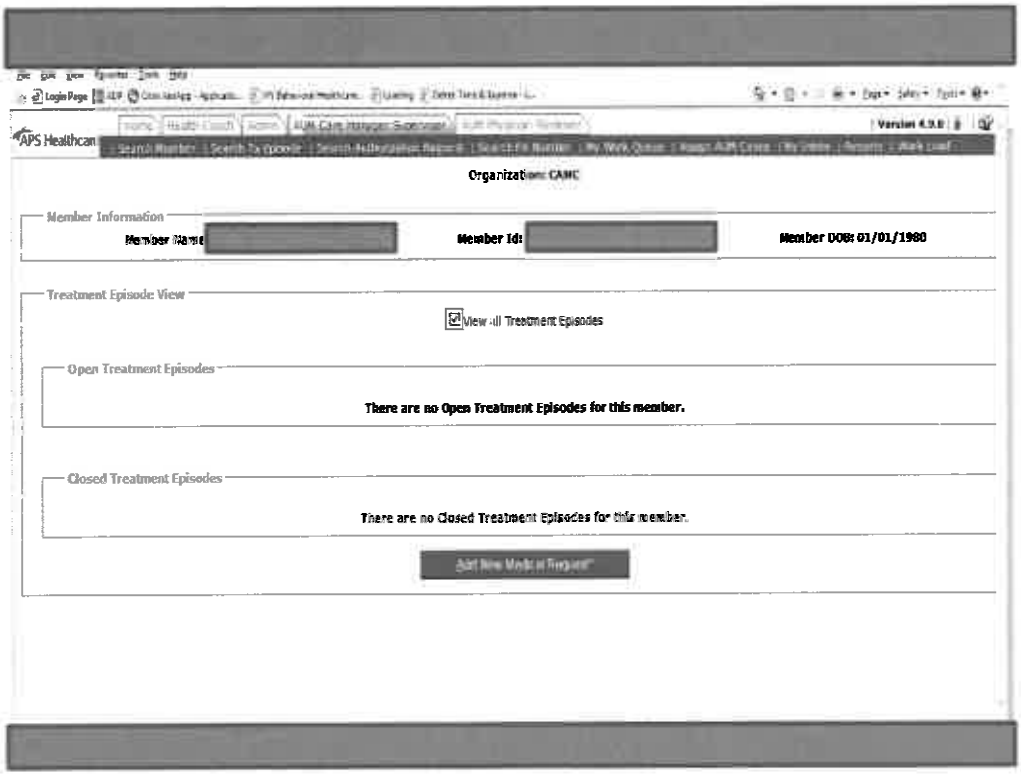
The home screen shows current user roles for the person logged on to the site.



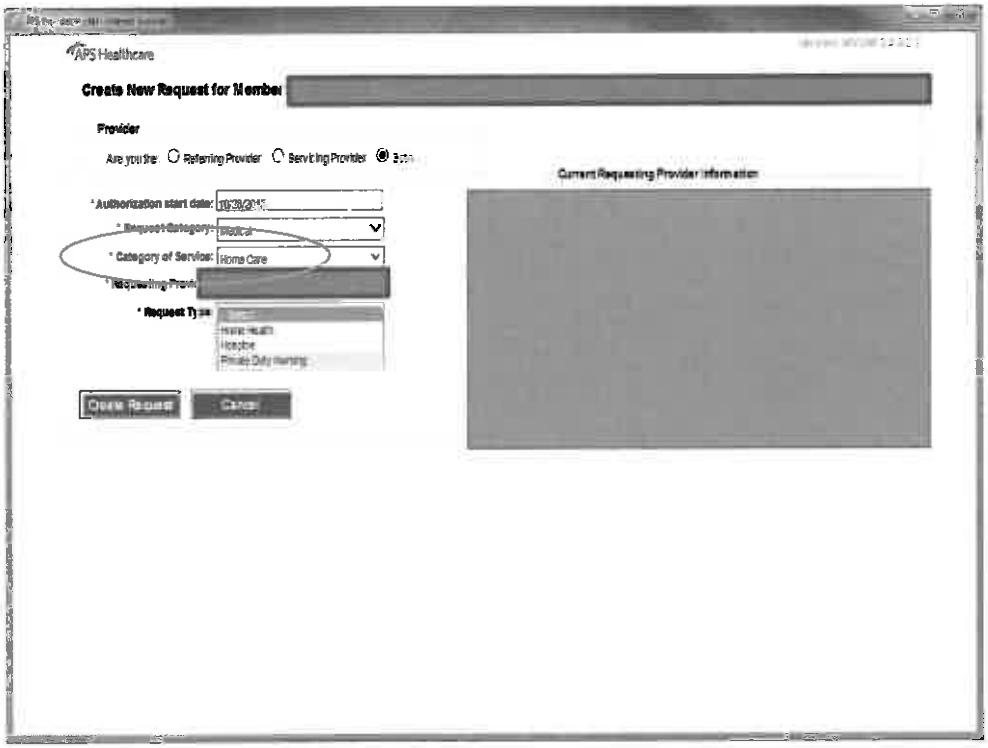
Member Search Results



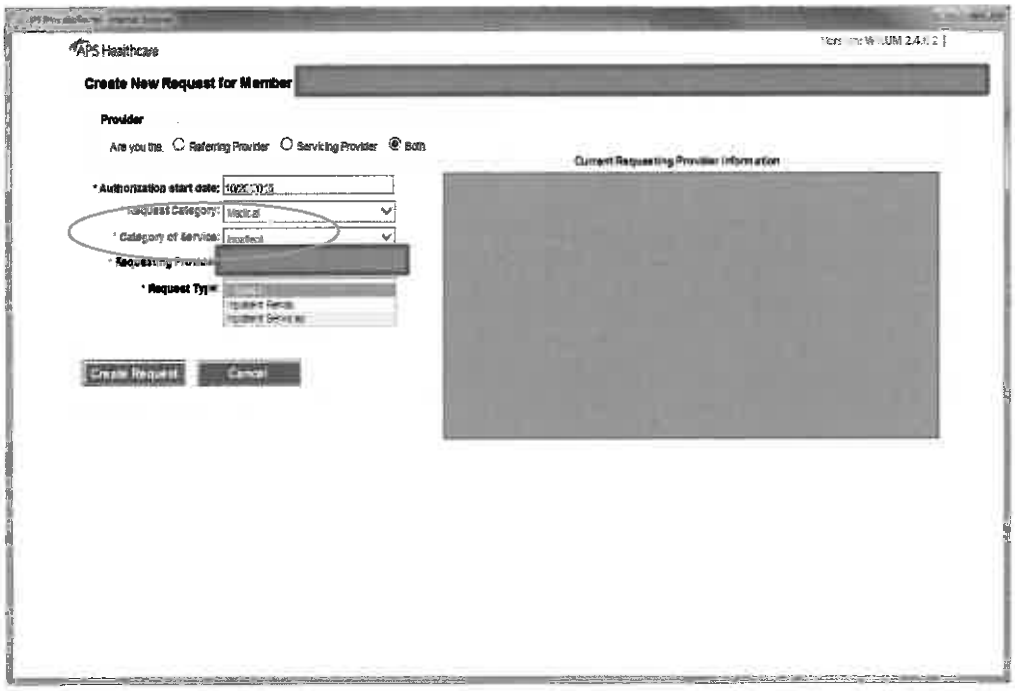
All Existing Requests for a Specific Member:



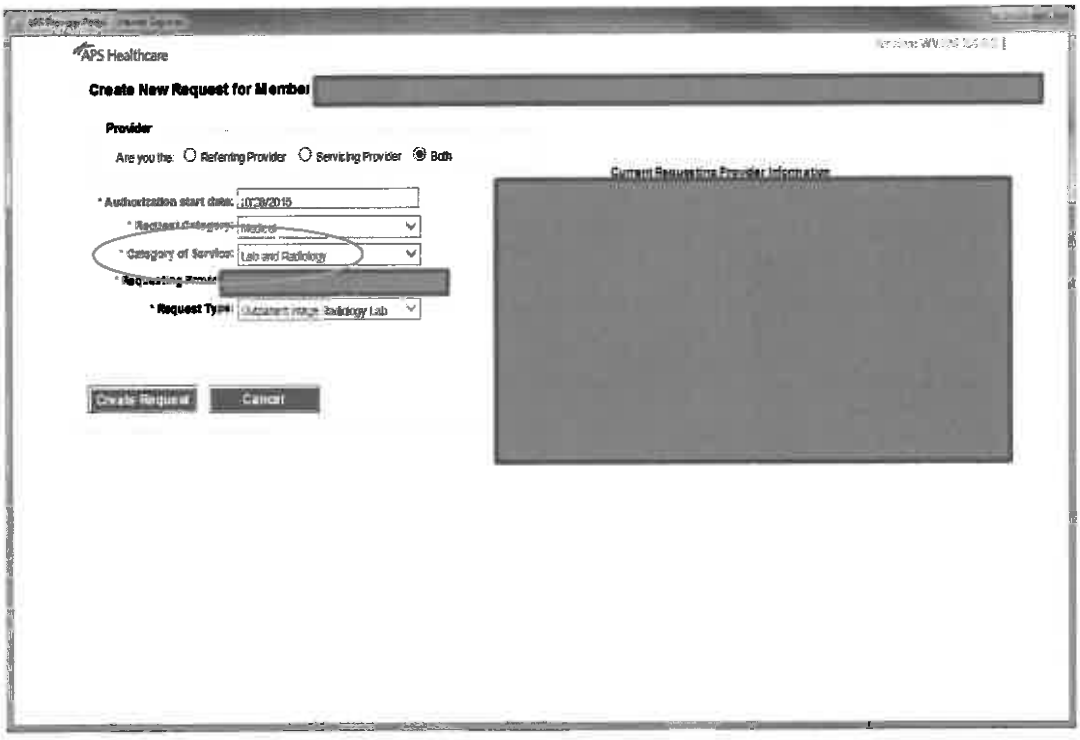
Home Care


APS Healthcare
Create New Request for Member
Provider
Are you the:
Referring Provider
Servicing Provider
Current Requesting Provider Information
* Authorization start date:
* Request Category:
Medical
* Category of Service:
Home Care
* Request Type:
Create Request
Cancel

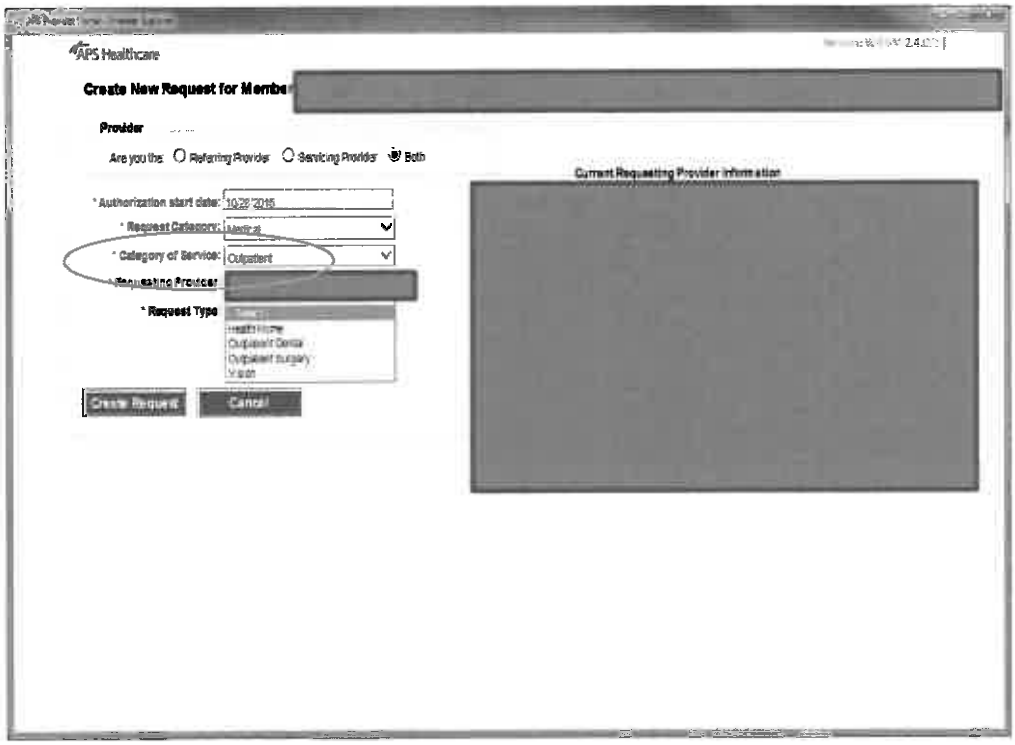
Inpatient Services



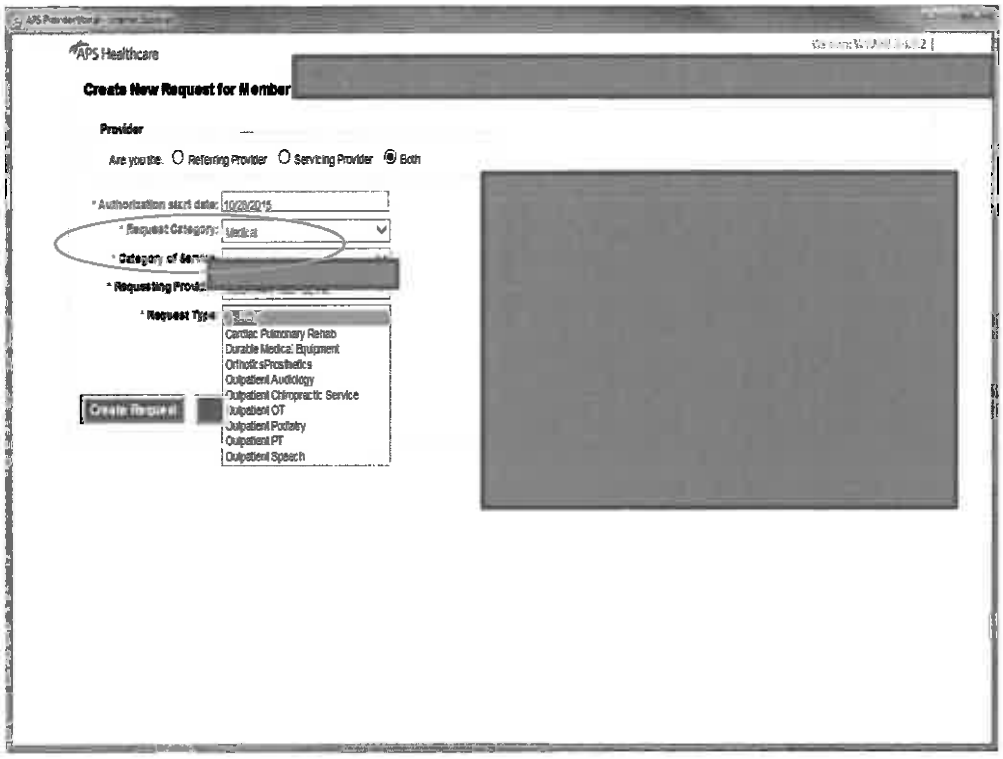
LAB AND RADIOLOGY



OUTPATIENT SERVICES



REHABILITATION OPTIONS



Section Four, Subsection 5.4

5.4 Vendor shall maintain a main office and professional staff in a separate location from the state agency or Medicaid Bureau located at 350 Capitol Street, Charleston, WV. The vendor shall secure a main office located within fifteen (15) mile proximity of the state agency or Medicaid Bureau due to frequent meetings with BMS, BBHHF, and BCF staff by the Operational Start Date. The vendor may have other satellite offices located throughout WV. Staff as specified by the agency must be accessible to the Agency and/or located and managed in WV. Professional staff shall include, at a minimum, registered nurses, dentists, physician advisors, psychiatrists, psychologists, certified brain injury specialists, Masters of Social Work (MSW's), and physicians who must be accessible to the Agency and/or located, managed and licensed in the state of West Virginia within their specialty required as determined by each profession's professional licensing board. Vendor must agree to comply with these staffing provisions, specifically that they will provide at least all of the professions indicated as part of their professional staff. Vendors should provide applicable licensure within their Technical Proposal, but shall be required to provide copies of valid licenses for all proposed professional staff prior to award.

Vendor Response

APS-WV will comply with the requirements of this section. As the incumbent for the last 15 years, APS fully recognizes the need for close proximity to the state agencies for on-going and urgent communication, meetings, planning, and consultation. Additionally, we understand the criticality of having staff not only located in close proximity but also managed locally to address the immediate requests the Bureaus may have for reporting, analysis, IT, clinical consultation, support for requested information by legislators/etc. and addressing critical issues. APS-WV will manage all clinical, reporting/analysis, quality, consumer, provider, training/education, call center activity, consultation, etc. locally. The parent company will manage the corporate business support functions (i.e. HR, Finance, IT development and legal) that will support the local operations.

Professional staff will be West Virginia licensed in their discipline and meet all qualifications to perform the functions necessary to implement the comprehensive utilization management/ASO programs for BMS, BCF, and BBHHF. APS-WV will have office staff housed in Charleston as well as field-based staff strategically located in various regions of the state for optimal assistance to providers and members.

In order to meet all deliverables and provide timely and critical dialog, APS will recommends the communication structure maintained over the last 8 years continue with the Bureaus' participation as shown in Figure 1 Proposed Communication Structure.

To demonstrate our compliance with this section:

- **APS-WV Office Location is 100 Capitol Street, Charleston, WV**
- **Job Descriptions for APS-WV positions, which document credentials and qualifications, are in Exhibit 1.**
- **APS-WV will provide copies of professional staff licensure prior to award upon notification from the Department.**

CONTRACT MANAGEMENT ORGANIZATIONAL STRUCTURE

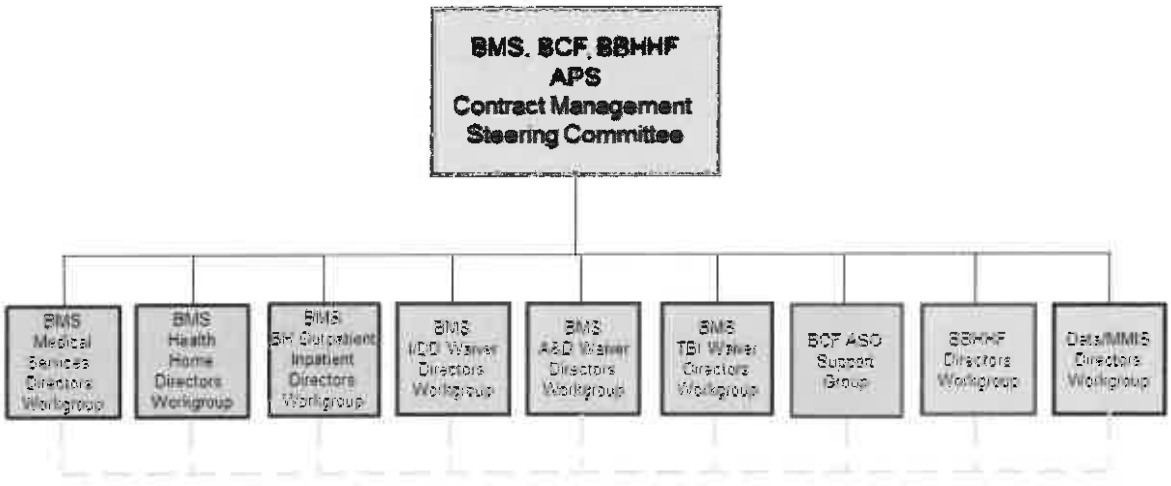


Figure 1 Proposed Communication Structure

Communication /Coordination Plan for APS with BMS, BCF and BBHHF

As the single vendor providing a comprehensive Administrative Services Organization (ASO) that will coordinate systems, services, dollars and data for the Bureau for Medical Services, Bureau for Children and Families and Bureau for Behavioral Health and Health Facilities, we provide the Communication/Coordination Plan for On-going Operations and Implementation Activities.

APS-WV Contract Management Steering Committee

Members: BMS Commissioner and/or Designee, BCF Commissioner and/or Designee, BBHHF Commissioner and/or Designee, BMS Contract Manager and APS-West Virginia Vice President.

Scope of Work: Implementation sign-off; review contract deliverables; identify and solve systemic, political/stakeholder and policy issues; and, evaluate coordination of programs, policies, data, etc. across the Bureaus.

Meetings: Bi-weekly for 1 hour and as needed

Bureau Directors Workgroups

Members: Designated Bureau Directors and APS-WV Directors of Medical Services, BH Outpatient/Inpatient, BCF Socially Necessary, BBHHF ASO & Data Integration, Intellectually/Developmentally Disabled Waiver, Aged & Disabled Waiver, Traumatic Brain Injury Waiver, Health Home, and Data/MMIS.

Scope of Work: Identify clinical and data processes and reporting for implementation and on-going operations; review and refine workflows; identify systemic and policy issues; and, review best practices and on-going program performance.

Meetings: Weekly, bi-weekly, or monthly (depending on need)

Section Four, Subsection 5.5

5.5 Vendor is responsible for providing start-up and operations tasks and subtasks including, but not limited to, access to agency or other systems including the Medicaid Management Information System (MMIS), Family and Children's Tracking System (FACTS), Recipient Automated Payment Information Data System (RAPIDS), and the data warehouse, utilization review and authorization of utilization management of all behavioral, medical, and dental services listed and socially necessary services in this document. The Families and Children Tracking System (FACTS) bi-directional interface and all of the associated electronic data structures, data transmittal processing and application functionality will remain unchanged. The Vendor is required to accept data transfers in the current formats and correct exceptions for processing. This includes but is not limited to changes in the client identification that supports utilization reporting. Any work product developed during the course of implementation cannot be considered proprietary.

Vendor Response

APS-WV will comply with the requirements of this Section. APS-WV will provide for the start-up and operations, which will include access to the MMIS, FACTS, RAPIDS, and the data warehouse. APS will provide utilization review and authorization of all behavioral, medical, dental services and socially necessary services delineated in the CRFP. These APS activities are comprehensively presented in various sections in the Vendor Response for each program.

APS will continue the bi-directional interface with BCF and its associated electronic data structures, data transmittal processing and application functionality, which will remain unchanged. APS will accept data transfers in the current formats and make needed corrections for processing, which includes change in the client identification that supports utilization reporting.

APS-WV will work closely with each of the Bureaus to ensure the access to the appropriate systems as well as requirements for data and data transfers.

Department: **Multiple**

Position Title: **Administrative Assistant**

Position Summary: Provides a broad range of administrative support to a team, department and/or individual and reports to the BBHHF Director. The position supports office employees with day-to-day office functions, training and non-clinical support functions (e.g. data entry and report tracking) and performs functions to support external customer access to APS staff and services; arrange training venues; arrange conference calls, copy and organize materials for training, enter data into various software programs; answer and respond to routine calls, inquiries and questions and route calls appropriately; ensure timely and proper handling and safeguarding of confidential, private or sensitive material; performs special projects as required as well as other duties as assigned to meet business needs

Essential Functions: 1) Day to day office functions including maintaining correspondence, training and clinical files; preparing and mailing correspondence; schedule appointments and meetings as directed; assist with data entry and compiling monthly, quarterly and annual reports required to meet contract specifications; direct calls appropriately, and; ensure timely and proper handling of all confidential, classified, private or sensitive material. 2) Track daily and weekly department activities and complete appropriate tracking reports; prepare and send out correspondence related to department activities (e.g. notifications, reports etc.), and; data entry and import of information required for reports and notification. 3) Continue professional development, cross-train to provide administrative coverage to other departments and perform other duties as assigned.

Education, Experience and Skills: Applicants must have an AA degree or equivalent work experience; 2 years' experience, preferably in a healthcare setting. Applicant will possess knowledge of day to day office operations, project management, customer service, and phone etiquette. Applicant must have excellent written and verbal communication skills; Computer skills, including word processing and spreadsheets; Data entry experience in a wide variety of platforms; Proficient use of office equipment, including faxes, copiers, phone systems; Excellent phone etiquette; Customer service skills; Ability to manage multiple tasks and projects; Prioritize day to day tasks to meet established timelines; Handle customers and route appropriately; Organize and review work flow to ensure completion of necessary tasks.

Department: Aged and Disabled Waiver

Position Title: ADW Nurse Manager

Position Summary: The Aged and Disabled Waiver RN Manager will provide direction to staff regarding the achievement of service deliverables related to initial and re-evaluation Aged and Disabled Waiver assessments, the Personal Care and other programs, as needed. The ADW Manager will provide general supervision, coordinate inter-rater reliability functions and establish team policies and procedures.

Essential Functions: 1) Provide operational oversight to ensure contract deliverables are achieved 2) Develop and maintain operational guidelines 3) Provide leadership and supervision to staff 4) Review performance measures and problem-solve to improve deliverables, when necessary 5) Develop and conduct inter-rater reliability activities (including observation) for consistency in ADW assessments 6) Other duties as assigned.

Education, Experience and Skills: Education requirements include a minimum of a Bachelor's Degree in Nursing (Master's preferred). Desired applicant must have a valid WV Registered Nurse License, a minimum of 2 years' experience in the West Virginia Aged and Disabled Waiver program and prior leadership and supervisory experience. Applicant must possess knowledge of the Pre-Admission Screening, Aged and Disabled Waiver and Personal Care program policies and procedures. Applicant must be organized, have effective and professional written and verbal communication skills, be flexible, and have the ability to use Microsoft software. Experience with the Aged and Disabled Waiver Care Connection© system is a plus. Some travel may be required.

Department: **Aged and Disabled Waiver**

Position Title: **ADW Quality Nurse**

Position Summary: The Aged and Disabled Waiver Quality Nurse performs education and initial/re-evaluation assessments of Aged and Disabled Waiver members for the purposes of determining program medical eligibility. RNs will provide education to applicants/members and conduct the Pre-Admission Screening assessment. ADW RNs must manage a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed and data is entered into the APS Care Connection© within prescribed timelines. The Quality Nurse will monitor ADW RN quality, recommend and implement quality assurance and improvement protocols and assist with training.

Essential Functions: 1) Travel to, conduct and appropriately administer and document assessments within prescribed timelines 2) Participate in inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols 3) Participate in denial hearings as necessary 4) Contact physicians and facilities to confirm medical information 5) Monitor ADW RN quality, recommend and implement quality assurance and improvement protocols and assist with training 6) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Nursing degree (BSN preferred) and a valid WV Registered Nurse license, must have a minimum of 2 years' experience with aging population or with persons with disabilities (preferably working within the WV Aged and Disabled Waiver program). Applicant must possess knowledge of the Aged and Disabled Waiver program policies and procedures and be willing to travel to homes and facilities within the catchment area (travel outside one's catchment area is occasionally required to fill-in for others or to attend staff meetings/events). Applicant should be organized and have excellent customer service skills, good interpersonal communication and be flexible. Applicant must be able to accurately assess medical conditions and symptoms and functional abilities.

Department: Aged and Disabled Waiver

Position Title: ADW RN

Position Summary: The Aged and Disabled Waiver RN performs education and initial/re-evaluation assessments of Aged and Disabled Waiver members for the purposes of determining program medical eligibility. RNs will provide education to applicants/members and conduct the Pre-Admission Screening assessment. ADW RNs must manage a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed and data is entered into the APS CareConnection© within prescribed timelines.

Essential Functions: 1) Travel to, conduct and appropriately administer and document assessments within prescribed timelines 2) Participate in inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols 3) Participate in denial hearings as necessary 4) Contact physicians and facilities to confirm medical information 5) Other duties as assigned.

Education, Experience and Skills: Must possess a Nursing degree (BSN preferred) and a valid WV Registered Nurse license. Must have a minimum of 2 years' experience with aging population or with persons with disabilities (preferably working within the WV Aged and Disabled Waiver program). Must possess knowledge of the Aged and Disabled Waiver program policies and procedures and be willing to travel to homes and facilities within the catchment area (travel outside one's catchment area is occasionally required to fill-in for others or to attend staff meetings/events). Candidate should be organized and have excellent customer service skills, good interpersonal communication and be flexible. Applicant must be able to accurately assess medical conditions and symptoms and functional abilities.

Department: Aged and Disabled Waiver

Position Title: ADW UM Support Staff

Position Summary: The ADW UM staff provides a broad range of administrative service support to the WV Aged and Disabled Wavier and Personal Care team and to the external customer. The position supports the ADW and PC clinical staff with day-to-day functions as well as performing primary customer service and technical assistance functions. The ADW UM staff provides telephone support to ADW members and providers/facilities.

Essential Functions: 1) Provides program support to the ADW and PC programs that include scheduling ADW assessments 2) Preparing and mailing notice of decision and other program letters 3) Assist callers with billing, CareConnection©, general program and other questions/concerns 4) Other duties as assigned.

Education, Experience and Skills: Candidates must have a high school diploma or GED equivalent (advance degree/certificate preferred), 1-2 years in an administrative support or customer service position. The preferred candidate will possess knowledge of the Aged and Disabled Wavier program policies and procedures. Applicant must have excellent customer service and communication skills, must be able to multi-task and prioritize, must have experience with Microsoft programs, experience with ADW CareConnection© preferred, and be flexible.

Department: Aged and Disabled Waiver

Position Title: ADW UM Support Team Leader

Position Summary: The ADW UM Team Leader provides direction to staff regarding the achievement of service deliverables related to utilization management, provider education, and customer service related to the WV Aged and Disabled Waiver and Personal Care programs. The Team Leader provides general supervision, coordinates inter-rater reliability functions and establishes team policies and procedures.

Essential Functions: 1) Provide operational oversight to ensure contract deliverables are achieved 2) Identify, assess and provide training to staff related to their functions within the Aged and Disabled Waiver and related departments 3) Develop and maintain operational guidelines 4) Provide leadership and supervision to UM Support staff 5) Assist and fill-in when UM staff are unavailable to fulfill duties and when the business need exceeds normal standards 6) Prepare monthly reports 7) Maintain excellent customer service 8) Develop and implement training for inter and intra-departmental needs 9) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Bachelor's degree, minimum of 2 years' experience (preferably within the WV Aged and Disabled Waiver program), and prior leadership and supervisory experience. Applicant must possess knowledge of the Aged and Disabled Waiver program, be organized, have excellent customer service and have excellent written and verbal communication skills, must be flexible and have experience using Microsoft software and (preferably) ADW Care Connection©. The ADW UM Team Leader will manage the departmental responsibilities which include: Contacting ADW program applicants/members to schedule eligibility assessments, processing letters, and assisting callers with billing, Care Connection©, general program questions/concerns.

Department: Traumatic Brain Injury (TBI) Waiver

Position Title: Assessment Coordinator

Position Summary: The TBI Waiver Assessment Coordinator performs initial/re-evaluation medical eligibility assessments for TBI Waiver applicants and/or members for the purposes of determining program medical eligibility. Assessment Coordinator also provides education to applicants/members on such topics as: program covered services, service delivery models options and rights and responsibilities. In addition, information and training on recognizing and reporting abuse, neglect and exploitation is conducted annually during member's re-evaluations. The Assessment Coordinator conducts the Pre-Admission Screening assessment and the Rancho Los Amigos Scale and reviews supporting medical documentation to verify assessment observation and findings. The Assessment Coordinator must manage a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed and medical eligibility determinations are rendered in prescribed timelines.

Essential Functions: 1) Travel to, conduct and appropriately administer and document assessments within prescribed timelines 2) Participate in inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols 3) Participate in denial hearings as necessary 4) Contact applicant/members referent and/or facilities to confirm medical information 5) Other duties as assigned.

Education, Experience and Skills: Must have a minimum of a Bachelor's Degree in a Human Service Field (Master's preferred), a minimum of 1 years' experience with disabilities and be Licensed as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor or Psychologist and have the Certified Brain Injury Specialist (CBIS) certification. Must have a working knowledge of Microsoft software, be organized and have excellent customer service skills, good interpersonal communication and be flexible. Assessment Coordinator must be willing to travel to homes and facilities within the catchment area (travel outside one's catchment area is occasionally required to fill-in for others or to attend staff meetings/events). Must be able to accurately assess medical conditions, symptoms and functional abilities.

Department: BBHHF

Position Title: Program Director

Position Summary: The APS-WV Program Director is responsible for the management and deliverables of one of the five assigned contracts. The Program Director ensures that all the ASO functions are performed to the highest standards and contract requirements. The functions include UM, retrospective reviews, provider training/education, consumer training/education, QI activities, data collection, analysis, and reporting, technical assistance to stakeholders and consultation to the Contract Managers. Through collaboration with the other contracted WV programs areas, the state is guaranteed an effective and efficient system of care. Additionally, the Program Director assists with the enhancement of the RFP (e.g. change orders), new RFP cycles and related new business.

Essential Functions: 1) Effectively manage the ASO operations in order to meet contract deliverables. 2) Provide leadership & supervision to staff assigned to contract. 3) Provide consultation to the respective Contract Manager in area of expertise. 4) Assess policy & procedure continually to ensure a high level of customer satisfaction to all stakeholders. 5) Monitors, evaluate, and recommend changes to the existing contract (for possible change order), rebid, and new business.

Education, Experience and Skills: Applicant must have BA/BS minimum in a related field; license and/or certification and /or credentialed Q related to the field; minimum 3-5 years' experience related to area of contract; 3-5 years supervisory and program management experience. Applicant will have knowledge of the best practice in content area; Knowledge of government policy and structure; Computer skills/knowledge relevant to the particular contract; Knowledge of management and leadership functions/skills. Applicant must be able to lead and manage direct reports to achieve contract deliverables; Aptitude for systems planning and prioritization of tasks; Competent communication skills (written & verbal & listening); Ability to use appropriate interpersonal skills with variety of stakeholders. Candidate needs to provide ongoing monitoring and supervision to meet contract deliverables for all ASO functions; Provide supervision to staff that ensure excellent customer satisfaction; Provide data analysis and reporting that meets the contractor's goals of quality care and cost effectiveness in a timely manner; Provide consultation to contractor on system and policy issue.

Department: BCF

Position Title: Program Director

Position Summary: The APS-WV Program Director is responsible for the management and deliverables of one of the five assigned contracts. The Program Director ensures that all the ASO functions are performed to the highest standards and contract requirements. The functions include UM, retrospective reviews, provider training/education, consumer training/education, QI activities, data collection, analysis, and reporting, technical assistance to stakeholders and consultation to the Contract Managers. Through collaboration with the other contracted WV programs areas, the state is guaranteed an effective and efficient system of care. Additionally, the Program Director assists with the enhancement of the RFP (e.g. change orders), new RFP cycles and related new business.

Essential Functions: 1) Effectively manage the ASO operations in order to meet contract deliverables. 2) Provide leadership & supervision to staff assigned to contract. 3) Provide consultation to the respective Contract Manager in area of expertise. 4) Assess policy & procedure continually to ensure a high level of customer satisfaction to all stakeholders. 5) Monitors, evaluate, and recommend changes to the existing contract (for possible change order), rebid, and new business.

Education, Experience and Skills: Applicant must have Master's degree in social work, counseling or psychology; license at the master's level; 3-5 years' experience related to child welfare, behavioral health services, utilization management and systems planning; 3-5 years supervisory and program management experience. Applicant will have knowledge of the best practice in content area; Knowledge of government policy and structure; Computer skills/knowledge relevant to the particular contract; Knowledge of management and leadership functions/skills. Applicant must be able to lead and manage direct reports to achieve contract deliverables; Aptitude for systems planning and prioritization of tasks; Competent communication skills (written & verbal & listening); Ability to use appropriate interpersonal skills with variety of stakeholders. Candidate needs to provide ongoing monitoring and supervision to meet contract deliverables for all ASO functions; Provide supervision to staff that ensure excellent customer satisfaction; Provide data analysis and reporting that meets the contractor's goals of quality care and cost effectiveness in a timely manner; Provide consultation to contractor on system and policy issue.

Position Title: Behavioral Health Care Manager

Position Summary: : The Care Manager performs medical necessity review of WV Medicaid behavioral health services offered through Licensed Behavioral Health Centers, Private Practitioners, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC). Care Managers perform clinical reviews using national and state criteria; provide training and consultation to providers, interact with APS Physician Reviewers, and meet contract deliverables.

Essential Functions:

1) Perform medical necessity review of behavioral health service requests
2) Exhibit excellent customer service and communication skills to providers and members
3) Utilize and update clinical parameters to preserve inter-rater reliability
4) Provide consultation and training to providers
5) Other duties as assigned.

Education, Experience and Skills: Applicants must have a Master's Degree in Social Work, Counseling or Psychology, and an active WV clinical license in Social Work (LGSW, LCSW, and LICSW) or Counseling (LPC). A minimum of two years' experience in behavioral health with a minimum of one year direct service experience, and demonstrate ability to integrate clinical knowledge and experience when applying criteria and policies is required. Prior experience with WV Medicaid behavioral health services desired. Applicants must have excellent customer service skills, must be able to multi-task, prioritize and be flexible.

Position Title: Behavioral Health RN Care Manager

Position Summary: The RN Care Manager performs medical necessity review of WV Medicaid behavioral health services offered through Licensed Behavioral Health Centers, Private Practitioners, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Psychiatric Hospitals. RN Care Managers perform clinical reviews using national and state criteria; interact with APS Physician Reviewers, provide training and consultation to providers, and meet to contract deliverables.

Essential Functions:

1) Perform medical necessity review of behavioral health service requests
2) Exhibit excellent customer service and communication skills to providers and members
3) Utilize and update clinical parameters to preserve inter-rater reliability
4) Provide consultation and training to providers
5) Other duties as assigned.

Education, Experience and Skills: Applicants must have a Nursing Degree, a valid, unrestricted West Virginia RN license, a minimum of two years behavioral health experience with a minimum of one year direct service experience, and demonstrate ability to integrate clinical knowledge and experience when applying criteria and policies. Prior experience with WV Medicaid behavioral health services desired. Applicants must have excellent customer service skills, must be able to multi-task, prioritize and be flexible.

Position Title: **Behavioral Health Team Leader**

Position Summary: The Behavioral Health Team Leader provides daily operational oversight to the behavioral health care managers to ensure contract deliverables are achieved. The Team Leader performs inter-rater reliability activities, recruits and interfaces with APS Physician Reviewers, and establishes team policies and procedures. Consultation, participation in policy reviews and recommendations are provided at the Contractor's request.

Essential Functions:

1) Ensure daily operational requirements and contract deliverables are achieved
2) Develop, implement and track staff performance measures
3) Provide clinical guidance and medical necessity review of behavioral health service requests
4) Develop, evaluate and implement strategies to maintain team inter-rater reliability
5) Provide consultation and training to providers
6) Other duties as assigned.

Education, Experience and Skills: Applicants must have a Master's Degree in Social Work, Counseling or Psychology, and an active WV clinical license in Social Work (LGSW, LCSW, and LICSW) or Counseling (LPC). A minimum of two years' experience in behavioral health with a minimum of one year direct service experience, and demonstrate ability to integrate clinical knowledge and experience when applying criteria and policies is required. Prior experience with WV Medicaid behavioral health services desired. Applicants must have excellent customer service skills, must be able to multi-task, prioritize and be flexible. Prior supervisory experience is preferred.

Department: Socially Necessary Services (SNS)

Position Title: Care Manager

Position Summary: The SNS Care Manager performs utilization management tasks, training and technical assistance for SNS providers in a concise and clear manner to maintain high customer satisfaction and aims of the program for the WV DHHR Bureau for Children and Families. SNS providers range from biological parents to professional agencies requiring assistance with the authorization process. The SNS Care Manager must provide consultation regarding child welfare cases to BCF Policy/Management staff as well as DHHR field staff related to abuse/neglect and juvenile justice cases to ensure the appropriate services are being authorized. Care Manager represents the contractor at public forums, conferences and meetings regarding the program and assists with further refinement of the model.

Essential Functions: 1) Review pended cases within 2 business days of receipt by utilizing the UM manual, interpretive guidelines, BCF policy and BCF procedures 2) Provide consultation regarding child welfare cases to BCF Policy/Management staff as well as DHHR field staff related to abuse/neglect and juvenile justice cases to ensure the appropriate services are being authorized 3) Conduct training and consultation to providers and BCF staff regarding SNS policies and procedures, consultation instruments based upon analysis of information obtained via authorization process and review of individual cases 4) Represents the contractor at public forums, conferences and meetings regarding the program and assists with further refinement of the model 5) Will participate in monthly ASO Group Support meetings, quarterly all staff meetings and other required meeting as needed.

Education, Experience and Skills: Applicant must have a Master's degree in social work, counseling or psychology from an accredited program; Current WV Social Work, WV Counseling or WV Psychology License in good standing with the corresponding board. Applicant must have 1-2 years' experience in direct practice with children and families involved with the child welfare system, writing and evaluating services plans; leading multi-disciplinary teams; Customer Service in which both verbal and written communication were required; providing educational/training to diverse populations and/or public speaking preferred. Applicants will possess knowledge of WV DHHR Child Protective and Youth Services Policy; WV statute related to abuse, neglect and juvenile proceedings; Child Welfare Best Practice Standards; Supports and services available across the state; Health Information Privacy and Portability Act. Applicant must be skilled in utilizing Word Perfect/Microsoft word, Excel, PowerPoint and Web applications; communicate clearly through verbal and written means with providers with different levels of experience; Organize work time and tasks effectively to meet contract deliverables; Negotiation and de-escalation capabilities. Applicant should have the ability to learn the basic policy and procedures of each contract/be cross trained to provide support to other programs when needed. Applicants should have the ability to analyze/assess service request to determine if eligibility, admission, continued stay and/or discharge criteria are met; Prioritize tasks effectively; Interpret utilization management, training/consulting score and Care Connection® data; Evaluate provider case records against designated documentation and practice standards; Interpret RFP and program data to allow team to respond to announcements innovatively.

Department: Consumer Affairs

Position Title: Consumer & Community Affairs Liaison

Position Summary:

- Coordinate statewide trainings that provide efficient and accurate information that directly affects both Medicaid and Socially Necessary Services recipients
- Conduct focus groups to obtain stakeholder feedback on a variety of topics chosen and/or approved by Medicaid or the Bureau for Children and Families
- Provide training/educational workshops to stakeholders
- Provide non-clinical support to all APS-West Virginia programs
- Conduct research on current trends that may affect all recipients of DHHR services
- Coordinate information & referral with external resources
- Serve on related statewide committees as appropriate

Essential Functions: 1) Facilitate Focus Groups with youth and adults in the identified DHHR regions of WV, allowing for adequate stakeholder input on topics that are approved and put forth by the Contractors of APS Healthcare; 2) Coordinate and conduct trainings specific to identified populations; 3) Distribute, analyze and report to BBHHF the YSS/YSS-F and MSHIP Surveys to youth, families and adults receiving mental health services; 4) Provide non-clinical program support to the various programs that include –TAs, Consumer information and referral, call triaging, data entry, editing & final quality check of materials.

Education, Experience and Skills: BA/BS or equivalent; a minimum of 10 years supervised work and experience in the field of Behavioral Health. It is highly desirable that the candidate have a familiarity with WV Medicaid; knowledge of the office environment and business processes; and an understanding of an excellent customer service approach for working with various stakeholders. The preferred candidate will possess excellent communication skills, as well as the ability to multitask, prioritize and serve a variety of staff, and have extensive PC skills, such as working with Microsoft Office applications, or equivalent. Certificates of completion or training from the WV Leadership Academy, First Aid Mental Health, WRAP (Wellness Recovery Action Plan) are a plus.

Department: Data Integration

Position Title: Data Analyst

Position Summary: The data analyst champions the quality and integrity of data collected and works to ensure consistent reporting of information. Through analyses of data, identify data integrity gaps, take correction action, or make recommendations to management for data improvement opportunities. The Data Analyst is responsible for assessing the information needs of customers and developing meaningful ad-hoc and production reports to meet those needs and writing high quality documentation. Furthermore, the analyst can facilitate design and creation of data collection and reporting tools with co-workers and customers.

Essential Functions: 1) Analyze data to identify integrity gaps and opportunities to improve the quality of data I/O 2) Design, Development, Implementation and Maintenance of Reports for Internal and external customers 3) Collaborate/Assist or gain assistance from corporate IT units (i.e., requirements gathering for new systems) 4) Design, Development, Implementation and Maintenance of operations databases for APS-West Virginia 5) Documentation of each ad hoc reports in database and the methodology, code, specifics of routine reports 6) Provides technical assistance/training to the provider users and staff regarding the APS' utilization management systems, local operations databases, and reporting. 7) Travel may be required using personal vehicle (mileage reimbursement will be made) 8)Other duties as assigned

Education, Experience and Skills: A minimum of a bachelor's degree in computer science or related field; Experience in healthcare preferred; Critical Thinking and Analytic creativity; Ability to analyze and plan database design, structure and development; Excellent working knowledge of relational databases and report writers (i.e. Crystal Reports); Proficient with Microsoft Office Suite; Strong verbal and written communication skills; Ability to work independently as well as part of a team; Commitment to maintain a high level of confidentiality and adhere to all policies and procedures; Excellent customer service skills; Ability to multi-task and prioritize to accomplish all assignments by deadline; Flexibility and Willingness to complete other duties/assignments; Ability to lift and carry 40 pounds; Driver's License

Department: Health Homes

Position Title: Director of Health Homes

Position Summary: The Health Homes Program Director will design, implement and direct the day-to-day ASO operations for the Health Homes Program. The Director will work with BMS to consult, refine and expand the Health Homes project.

Essential Functions: 1) Lead the Implementation of the program across various departments/stakeholders 2) On-going coordination/consultation with the Client (BMS) for the design, implementation, policy development and roll out of additional HH projects 3) Ensure all ASO functions are performed to highest standards and contract deliverables are met including daily operations and staff supervision 4) Collaborate with other APS-WV programs/contracts as needed 5) Participate in the development of the RFP

Education, Experience and Skills: Applicant must have a Nursing degree and licensed or Masters level and licensed in social work. Applicant needs to have 2 years or more working with Medicaid and/or Medicare Programs, Utilization Management Programs, and providers and other stakeholders. Applicant requires Utilization Management skills with Medical and/or Behavioral service requests; Ability to research, design and implement Policy per the client's requirements; Ability to design, prepare and present training/education to providers & related stakeholders; Knowledge of care coordination; Performed clinical records reviews; and knowledge of Medicaid software applications and development.

Department: WV ASO

Position Title: Director of Long-Term Care

Position Summary: The Director of Long-Term Care program is responsible for the management and deliverables of work performed in the Long-Term Care Department, including the home and community-based I/DD Waiver, TBI Waiver, A&D Waiver, Personal Care and also the Nursing Home-PAS. The Director ensures that all ASO functions are performed to the highest standards and meet contract requirements.

Essential Functions: 1) Effectively manage the ASO operations to meet contract deliverables 2) Provide leadership and supervision to staff assigned to contract 3) Provide consultation to the respective Contract Manager in the area of expertise 4) Assess policy and procedure to continually ensure a high level of customer satisfaction by all stakeholders 5) Monitors, evaluates and recommends changes to existing contract and potential new business 6) Other duties as assigned.

Education, Experience and Skills: Applicant must have a minimum of a Bachelor's Degree in a Human Service Field (Master's preferred), a minimum of 3 years' experience in West Virginia Long-Term Care programs and 3-5 years' prior leadership and/or supervisory/management experience. Applicants must have a working knowledge of best practice in content areas and government policy and structure. Applicant must be able to lead and manage direct reports, have an aptitude for systems planning and prioritization, excellent written and communication skills and appropriate interpersonal skills. Applicant must be able to analyze data and develop reports to meet the contractor's goals of quality care and cost effectiveness.

Department: Medical UM

Position Title: Eligibility Specialist

Position Summary: Within specified timelines, verifies Medicaid and program eligibility for members with requests for Medicaid health and behavioral health services requiring prior authorization. Follows approved procedures to inform relevant parties of requests that do not meet eligibility and/or program requirements and resolves issues related to such requests. Handles queries from providers and members related to program and service eligibility and resolves issues or refers to appropriate parties for resolution. Handles correspondence related to program and service eligibility and prior authorization of services within specified timelines. Researches, investigates, and assists in resolving inquiries related to program or service eligibility or prior authorization status.

Essential Functions: 1) Reviews and verifies Medicaid and program/service eligibility for prior authorization requests within specified timelines before requests are clinically reviewed 2) Establish a client record when necessary for fax and telephonic requests 3) Generates necessary notification to inform relevant parties within specified timelines of requests that do not meet eligibility and/or program requirements 4) Handles and tracks queries from providers and members related to program and service eligibility and resolves issues or refers to appropriate parties for resolution within established timelines.\ 5) Processes/generates correspondence related to program and service eligibility and prior authorization of services within specified timelines and completes required tracking 6) Researches, investigates and assists providers to ensure appropriate resolution and tracking of inquiries related to prior authorization status and documents activities per established protocols 7) Documents and logs inquiry and complaint information within established timelines and protocols 8) Other duties as assigned to ensure contract deliverables relevant to eligibility are complete and within required timelines; Assist other departments as necessary to meet contract deliverables.

Education, Experience and Skills: Applicant must have a high school diploma or GED equivalent (Associates or Bachelor's Degree in Human Services field preferred). Applicant must have a minimum 3 years of customer service experience and in the Medicaid or health care industry preferred; One (1) year of claims experience preferred. Basic data entry skills and PC proficiency to Microsoft office programs is required. The applicant will possess general knowledge of Medicaid behavioral health services, eligibility verification (Medicaid eligibility and program requirements for behavioral health preferred), CPT, HCPCS and ICD-10 coding; Excellent customer service, verbal and written communication skills and must possess the ability to work well with management and team members to contribute to the achievement of departmental goals; The ability to multi-task, prioritize assignments and demonstrate flexibility to meet departmental and established workload standards; Ability to apply Medicaid eligibility and program requirements and APS specific guidelines to demographic data to make valid decisions on program/service eligibility and determine appropriate disposition/notification.

Department: **Socially Necessary Service (SNS)**

Position Title: **Family Support Educator B1**

Position Summary: **The Family Support Educator provides training/assistance to consumers and stakeholders regarding participation in the Socially Necessary Service program and the specific guidelines/procedures to obtain authorizations for services within the context of the Bureau for Children and Families ASO scope of work. Gathering state-wide data and feedback at SNS and children's behavioral health recipient focus groups to analyze/track the consumer's perception of the program and present to the contractor is completed by the Family Support Educator. This position is also responsible for assisting biological and foster parents submit for ASO authorizations for transportation, meals, lodging and respite. Contract mandates that this position must be a WV Resident.**

Essential Functions: **1) Complete educational opportunities regarding enrollment in the SNS program for DHHR Workers, DHHR foster parents and biological parents in which training evaluations are submitted 2) Complete focus groups with families participating in the SNS and behavioral health programs following the approved questions, completing a typed summary for each group and analyzing the data for the annual report 3) Consult with BCF administrative and field staff regarding the family centered/drive approach to child welfare services 4) Provide referrals to appropriate services, community supports or governmental agencies to children and families 5) Participate in quarterly all-staff meetings and other required meeting as needed 6) Keep phone, referral and complaint logs for SNS program.**

Education, Experience and Skills: **Candidates must have a high school diploma or GED equivalent. The Applicant will have personal or professional experience with children and families involved with the child welfare system; Presenting information in order to educate others; Documenting information and/or opinions of others; Providing customer service through verbal and written means; Planning and scheduling events such as trainings and focus groups. Applicants must have knowledge of the basic components of child welfare programs; Supports and services available across the state. Applicant must have skills in active listening; Utilize basic Word Perfect/Microsoft word, PowerPoint and Web applications; Communicate clearly through verbal and written means; Organize work time and tasks effectively to meet contract deliverables; Driving; Ability to learn the basic policy and procedures of each contract/be cross trained to provide support to other programs when needed. Applicant must have the ability to assess training needs; Prioritize tasks effectively; Analyze trends in participants' responses.**

Department: Behavioral Health

Position Title: High Intensity Nurse Reviewer

Position Summary: The primary function of this position is to perform retrospective reviews of psychiatric residential treatment facilities in which WV youth are receiving services. These facilities are located throughout West Virginia and several other states. This nurse reviewer will also complete prior authorization medical necessity reviews for outpatient and inpatient behavioral health services. within established timelines through review of related documents.

Essential Functions: 1) Evaluate provider's adherence to DHHR's standards regarding quality and appropriateness of care at the treatment location 2) Provide individualized recommendations and training to providers based upon approved assessment criteria and tools 3) Certify medical necessity through use of identified national criteria and nursing judgment 4) Provide excellent customer service and consultation with providers and contractors 5) Collect clinical data and enters information into database as required.

Education, Experience and Skills: Applicant requires a degree from accredited nursing program and current, unrestricted West Virginia RN license; Psychiatric nursing certification a plus; Minimum of 2-3 years' experience in outpatient or inpatient behavioral health settings; Medicaid/Public sector service experience preferred; Strong skills related to utilizing Microsoft software, web applications, and multiple screens; Willingness to travel.

Department: I/DD Waiver

Position Title: I/DD Member/Family Liaison

Position Summary: The I/DD Waiver Member/Family Liaison provides support to program members by responding to complaints and providing education about the program to members and their families. In addition, this position assists with processing all aspects of service negotiation and Medicaid Fair Hearing for service denials and processes documents and correspondence associated with program eligibility. This position also conducts Participant Experience Surveys for an assigned caseload.

Essential Functions: 1) Responds to, processes, and tracks all member/family complaints 2) Provides program education to members/families 3) Maintains program flow documents, tracks, and schedules service negotiation hearings related to denial of services or eligibility; communicates disposition to negotiations and hearings to members, the department, and other stakeholders, 4) Be informed of (and notify Waiver department of) member/family perspectives on I/DD Waiver policy and related issues based on identified systemic trends ,public opinions and research 5) Other duties as assigned.

Education, Experience and Skills: Applicant must have a high school diploma or GED equivalent (advance degree/certificate preferred) and at least 1 year of experience in the I/DD Waiver field. Applicant will possess a Bachelor's degree and knowledge of the I/DD Waiver program policies and procedures. Applicant must have excellent customer service and communication skills, must be able to multi-task and prioritize, must have experience with Microsoft programs, experience with I/DD Waiver Care Connection© preferred, and be flexible.

Department: I/DD Waiver

Position Title: I/DD Waiver Hearings Coordinator

Position Summary: The I/DD Waiver Hearings Coordinator provides management of and direction to the I/DD Waiver Registration Coordinator and Consumer Family Educator staff and the hearings processes as related to APS involvement with I/DD Waiver service denials. The Hearings Coordinator will oversee and manage that contract deliverables are met and will providing general supervision to staff. The Hearings Coordinator will work with BMS and prepare for, attend and provide testimony at Medicaid Fair Hearings.

Essential Functions: 1) Provide operational oversight to the Registration Coordinator and Consumer Family Educator staff to ensure contract deliverables are achieved 2) Review and act upon provider requests for prior authorization 2) Facilitate 2nd level negotiation 3) Provide testimony at Medicaid Fair Hearings related to service denials 4) Identify, assess and provide training to staff related to their functions within the I/DD Waiver departments 5) Develop and maintain operational guidelines 6) Prepare necessary monthly and other reports 7) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Bachelor's degree and a minimum of 2 years' experience (preferably within the I/DD Waiver program). Applicant must possess knowledge of the I/DD Waiver program, be organized, have excellent customer service and have excellent written and verbal communication skills, must be flexible and have experience using Microsoft software and (preferably) I/DD Waiver Care Connection©. Applicant must have at least one year of management/supervisory experience. Registered Nurse and/or Behavior Support Professional preferred.

Department: I/DD Waiver

Position Title: I/DD Waiver Provider Educator

Position Summary: The I/DD Waiver Provider Educator conducts provider reviews, including completing associated reports, develops and conducts training and technical assistance with agency providers, and completes special projects as assigned.

Essential Functions: 1) Conduct agency provider reviews 2) Complete and submit reports associated with provider reviews 3) Develop and conduct training with provider agencies and other stakeholders as needed/assigned 4) Conduct technical assistance with provider agencies as required/requested 5) Complete inter-rater reliability tasks as assigned 6) Complete special projects as assigned 9) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Bachelor's degree and a minimum of 2 years' experience (preferably within the I/DD Waiver program). Applicant must possess knowledge of the I/DD Waiver program, be organized, have excellent customer service and have excellent written and verbal communication skills, must be flexible and have experience using Microsoft software and (preferably) I/DD Waiver Care Connection©.

Department: I/DD Waiver

Position Title: I/DD Waiver Registration Coordinator

Position Summary: The I/DD Waiver Registration Coordinator reviews and makes decisions on provider requests for prior authorization of I/DD Waiver services for program participants. This position works closely with provider agencies to obtain needed information in order to process requests, facilitates 2nd level negotiation, and provides testimony at Medicaid Fair Hearings related to service denials.

Essential Functions: 1) Review and act upon provider requests for prior authorization 2) Facilitate 2nd level negotiation 3) Provide testimony at Medicaid Fair Hearings related to service denials 4) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Bachelor's degree and a minimum of 2 years' experience (preferably within the I/DD Waiver program). Applicant must possess knowledge of the I/DD Waiver program, be organized, have excellent customer service and have excellent written and verbal communication skills, must be flexible and have experience using Microsoft software and (preferably) I/DD Waiver Care Connection©.

Department: I/DD Waiver

Position Title: I/DD Waiver Registration Coordinator-RN

Position Summary: The I/DD Waiver Registration Coordinator reviews and makes decisions on provider requests for prior authorization of I/DD Waiver services for program participants. This position works closely with provider agencies to obtain needed information in order to process requests, facilitates 2nd level negotiation, and provides testimony at Medicaid Fair Hearings related to service denials.

Essential Functions: 1) Review and act upon provider requests for prior authorization 2) Facilitate 2nd level negotiation 3) Provide testimony at Medicaid Fair Hearings related to service denials 4) Other duties as assigned.

Education, Experience and Skills: Applicant will have a minimum of Bachelor's Degree in a Human Services field, and at least 2 years' experience with the WV I/DD Waiver program serving members with I/DD. Applicant must be a WV Registered Nurse. Applicant must possess knowledge of the I/DD Waiver program, be organized, have excellent customer service and have excellent written and verbal communication skills, must be flexible and have experience using Microsoft software and (preferably) I/DD Waiver Care Connection©.

Department: I/DD Waiver

Position Title: Lead Provider Educator

Position Summary: The I/DD Waiver Lead Provider Educator provides direction to the Provider Educator Team and the Registration Coordinator Team regarding the achievement of service deliverables related to utilization management, provider education, and customer service related to the I/DD Waiver program. The Lead Provider Educator provides general supervision, coordinates inter-rater reliability functions, and establishes team policies and procedures. In addition, the Lead Provider Educator coordinates the I/DD Waiver Quality Improvement Advisory Council quarterly meetings, Quarterly Provider Meetings, and required provider/stakeholder training. This position also maintains a monthly activity report and the Discovery & Remediation report.

Essential Functions: 1) Provide operational oversight to the Provider Educator Team and the Registration Coordinator Team to ensure contract deliverables are achieved 2) Identify, assess and provide training to staff related to their functions within the I/DD Waiver and related departments 3) Develop and maintain operational guidelines 4) Prepare monthly reports 5) Coordinate quarterly Quality Improvement Advisory Council meetings and complete associated tasks 6) Coordinate Quarterly Provider Meetings 7) Coordinate and conduct training as needed with providers and stakeholders 8) Develop and implement training for inter and intra-departmental needs 9) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Bachelor's degree, minimum of 2 years' experience (preferably within the I/DD Waiver program), and prior leadership and supervisory experience. Applicant must possess knowledge of the I/DD Waiver program, be organized, have excellent customer service and have excellent written and verbal communication skills, must be flexible and have experience using Microsoft software and (preferably) I/DD Waiver Care Connection©.

Department: I/DD Waiver

Position Title: Lead Service Support Facilitator

Position Summary: The I/DD Waiver Lead Service Support Facilitator will provide training, direction and manage staff regarding the achievement of service deliverables related to re-evaluation I/DD Waiver assessments. The Lead SSF will provide general supervision, coordinate inter-rater reliability functions and establish and/or refine team policies and procedures.

Essential Functions: 1) Provide operational oversight to ensure contract deliverables are achieved related to SSF and other functions 2) Develop, maintain and/or refine operational guidelines 3) Provide leadership and supervision to staff 4) Review performance measures and problem-solve to improve deliverables, when necessary 5) Develop and conduct inter-rater reliability activities with staff 6) Manage and oversee the I/DD Waiver eligibility processes and reports including: liaison with Medical Eligibility Contract Agent, completing monthly reports, manage slots released, process special requests related to eligibility 7) Other duties as assigned.

Education, Experience and Skills: Applicant must have a minimum of a Bachelor's Degree in a Human Service Field (Master's preferred), a minimum of 2 years' experience in the West Virginia I/DD Waiver program and prior leadership and/or supervisory experience. Applicant must have a working knowledge of Microsoft software, experience with I/DD Wavier Care Connection© is a plus. Applicant must possess knowledge of the I/DD Waiver program policies and procedures, be organized and efficient, have effective and professional written and verbal communication skills, and be flexible and willing to learn new skills/tasks.

Department: Medical UM

Position Title: Medical Director

Position Summary: The Medical Director provides the principal leadership to the operation on all medical aspects relating to the peer review process, utilization review activities, case management, and other activities requiring clinical leadership and consultation. The position encompasses a wide range of clinical line responsibilities. Additional key responsibilities may include assisting and promoting business development and strategic planning activities.

Essential Functions: 1) Evaluate, redirect and/or respond to inquiries from physicians, providers and customer 2) Represent and promote KEPRO at seminars, professional societies, hospital medical staff meetings and other professional meetings as appropriate . Conduct appropriate external relationships with attending physicians/surgeons by response to telephone calls and letters, relationships with attending physicians/surgeons by response to telephone calls and letters. Speaking engagements before physician and provider organizations 3) Analyze and remain breast of national, state, and local regulations and legislation, which impacts the health care profession. Works with staff in addressing and meeting changing requirements 4) Assure compliance with regulatory and accreditation requirements 5) Responsible for oversight of medical content of company publications 6) Participate in activities specific to contractual arrangements, i.e. Fair Hearings 7) Participate in KEPRO'S Quality Management Committee to ensure organization compliance 8) Provide medical expertise with respect to planning and establishing goals and policies to improve medical management 9) Provides oversight of physician consultants and advisors 10) Ensures accountability of qualified physicians and physician consultants to organizational decisions affecting consumers 11) Recruit, train, manage, monitor and provide on-going education to physician consultants in order to ensure true and accurate reviews and an efficient an productive environment. Conduct peer-to-peer physician consultations as request/required; documents consultations 12) Review medical information trends, experiences and approaches, and assists in the development of strategic plans for clinical improvements 13) Work with medical, nursing and administrative staff to identify matters needing shared attention. Discuss, inform, and facilitate communication and interaction between staff with customers.

Education, Experience and Skills: Applicant must have MD or DO with current non-restricted license to practice medicine by the Board of Medical Examiners. License must be in same state as contractually required. Board certification in a clinical specialty is required. Applicant is required to have training in quality assurance and utilization review; Understanding major trends in healthcare and managed care; Systems thinker with strong organizational skills who can meet deliverables on time and within budget; Adaptable with strong collaborative management style. Applicant needs to have 10 or more years of clinical practice with preferable, 5 to 7 years' experience as a physician executive with significant accomplishments in development programs and coaching medical staff on healthcare business and practice issues; Minimum 2 years' as a Medical Director in a managed care company preferred; Experience in Utilization Management, Case and Disease Management with knowledge of Medicaid and Medicare programs; Prior experience or quality assurance committee responsibility in a hospital setting preferred. Working knowledge of Federal, State and private health related activities.

Department: **Medical UM**

Position Title: **Medical Physician/Consultant Reviewer**

Position Summary: **The Medical UM Physician Consultant Reviewer will provide medical review support to APS Healthcare/KEPRO in support of West Virginia Medicaid Program in its role as the Administrative Service Organization (ASO) for the Department of Health and Human Resources (DHHR) / Bureau of Medical Services (BMS). The ASO will support services by applying specific standards to determine medical necessity for children and adults seeking medical services through prior authorization (PA).**

Essential Functions: **1) Applicant will review cases for determination of medical eligibility that did not meet criteria at nurse reviewer level within specified timelines 2) Apply relevant utilization criteria (IQ and any additional applicable criteria) to determine medical necessity and indicate findings in and appropriate case information to determine medical necessity of requested medical services.**

Education, Experience and Skills: **Applicant shall be licensed to practice medicine in all branches in West Virginia and be board certified or board eligible in his or her specialty; Maintain an active license and/or recertification in good standing; Notify APS Healthcare/KEPRO immediately upon receiving notification that his active license and/or certification as a healthcare professional becomes restricted, suspended, expires, lapses, is revoked, or lost for any reason. Applicant shall have clinical experience treating persons with medically complex needs; Apply relevant utilization criteria (IQ and any additional applicable criteria) and appropriate case information to determine medical necessity of requested medial services; Provide customer service related to internal and external clinical case specific inquires, as appropriate.**

Department: **Medical UM**

Position Title: **Medical Services Director**

Position Summary: **The Medical Services Director is responsible for the management and deliverables of the Medical UM Program. The Program Director ensures that all the ASO functions are performed to the highest standards of the contract. The medical functions include prior authorization of service in all medical areas, including ambulance and air transportation, provider education, training and technical assistance, QI activities, data collection, analysis of metrics and reports.**

Essential Functions: **1) Effectively manage the medical program in order to meet all contract deliverables 2) Provide leadership and supervision for all medical staff 3) Provide consultation to the Bureaus for medical services 4) Assess policy and procedures on an ongoing basis to ensure a high level of customer satisfaction for all stakeholders.**

Education, Experience and Skills: **Applicant must be a RN or MA in a health related field, licensed and/or certified or have credentials in a related field, and have 3-5 years of supervisory and program management experience. Applicant must possess knowledge and experience with medical utilization management processes; Understanding of customer service approach for medical provider stakeholders; Familiarity with Interqual criteria for all review areas, Medicaid and Medicare, government structure and policy and related programs; Be a Systems thinker with strong organizational skills who can meet deliverables on time and within budget; and adaptable with strong collaborative management style.**

Department: **Medical**

Position Title: **Trainer/Educator**

Position Summary: **The Trainer/Educator provides training and technical assistance to any and all medical providers as requested, either onsite or via webinar. The Trainer/Educator will conduct regional and statewide training for medical groups.**

Essential Functions: **1) Provide regional and statewide training for medical groups; 2) Provide training and technical assistance to providers and identify training needs; 3) Will prepare training materials and other educational materials for various stakeholder audiences as necessary; 4) Will prepare and update materials on the APS website; 5) Will participate in monthly Trainer/Educator meetings, quarterly all-staff meetings and other required meetings as needed.**

Education, Experience and Skills: **Applicant must have a Bachelor's degree ; Effectively communicate verbally and in writing findings and recommendations; General knowledge of the needs of the population being served; Knowledge of Microsoft Word and Excel and general usage of the computer; Health Information Privacy and Portability Act; Ability to work independently to meet timelines and expectations; Ability to interact appropriately with providers who may be hostile or upset; Organize work time and tasks effectively to meet contract deliverables; Assesses training needs and can develop training materials.**

Department: **Medical UM**

Position Title: **Medical UM Nurse Reviewer**

Position Summary: **The Medical UM Nurse Reviewer will review criteria to resolve prior authorization requests within established time frames for Medicaid inpatient and outpatient medical services.**

Essential Functions: **1) Select , document, and apply relevant utilization criteria (IQ) and any additional applicant criteria) and appropriate case information to determine medical necessity of requested medical services 2) Manage referrals that require physician review 3) Coordinate member services 4) Request and clarify medical information required to resolve request 5) Provide customer service related to internal and external clinical case specific inquires , as appropriate.**

Education, Experience and Skills: **Applicant must possess knowledge and experience with medical utilization management process; Understanding of customer service approach for medical provider stakeholders; Familiarity with Interqual criteria for all review areas, with government structure and related programs and medical coding is preferred. Applicant must have at least a 2 year Associate Degree in Nursing but BS Nursing is preferred. Applicant must have an active WV RN license.**

Department: Medical UM

Position Title: Medical UM Nurse Supervisor

Position Summary: The Medical UM Nurse Supervisor provides direction to medical nursing staff regarding the completion of day-to-day functions for the achievement of utilization review service deliverables related to the WV Medical UM program. The Medical UM Nurse Supervisor provides general supervision, monitors deliverable reports, coordinates inter-rater reliability functions and establishes nursing staff team policies and procedures.

Essential Functions: 1) Supervision of clinical UM staff and monitoring Medical UM deliverables that are the responsibility of a WV Medicaid UM contractor 2) Assist the contractor with updating utilization criteria 3) the development of internal review protocols 4) Establishing recommendations for provider technical assistance and training related to feedback from medical staff and identified provider needs.

Education, Experience and Skills: Applicant must have at least a 2 year Associate Degree in Nursing but a BS Nursing is preferred. Applicants must have an active WV RN license and atleast 2 years of supervisory experience in a UM setting is required. Applicant must possess knowledge and experience with medical utilization management processes; Must have an understanding of customer service approach for medical provider stakeholders; Familiarity with Interqual criteria for all review areas, with government structure and related programs; Medical coding is preferred.

Department: Medical UM

Position Title: Medical UM Office Manager

Position Summary: Applicant performs a variety of duties to provide and coordinate quality nursing care to residents. Participates with the Director of Nursing and the Nurse Manager in establishing specific goals; determines work procedures and expedites work flow; insures compliance with all operating policies and procedures and {enter state name} Department of Health regulations and Federal Health Care Administration regulations; communicates with and supervises personnel; provides daily reports and other periodic reports as required.

Essential Functions: 1) Provides primary non-clinical program support to the AUM Medical Program that include – provider TAs and training (phone and face-to-face) 2) Customer service 3) Call triaging 4) Authorization preparation 5) Workload management and tracking deliverables 6) Data entry 7) Preparation, editing and final quality check of training and other materials 8) Continually assess the office functions and report potential issues to Director 9) Identify weak programmatic activities and processes that result in failed contract deliverables 10) Proactively track licenses, RFPs, financials, leases, etc. to ensure issues are addresses in a timely manner 11) Provides back-up for the essential office services of financial/budget tracking 12) Basic accounting and bookkeeping 13) Coordination of supplies/equipment/ etc. 13) Contract billing and renewal, record keeping, facility maintenance, and reporting related to these activities 14) Provides non-clinical support to other programs as needed.

Education, Experience and Skills: Applicant must have knowledge of the office environment and business processes; Extensive PC skills-minimum Word, Excel, and PowerPoint: Familiarity with other programs is a plus; Understanding of customer service approach for medical provider stakeholders; Familiarity with government structure and related programs with medical codes and hilling procedures. BA/BS degree preferred, AA in office management or medical related field accepted if minimum experience requirement is met. Applicant must have 2-3 years' experience in administrative support position or office management position; Familiarity with medical health care preferably WV Medicaid; Needs excellent communications skills; Ability to multitask; Prioritize and serve a variety of staff; Experience with staff and provider training; and Public speaking skills.

Department: Medical UM

Position Title: Medical UM Support Staff

Position Summary: The Medical UM Administrative Support staff provides a broad range of utilization management support to the medical team/department and external customers. This position supports the medical review staff with completion of day-to-day functions as well as performing primary customer service and technical assistance functions. The Medical UM Administrative Support staff provides telephone support to external providers/agencies/facilities. This is primarily a customer service support role.

Essential Functions: 1) Preparing and mailing authorization request decision letters to Providers and Members 2) Entering prior authorization request on behalf of Providers who elect to fax rather than use DDE 3) Assist external providers/agencies/facilities with Molina billing questions, general program and other questions/concerns 4) Perform special projects as needed to improve customer service and other duties as assigned.

Education, Experience and Skills: Applicant must have a high school diploma or GED equivalent (advance degree/certificate preferred) and 1-2 years in an administrative support or customer service position. The applicant will possess knowledge of medical billing policies and procedures. Applicant must have excellent customer service and communication skills; Be able to multi-task and prioritize; Experience with Microsoft programs, and be flexible.

Department: Medical UM

Position Title: Medical UM Support Team Lead

Position Summary: The Medical UM Support Team Lead provides direction to medical UM Support staff regarding the achievement of service deliverables related to utilization management, provider education, and customer service related to the WV Medical UM program. The Medical UM Support Team Lead provides general supervision, monitors deliverable reports, coordinates inter-rater reliability functions and establishes administrative team policies and procedures.

Essential Functions: 1) Provide operational oversight to ensure contract deliverables are achieved 2) Identify, assess and provide training to administrative and eligibility staff related to their functions within the medical department 3) Develop and maintain operational guidelines 4) Provide leadership and supervision to medical administrative staff 5) Assist and fill-in when UM staff are unavailable to fulfill duties and when the business need exceeds normal standards 6) Other duties as assigned.

Education, Experience and Skills: Applicant must have a high school diploma or GED equivalent (Associates or Bachelor's Degree in Human Services field preferred); Minimum 3 years of customer service experience in the Medicaid or health care industry; One (1) year or more of supervisory experience; Basic data entry skills and PC proficiency to Microsoft office programs is required. Applicant must possess knowledge of utilization management programs and have experience using Microsoft software. Applicant must be organized, flexible, and have excellent customer service and communication skills. Knowledge of medical coding and billing procedures preferred but not required. Previous supervisory experience is preferred.

Department: All

Position Title: Office Manager/Clinical Coordinator

Position Summary: The WV Office Managers have a two fold responsibility. First, the OM is responsible for coordination of office services that ensure efficient and accurate varied and complex administrative functions are performed to meet contract deliverables with effective business process support. Second, the OM provides non-clinical support to all programs.

Essential Functions: 1) Provides the essential office services of HR Liaison, financial/budget tracking, basic accounting & bookkeeping, coordination of supplies/equipment/etc., contract billing & renewal, record keeping, facility maintenance, phone support and tracking, basic IT triage, and reporting related to these activities. Also provides direct support to the ED/VP of WV programs. 2) Provides non-clinical program support to the various programs that include – provider TAs, consumer budget process, call triaging, authorization preparation, caseload management, CEU tracking, caseload tracking, data entry, editing & final quality check of materials.

Education, Experience and Skills: BA/BS with at least 2 years in a progressive administrative support position of office management position. Familiarity with WV Medicaid; knowledge of the office environment and business processes; Understanding of customer service approach for various stakeholders; Needs excellent communication skills; ability to multitask, prioritize and serve a variety of staff, and extensive PC skills; Continually assess the office functions and report potential issues to Director; identify weak programmatic activities that may result in failed contract deliverables and proactively track licenses, RFPs, financials, leases, etc to ensure addressed in a timely manner.

Department: BCF Socially Necessary Services

Position Title: Ph.D. Psychologist

Position Summary: The employee will review request for psychological evaluations and residential placements to ensure medically necessity for services funded by Medicaid to ensure compliance with the contractor's requirements. This position also provides training and technical assistance to any and all providers as requested.

Essential Functions: 1) Conduct utilization management activities regarding psychological evaluations to determine medical necessity utilizing APS UM guidelines, Medicaid Manual and/'or BCF manual and any other documentation available according to established time frames 2) Provide training and technical assistance to providers and identify training needs 3) Interface with APS staff regarding consultative reviews 4) Report and analyze data from service requests and chart reviews according to set timelines 5) Will participate in monthly meetings, quarterly all-staff meetings and other required meetings as needed.

Education, Experience and Skills: Applicant must have a Ph.D. in psychology and be fully licensed by WV Board of Examiners of Psychology; Minimum 1-2 years' experience in direct practice with consumers testing and completing evaluations. Customer service in which both verbal and written communication are required; Effectively communicate verbally and in writing findings and recommendations; Knowledge of best practice guidelines of the service being reviewed; General knowledge of the needs of the population being served; Knowledge of Microsoft Word and Excel and genera usage of the computer; Health Information Privacy and Portability Act; Review and analyze documentation against set standards; Ability to adequately communicate findings and recommendations to providers verbally and through writing; Ability to work independently to meet timelines and expectations; Ability to interact appropriately with providers who may be hostile or upset; Organize work time and tasks effectively to meet contract deliverables; Assesses adherence to documentation standards as set by contractor; Assesses training needs based upon deficiencies noted.

Department: Traumatic Brain Injury (TBI) Waiver

Position Title: Provider Educator

Position Summary: The Provider Educator conducts consultative retrospective reviews of TBI providers to ensure compliance with the requirements. Conducts on site initial visits of prospective TBI Waiver providers to evaluate and certify qualified providers and conducts continuing annual certifications through desk audits. Provider Educator also provides training and technical assistance to any and all providers as requested. Provider Educator also provides orientation and ongoing technical assistance for new providers.

Essential Functions: 1)Conduct and appropriately document provider retrospective reviews utilizing APS UM guidelines, Medicaid Manual and/or TBI manual according to established time frames.2) Conduct provider program certifications 3) develop and conduct Waiver provider trainings as contracted 4) Provide technical assistance when requested or identified to enrolled providers 5) Other duties as assigned.

Education, Experience and Skills: Must have a minimum of a Bachelor's Degree in a Human Service Field (Master's preferred), a minimum of 1 years' experience with disabilities and be Licensed as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor or Psychologist Experience with customer service required. Effective communication skills both verbally and in writing are required. Must have the ability to review and analyze documentation against set standards.

Department: Quality Improvement

Position Title: Quality Improvement Analyst

Position Summary: The Quality Improvement Analyst provides support to the Quality Improvement Coordinator in coordinating the design, implementation, and refinement of the Quality Improvement Plan. The Quality Improvement Analyst assists the Coordinator in the coordination and facilitation of all QI activities, and performs activities to help assure that the Program achieves and maintains accreditation and certification status through adherence to Agency specifications. The Quality Improvement Analyst assists in the training of staff to ensure that all operations conform to the principles of continuous quality improvement and guides the training staff on these concepts for incorporation into all provider training. The Quality Improvement Analyst, with the oversight of the Quality Improvement Coordinator, helps develop UM and UR policies and assists in the measuring and meeting of performance specification.

Essential Functions: 1) Assists in the facilitation of the development and implementation of quality improvement plans, including policies, procedures, and guidelines; 2) Responsible for assisting in the maintaining of documented standards of performance and identifying all deviations from the quality improvement plans; 3) Responsible for assisting in compilation and analysis of financial, utilization management, and other statistical data for use in the quality reporting; 4) Reports all findings to the Quality Improvement Coordinator, or in the Quality Improvement Coordinator's absence, to the program managers; 5) Under the direction of the Quality Improvement Coordinator, the Quality Improvement Analyst works with the Service Integration Department to contribute to the development of training sessions and manuals related to providers' quality improvement plans and audits; 4) Other duties as assigned.

Education, Experience and Skills: Applicant must have at a minimum a Bachelor's Degree in business, public administration, health, mental health, social work, or nursing, and/or equivalent licensure; At least one years' experience in a quality improvement programming position, preferably in a Quality Improvement or Healthcare setting; Applicant will have knowledge of utilization review and utilization management processes; Experience in West Virginia health and human services system is desirable.

Department: Quality Improvement

Position Title: Quality Improvement Coordinator

Position Summary: The Quality Improvement Coordinator is responsible for coordinating the design, implementation, and refinement of the Quality Improvement Plan. The Quality Improvement Coordinator coordinates and facilitates all QI activities, and assures that the Program achieves and maintains accreditation and certification status through adherence to Agency specifications. The Quality Improvement Coordinator trains staff to ensure that all operations conform to the principles of continuous quality improvement and guides the training staff on these concepts for incorporation into all provider training. The Quality Improvement Coordinator helps develop UM and UR policies and oversees the measuring and meeting of performance specification.

Essential Functions: 1) Facilitates the development and implementation of quality improvement plans, including policies, procedures, and guidelines; 2) Responsible for maintaining documented standards of performance and identifying all deviations from the quality improvement plans; 3) Responsible for compiling and analyzing financial, utilization management, and other statistical data for use in the quality reporting; 4) Reports all findings to the program directors; 5) Works with the Service Integration Department to develop training sessions and manuals related to providers' quality improvement plans and audits; 4) Other duties as assigned.

Education, Experience and Skills: Applicant must have a Master's Degree in business, public administration, health, mental health, social work, or nursing, or equivalent licensure, and/or licensed RN; At least three years' experience in a quality improvement programming position, preferably in a Quality Improvement or Healthcare setting; Applicant will have knowledge of utilization review and utilization management processes; Experience in West Virginia health and human services system is desirable.

Department: **Data Integration**

Position Title: **Reporting Specialist**

Position Summary: **The Reporting Specialist is responsible for obtaining the internal and external customers' ad hoc and routine reports' specifications, completing requirements, gaining customers' approval of requirements, developing, testing, demonstrating/sharing with customers, generating reports as scheduled and delivering reports. Primary source data are utilization management databases, Medicaid eligibility data and claims data. Must acquire working knowledge of all databases and data sources to provide technical assistance and realize the data needed to compile requested reports.**

Essential Functions: **1)Design, Development, Implementation and Maintenance of Reports for Internal and external customers 2)Collaborate/Assist or gain assistance from corporate IT units (i.e., requirements gathering for new systems) 3)Design, Development, Implementation and Maintenance of operations databases for APS-West Virginia 4)Documentation of each ad hoc reports in database and the methodology, code, specifics of routine reports 5)Provides technical assistance/training to the provider users and staff regarding the APS' utilization management systems and local operations databases, etc. 6)Travel may be required using personal vehicle (mileage reimbursement will be made) 7)Other duties as assigned**

Education, Experience and Skills: **A minimum of a bachelor's degree in computer science or related field or a combination of experience and education (i.e., associate's degree and experience with APS-WV); Experience in healthcare preferred; Excellent customer service and communication skills; Ability to multi-task and prioritize to accomplish all assignments by deadline; Flexibility and Willingness to complete other duties/assignments; Ability to lift and carry 40 pounds; Proficiency with MS Office pre-hiring testing; Mastery of a minimum of one reporting software (i.e., Crystal, SQL, Access) pre-hiring testing; Ability to work within a team yet achieve individual objectives; Driver's License**

Department: School Based Health Services

Position Title: Trainer/Consultant

Position Summary: The Trainer/Consultant conducts consultative retrospective reviews of medically necessary services funded by Medicaid to ensure compliance with the contractor's requirements. Trainer/Consultant also provides training and technical assistance to any and all providers as requested. The Trainer/Consultant provides necessary information to APS care management staff and alerts other agencies (e.g. OQPI) as necessary regarding provider concerns. Trainer/Consultant also provides orientation and ongoing technical assistance for new providers.

Essential Functions: 1) Conduct and appropriately document provider retrospective reviews utilizing APS UM guidelines, Medicaid Manual and/'or BCF manual according to established time frames 2) Provide training and technical assistance to providers and identify training needs 3) Interface with APS staff regarding consultative reviews 4) Report and analyze data from reviews according to set timelines 5) Will participate in monthly TC meetings, quarterly all-staff meetings and other required meetings as needed.

Education, Experience and Skills: Applicant must have Master's degree in Social Work, counseling or Psychology; Fully licensed with a MA level license- LPC,LGSW, LICSW or by WV Board of Examiners of Psychology; Minimum 1-2 years' experience in direct practice with consumers or a licensed Registered Nurse; Customer service in which both verbal and written communication are required; Effectively communicate verbally and in writing findings and recommendations; Knowledge of best practice guidelines of the service being reviewed; General knowledge of the needs of the population being served; Knowledge of Microsoft Word and Excel and genera usage of the computer; Health Information Privacy and Portability Act; Review and analyze documentation against set standards; Ability to adequately communicate findings and recommendations to providers verbally and through writing; Ability to work independently to meet timelines and expectations; Ability to interact appropriately with providers who may be hostile or upset; Organize work time and tasks effectively to meet contract deliverables; Assesses adherence to documentation standards as set by contractor; Assesses training needs based upon deficiencies noted.

Department: I/DD Waiver

Position Title: Service Support Facilitator

Position Summary: The I/DD Waiver Service Support Facilitator performs assessments of I/DD Waiver members for the purpose of determining their individualized budgets which are utilized by the member's planning team to purchase the services necessary to support the individual in the community. Assessments are also used to determine re-eligibility into the program each year. Service Support Facilitators must manage a large caseload of assigned members to ensure that assessments are performed and data entry into the APS Care Connection© web system is completed within prescribed timelines.

Essential Functions: 1) Schedule, conduct and appropriately document member assessments within prescribed timelines 2) Enter assessment data into the APS CareConnection© web system 3) Participate in inter-rater activities to ensure consistency in the administration of the assessment instruments and adherence to assessment protocols 4) Participate in monthly I/DD Waiver staff meetings, quarterly all-staff meetings and other required training and meetings as necessary 5) Other duties as assigned.

Education, Experience and Skills: Educational requirements include a minimum of a Bachelor's Degree and be a Qualified Mental Retardation Professional (QMRP). Medicaid/Public Sector service experience is also preferred. Applicant must have a minimum of 2 years' experience with the I/DD Waiver population and possess knowledge of I/DD Waiver program policies and procedures as well as other programs/services available to program members. Applicant must also possess knowledge of person-centered planning fundamentals. Applicant must have a familiarity with computer applications and be able to navigate through multiple screens and have the ability to maintain confidentially standards and HIPAA compliance when evaluating all pertinent issues.

Department: Traumatic Brain Injury (TBI) Waiver

Position Title: TBI Waiver Manager

Position Summary: The TBI Waiver Manager will provide direction to program staff regarding the achievement of service deliverables related to activities performed by the Assessment Coordinators and the Provider Educators as needed. The TBI Waiver Manager will provide general supervision, coordinate inter-rater reliability functions, prepare reports, and establish team policies and procedures.

Essential Functions: 1)Provide operational oversight to ensure contract deliverables are achieved related to Assessment Coordinator and Provider Educator job functions 2) Develop, maintain and/or refine operational guidelines 3) Provide leadership and supervision to staff 4) Review performance measures and problem-solve to improve deliverables, when necessary 5) Develop and conduct inter-rater reliability activities with staff 6) Complete Care Management review of program participants' prior authorization requests within established timeframes for TBI Waiver services 7) Manage and oversee the TBI Waiver medical eligibility processes initial and re-evaluations 8) Manage and oversee the various TBI Waiver Provider reviews 9) Complete monthly reports 10) Other duties as assigned.

Education, Experience and Skills: Master Degree in Social Work, Registered Nursing, Rehabilitation Counseling and/or Counseling preferred. Must have unrestricted and valid professional license in the State of West Virginia. Minimum of 1-2 years' experience with disability and prior leadership and/or supervisory experience, required. Must be organized, have effective and professional written and verbal communication skills, be flexible, and have the ability to use Microsoft software. Some travel may be required. Medicaid/Public Sector experience strongly preferred.

Department: Socially Necessary Services

Position Title: SNS Trainer Consultant

Position Summary: The Trainer/Consultant conducts consultative retrospective reviews of medically necessary, out-of-state and socially necessary providers to ensure compliance with the contractor's requirements. Trainer/Consultant also provides training and technical assistance to any and all providers (Medically Necessary and Socially Necessary) as requested. The Trainer/Consultant provides necessary information to APS care management staff and alerts other agencies (e.g. OQPI) as necessary regarding provider concerns. Trainer/Consultant also provides orientation and ongoing technical assistance for new providers.

Essential Functions: 1) Conduct and appropriately document provider retrospective reviews utilizing APS UM guidelines, Medicaid Manual and/or BCF manual according to established time frames 2) Provide training and technical assistance to providers and identify training needs 3)Interface with APS staff regarding consultative reviews 4) Report and analyze data from reviews according to set timelines. 5) Participate in monthly TC meetings, quarterly all-staff meetings and other required meetings as needed.

Education, Experience and Skills: Applicant must have a Master's Degree in human service field; Licensed with a MA level license; Minimum 1-2 years' experience in direct practice with consumers; Customer service in which both verbal and written communication are required to communicate review findings and recommendations; Effectively communicate verbally and in writing findings and recommendations; Knowledge of best practice guidelines of the service being reviewed; General knowledge of the needs of the population being served; knowledge of Microsoft Word and Excel and general usage of the computer; Health Information Privacy and Portability Act; Review and analyze documentation against set standards; Ability to adequately communicate findings and recommendations to providers verbally and through writing; Ability to work independently to meet timelines and expectations; Ability to interact appropriately with providers who may be hostile or upset; Organize work time an tasks effectively to meet contract deliverables; Assesses adherence to documentation standards as set by contractor; Assesses training needs based upon deficiencies noted.

Department: Data Integration

Position Title: Technical Liaison

Position Summary: Responsible for the provision of technical assistance to the participating providers of the Medicaid, BBHHF, and BCF programs for which APS Healthcare provides utilization management. Typical customer assistance includes a basic overview of the utilization management process and then the actual registration of new providers, establishing new web user accounts to access the appropriate APS Healthcare UM application, and resetting existing users' accounts, the training of new users to navigate and utilize the features and functions of the software application and assisting provider callers with reimbursement and prior authorization of services issues. Tracking all technical assistance and training delivered. The Liaison, at times, interfaces with specific program staff to evaluate and triage UM website application issues.

Essential Functions: 1) Provides technical assistance and training to the provider users of APS' utilization management systems 2) Documenting all technical assistance and training delivered to providers/provider users 3) Conducts face-to-face trainings of providers' staff (may require travel and use of own vehicle) 4) Other duties as assigned.

Education, Experience and Skills: A minimum of a bachelor's degree in computer science or related field or three or more years' experience with APS Healthcare – West Virginia or a combination of experience and education (i.e. associate's degree and experience with APS – WV; Excellent customer service and communication skills; ability to multi-task and prioritize; Flexibility and Willingness to complete other duties/assignments; Ability to life and carry 40 pounds; Experience in the healthcare preferred; Microsoft Office Word, Outlook and Excel proficiency as measured by pre-hire testing.

Department:

Position Title: Trainer Consultant Team Leader

Position Summary: Provide leadership and oversight to Trainer/Consultants to ensure guidelines, policies, procedure and a timelines are followed.

Essential Functions: 1) Review specific cases 2) Clarify questions with Care Management and Training/Consultation staff 3) Provide oversight of monthly Grand Rounds 4) Provide input on internal and external training needs related to clinical policies and procedures and based on the analysis of information obtained through provider audits and utilization data analysis 5) Establish individualized recommendations for provider technical assistance and training related to clinical practices, based on information obtained through provider audits and utilization data analysis and provide agency specific technical assistance as needed and appropriate 6) Review denials of service for private practitioner psychologist and non-physician rehabilitation services and will conduct desk audits to monitor appropriateness of care and well as direct participation with providers as required. Participate as needed in refining utilization review and management criteria, the record review process, and policies and procedure s as needed for all programs (MNS, SNS, MR/DD Waiver).

Education, Experience and Skills: Applicant must have WV Licensed Masters Level Psychologist; Social Worker or Counselor; Experience in outpatient clinical settings; currently licensed in WV ; Minimum 3 years' experience in public sector human services or behavioral healthcare field; Strong vernal and communication skills; Customer service focus; Managed care experience preferred.

Department: Behavioral Health

Position Title: Trainer/Consultant

Position Summary: The Trainer/Consultant conducts consultative retrospective reviews of medically necessary behavioral health services funded by Medicaid to ensure compliance with the contractor's requirements. Trainer/Consultant also provides training and technical assistance to any and all providers as requested. The Trainer/Consultant provides necessary information to APS care management staff and alerts other agencies (e.g. OQPI) as necessary regarding provider concerns. Trainer/Consultant also provides orientation and ongoing technical assistance for new providers.

Essential Functions: 1) Conduct and appropriately document provider retrospective reviews utilizing APS UM guidelines, Medicaid Manual and/'or BCF manual according to established time frames 2) Provide training and technical assistance to providers and identify training needs 3) Interface with APS staff regarding consultative reviews 4) Report and analyze data from reviews according to set timelines 5) Will participate in monthly TC meetings, quarterly all-staff meetings and other required meetings as needed.

Education, Experience and Skills: Applicant must have Master's degree in Social Work, counseling or Psychology; Fully licensed with a MA level license- LPC,LGSW, LICSW or by WV Board of Examiners of Psychology; Minimum 1-2 years' experience in direct practice with consumers; Customer service in which both verbal and written communication are required; Effectively communicate verbally and in writing findings and recommendations; Knowledge of best practice guidelines of the service being reviewed; General knowledge of the needs of the population being served; Knowledge of Microsoft Word and Excel and genera usage of the computer; Health Information Privacy and Portability Act; Review and analyze documentation against set standards; Ability to adequately communicate findings and recommendations to providers verbally and through writing; Ability to work independently to meet timelines and expectations; Ability to interact appropriately with providers who may be hostile or upset; Organize work time and tasks effectively to meet contract deliverables; Assesses adherence to documentation standards as set by contractor; Assesses training needs based upon deficiencies noted.

Department: Health Homes

Position Title: UM Coordinator (Senior Administrative Assistant)

Position Summary: The Health Homes UM Coordinator provides a broad range of administrative services support to the Health Homes team and external customers. This position supports the clinical and clerical medical staff with day-to-day functions as well as performing primary customer service and training functions. The UM Coordinator provides telephone support to external providers/agencies/facilities, provides technical support and provides specific training both via webinar and on-site with the provider as well as manages communications with providers and/or members. This support role will perform special projects as needed to improve customer service; as well as other duties as assigned to meet business needs.

Essential Functions: 1) Provides primary non-clinical program support to the Health Homes Program that include – provider TAs and training (phone and face-to-face), customer service, call triaging, authorization preparation, data entry, editing & final quality check of training and other materials, development & tracking of ASO functions for members and providers 2) Provides non-clinical support to other programs as needed. 3) Other duties as assigned to meet contract deliverables

Education, Experience and Skills: Applicant must have a high school diploma or GED equivalent (advance degree/certificate in related area), 2-3 years in an administrative support or customer service position, and be familiar with health care, preferable WV Medicaid. Applicant will possess knowledge of the office environment and business processes; Understanding of customer service approach for medical provider stakeholders; Familiarity with government structure and related programs preferred. Applicant needs excellent communication skills; Ability to multitask, prioritize and service a variety of customers; PC skills- minimum Word, Excel (basic used of spreadsheets for tracking) and PowerPoint, familiarity with other programs is a plus; Experience with development and project activities; Experience with staff and provider training, public speaking skills preferred; The applicant continually assesses the office functions and reports potential issues to Director; Track provider issues and report appropriately; Learn the APS application and assist customer with resolving technical issues related to submission of Health Homes authorization request.

Department: **Multiple**

Position Title: **UM Support**

Position Summary: **Provides a broad range of administrative support to a team, department and/or individual and reports to the Office Manager. The position supports office employees with day-to-day office functions, training and non-clinical support functions (e.g. data entry and report tracking) and performs functions to support external customer access to APS staff and services; arrange training venues; arrange conference calls, copy and organize materials for training, enter data into various software programs; answer and respond to routine calls, inquiries and questions and route calls appropriately; ensure timely and proper handling and safeguarding of confidential, private or sensitive material; performs special projects as required as well as other duties as assigned to meet business needs**

Essential Functions: **1) Day to day office functions including maintaining correspondence, training and clinical files; preparing and mailing correspondence; schedule appointments and meetings as directed; assist with data entry and compiling monthly, quarterly and annual reports required to meet contract specifications; direct calls appropriately, and; ensure timely and proper handling of all confidential, classified, private or sensitive material. 2) Track daily and weekly department activities and complete appropriate tracking reports; prepare and send out correspondence related to department activities (e.g. notifications, reports etc.), and; data entry and import of information required for reports and notification. 3) Continue professional development, cross-train to provide administrative coverage to other departments and perform other duties as assigned.**

Education, Experience and Skills: **Applicants must have an AA degree or equivalent work experience; 2 years' experience, preferably in a healthcare setting. Applicant will possess knowledge of day to day office operations, project management, customer service, and phone etiquette. Applicant must have excellent written and verbal communication skills; Computer skills, including word processing and spreadsheets; Data entry experience in a wide variety of platforms; Proficient use of office equipment, including faxes, copiers, phone systems; Excellent phone etiquette; Customer service skills; Ability to manage multiple tasks and projects; Prioritize day to day tasks to meet established timelines; Handle customers and route appropriately; Organize and review work flow to ensure completion of necessary tasks.**

Department: **WV Behavioral Health Outpatient Program**

Position Title: **UM Support**

Position Summary: **Provides a broad range of administrative support to a team, department and/or individual and reports to the Office Manager. The position supports office employees with day-to-day office functions, training and non-clinical support functions (e.g. data entry and report tracking) and performs functions to support external customer access to APS staff and services; arrange training venues; arrange conference calls, copy and organize materials for training, enter data into various software programs; answer and respond to routine calls, inquiries and questions and route calls appropriately; ensure timely and proper handling and safeguarding of confidential, private or sensitive material; performs special projects as required as well as other duties as assigned to meet business needs**

Essential Functions: **1) Day to day office functions including maintaining correspondence, training and clinical files; preparing and mailing correspondence; schedule appointments and meetings as directed; assist with data entry and compiling monthly, quarterly and annual reports required to meet contract specifications; direct calls appropriately, and; ensure timely and proper handling of all confidential, classified, private or sensitive material. 2) Track daily and weekly department activities and complete appropriate tracking reports; prepare and send out correspondence related to department activities (e.g. notifications, reports etc.), and; data entry and import of information required for reports and notification. 3) Continue professional development, cross-train to provide administrative coverage to other departments and perform other duties as assigned.**

Education, Experience and Skills: **Applicants must have an AA degree or equivalent work experience; 2 years' experience, preferably in a healthcare setting. Applicant will possess knowledge of day to day office operations, project management, customer service, and phone etiquette. Applicant must have excellent written and verbal communication skills; Computer skills, including word processing and spreadsheets; Data entry experience in a wide variety of platforms; Proficient use of office equipment, including faxes, copiers, phone systems; Excellent phone etiquette; Customer service skills; Ability to manage multiple tasks and projects; Prioritize day to day tasks to meet established timelines; Handle customers and route appropriately; Organize and review work flow to ensure completion of necessary tasks.**

Department: Socially Necessary Services

Position Title: UM Support

Position Summary: Provides a broad range of administrative support to a team, department and/or individual and reports to the BCF Director. The position supports office employees with day-to-day office functions, training and non-clinical support functions (e.g. data entry and report tracking) and performs functions to support external customer access to APS staff and services; arrange training venues; arrange conference calls, copy and organize materials for training, enter data into various software programs; answer and respond to routine calls, inquiries and questions and route calls appropriately; ensure timely and proper handling and safeguarding of confidential, private or sensitive material; performs special projects as required as well as other duties as assigned to meet business needs

Essential Functions: 1) Day to day office functions including maintaining correspondence, training and clinical files; preparing and mailing correspondence; schedule appointments and meetings as directed; assist with data entry and compiling monthly, quarterly and annual reports required to meet contract specifications; direct calls appropriately, and; ensure timely and proper handling of all confidential, classified, private or sensitive material. 2) Track daily and weekly department activities and complete appropriate tracking reports; prepare and send out correspondence related to department activities (e.g. notifications, reports etc.), and; data entry and import of information required for reports and notification. 3) Continue professional development, cross-train to provide administrative coverage to other departments and perform other duties as assigned.

Education, Experience and Skills: Applicants must have an AA degree or equivalent work experience; 2 years' experience, preferably in a healthcare setting. Applicant will possess knowledge of day to day office operations, project management, customer service, and phone etiquette. Applicant must have excellent written and verbal communication skills; Computer skills, including word processing and spreadsheets; Data entry experience in a wide variety of platforms; Proficient use of office equipment, including faxes, copiers, phone systems; Excellent phone etiquette; Customer service skills; Ability to manage multiple tasks and projects; Prioritize day to day tasks to meet established timelines; Handle customers and route appropriately; Organize and review work flow to ensure completion of necessary tasks.

Department: All

Position Title: Vice President of WV Operations

Position Summary: The WV VP is responsible for the overall administration of the contract(s) with the WV Department of Health & Human Resources. Additionally, the WV VP is the primary contact with DHHR.

Essential Functions: The WV VP is responsible for the management and all deliverables for the various programs. The WV VP ensures that all the ASO functions are performed to the highest standards and meets or exceeds contract requirements and customer expectations. Additional functions include, but are not limited to:

- Oversees the design, development and implementation of all programs
- Responsible for State, Regional and Community Relations
- Responsible for all business management functions (budgeting, staffing, etc.)
- Responsible for the program(s) strategy, visions and leadership
- Responsible for team development/leadership
- Accountable to the various state contract managers.

Education, Experience and Skills: Master Degree (minimum) with 5 years management experience in the healthcare/social arenas. Experience with Direct Care Services a plus. Experience with the WV Medicaid, BCF and BHHF programs. Strong leadership and customer relations skills. Proven track record of success facilitating progressive change and development of innovative business functions and programs. Strong customer service skills, problem solving and coaching. Ability to operate as an effective tactical and strategic thinker.

Angela Ferrari

Consumer and Family Affairs Director, West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Charleston, WV
Phone: (304) 343-9663
Fax: (304) 343-9010
afferrari@apshealthcare.com

Professional History

Consumer and Community Affairs Director, APS West Virginia ASO, APS Healthcare, Inc.-WV

- Developed training modules specific to stake-holder's needs
- Implemented face-to-face trainings statewide on the ASO and Wellness/Advanced Directives
- Conducted 250+ in-depth focus group with all constituents
- Provided personal consultations/trainings to providers, consumer and family members
- Instructed families that were referred to apply for Title XIX Waiver Program
- Direct involvement in various boards of consumer, advocate and family groups
- Educated communities statewide on systemic issues
- Reviewed all denials of services, with administrative staff
- Provided information and referrals to all stake-holders
- Processed consumer complaints and issues
- Conducted 125+ site visits to licensed behavioral health centers
- Provided sensitivity and "topic specific" trainings
- Promote recover and empowerment
- Assisted in identifying gaps in the service delivery system
- Advocate for "client rights" and best practice in service delivery
- Presented at NASW conferences
- Promote Psycho-Social Model of inclusion of clients in the service delivery system
- WRAP facilitator for adults and youth

Program Development Specialist, NAMI West Virginia, Charleston, WV

- Developed Family Education Curriculum
- Implement Family Education throughout the State of WV
- Co-developed Organizing for Change Curriculum
- WV Leadership Academy instructor & family recruiter
- Organizing for Change instructor & recruiter
- Advocate for insurance parity, as well as Client Rights
- Conduct "topic specific" workshops
- Conduct on-site visits to all of the Mental Health Centers

ICF Supervisor, Shawnee Hills, Inc., Charleston, WV

- Supervised a 10 bed Intermediate Care Facility (ICF) with 18 staff
- Provided direct care and shift coverage
- Interacted frequently with social workers, licensure review teams
- Implemented staff schedules, maintained all functions necessary to provide the highest quality of life for the individuals that lived in the home
- Developed and implemented processes for ordering supplies, food, maintenance of mechanical devices & structural activities
- Developed schedules for the entire center, on call 24 / 7, part of a 3 member scheduling team
- Received and reviewed adverse incidents & forwarded to Client Rights or medical staff

Domestic Engineer (Maintained Home)

- Provided direct & intensive care for my child that has a dual diagnoses MI /MR
- Built a network of resources to improve my child's quality of life, as well as my own
- Developed a long range plan of action for re-entering the workforce

Behavioral Health Technician, Shawnee Hills, Inc., Charleston, WV

- Direct care, training and supervision to person with intellectual disabilities

Education

Presently acquiring Psychology / Social Work credits at West Virginia State College

Additional Course Work and Certifications

Excellent communication skills including written, verbal & technical instruction
Innovative & adaptive
Excellent organizational skills
Leadership & supervisory experience
Well developed interpersonal skills
Vast knowledge of confidentiality & ethics
Certified First Aid/CPR instructor
Strong word processing & documentation skills
NAMI West Virginia Ex-Officio
WV Leadership Academy graduate & instructor
Mental Health First Aid Instructor
WRAP Instructor
Parent Advisory Council MSPCAN / Ex-Officio
Organizing for Change instructor
35 + years' experience with serious mental illness & family

Caroline G. Duckworth, MSW, LCSW

Social Necessity Program Manager, West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Charleston, WV
Phone: (304) 343-9663
Fax: (304) 343-9010
cgduckworth@apshealthcare.com

Professional History

APS West Virginia ASO, APS Healthcare, Inc.-WV

Socially Necessary Program Manager

- Implemented the Socially Necessary Services program
- Oversee daily operations
- Supervise care management staff
- Coordinate communication between DHHR Bureau for Children and Families and APS Healthcare regarding Socially Necessary Services Program
- Evaluate and analyze Bureau for Children and Families data, quality and outcome measures
- Provide training and technical assistance for Child Protective Services and Youth Services DHHR workers, foster parents and biological parents
- Consult on cases in which children are involved in both child welfare and behavioral health services
- Participate in the Certificate of Need Summary Review Committee

Children's Specialist

- Provide consultation and review of the West Virginia Children's Home to assist in becoming a Medicaid provider
- Implemented prior authorization process and provided training for out of state contracted residential providers
- Trained WV DHHR Bureau for Children and Families employees and members of the legal community on the out of state residential prior authorization process
- Developed utilization guidelines for socially necessary services provided by the Bureau for Children and Families to the Child Protective and Youth Services population
- Assisted in CAPS initiative as a member of the assessment planning team for the Bureau for Children and Families

Care Manager

- Utilized data set with knowledge of all functional assessments to prior authorize requests within a two-day time period.
- Integrated use of diagnostic formulation, clinical assessment and treatment plan to prior authorize medically necessary services
- Provided individualized technical assistance and training regarding implementation of Utilization Management Guidelines, Medicaid and Targeted Case Management manuals and clinical best practice parameters
- Monitored for service outliers in order to address possible clinical or administrative issues with providers

Master's of Social Work Program, West Virginia University
Adjunct Professor

- Teach Child Welfare Continuum- administration, policy, supervision and practice
- Field Instructor for foundation and advanced practice level students

Child and Family Services, Shawnee Hills, Inc., Charleston, WV
Barboursville School Director

- Supervised over fifty employees from various backgrounds at a psychiatric residential treatment facility for children 12-17 with chronic severe mental illnesses
- Provided implementation and continual monitoring of WV Child Care, OHFLAC, OBHS, WV DHHR and Joint Commission regulations
- Coordinated continuing staff development, training and new employee orientation
- Completed compliance audits to ensure regulatory standards were maintained
- Oversaw implementations and use of programs behavior management system
- Lead case consultations regarding challenging behaviors and treatment plans
- Analyzed data from program behavior management systems and programs use of emergency control measures
- Monitored WVMI prior authorization and concurrent review process
- Implemented Away From Supervision Training Curriculum
- Provided diagnostic specific and child development continuing education units to direct care staff
- Implemented and developed multidisciplinary treatment plans
- Provided individual and group therapy, crisis intervention, CPI, behavior management services, basic living skills, clinical evaluation and case management
- Represented Child and Family services on the Clinical Best Practices, Patient Care Monitoring and Credentialing Teams
- Served as a Treatment Planning Trainer for the agency

Intensive Outpatient Crisis Stabilization Program Director

- Oversaw program for children 5-18 who were multi-system involved with mental illness in need of immediate stabilization to avoid hospitalization, placement disruption, and/or further penetration in the child welfare system
- Coordinated contacts with Child Protective Services and Youth Services
- Supervised 12 employees of various educational backgrounds
- Developed and evaluated budgets and developmentally appropriate program curriculum
- Trained new staff through clinical supervision, mentoring, counseling, and modeling
- Created and presented Continuing Education Units for staff development
- Collected and analyzed statistics monthly to track trends in clinical monitors
- Facilitated problem-solving activities for children and parents through a family centered practice approach
- Provided group, individual and family therapy, crisis intervention, clinical evaluation and treatment planning
- Represented Children and Family Services on the Clinical Best Practices and Credentialing Teams
- Completed prior authorization and concurrent reviews for participants
- Monitored implementation of OHFLAC, OBHS and Joint Commission regulations

Community–Based Case Manager

- Performed case management duties and crisis intervention in the home, schools and communities of consumers

- Developed and implemented treatment plans and behavior management plans
- Coordinated mental health services for families involved with the DHHR through Child Protective Services and Youth Services

Out Patient Case Manager

- Provided Targeted Case Management Services in a clinic setting
- Implemented and participated in treatment team meetings

Behavioral Health Technician

- Implemented treatment, training and behavioral support plans for adults diagnosed MR/DD in a residential group setting
- Modeled activities of daily living

Education

MSW – Masters Social Work, West Virginia, Charleston, WV
School Counseling Program, Marshall Graduate College
BS - Family and Consumer Science, Shepherd College, Shepherdstown, WV

Leadership/Specialized Training

Certified Child and Adolescent Functional Assessment Scales Trainer of Trainers (CAFAS)
Child Adolescent Needs and Strengths Trainer of Trainers (CANS)
WV Child Care Association Away From Supervision Trainer
Living with 10-15 Year Olds Trainer
Echo Structural Family Therapy

Licenses

West Virginia Temporary Licensed Social Worker, 1997
West Virginia Licensed Social Worker, May 2000
West Virginia Licensed Graduate Social Worker, June 2000
West Virginia Licensed Certified Social Worker, January 2003

Select Continuing Education Activities:

Understanding, Assessing and Treating Sexual Offenders
Family-Centered Practice
Identifying Levels of Care For Addictive and Co-Occurring Disorders
Treatment Strategies for the Dually Diagnosed
Assessment, Treatment Planning and Plan Review for Children
Community Development Training
Evaluation and Treatment for Sex Offenders
Addiction Issues with Adolescents
Invisible Scars: the Long-term Effects of Neglect
Childhood Developmental Disorders
Child Maltreatment Evaluations

APS Healthcare

Catherine Hayes, MA, LPC

Quality Improvement Coordinator, West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Charleston, WV
Phone: (304) 343-9663
Fax: (304) 343-9010
email@apshealthcare.com

Professional History

Quality Improvement Coordinator, APS West Virginia ASO, APS Healthcare, Inc.-WV

- Coordinated and facilitated all internal and external Quality Improvement activities related to all APS-WV programs.
- Monitored the internal and external Quality Improvement activities
- Initiated corrective action as necessary to ensure the high quality of all of the APS-WV products for each program.

Additional Professional Experience

Care Manager, APS West Virginia ASO, APS Healthcare, Inc.-WV

- Reviewed clinical assessments to determine medical necessity for services provided under the WV Medicaid Clinic, Rehabilitation and Targeted Case Management options.
- Provided clinical training and consultation to WV Behavioral Healthcare Providers

Director of Professional Services (Clinical Director), Family Service of Kanawha Valley, Charleston, WV

- Supervised and trained the professional staff (masters level therapists and case manager)
- Coordinated and facilitated quality improvement activities
- Tracked and reported utilization management
- Responsible for the agency meeting the requirements for all agency licensure (such as OHFLAC) and accreditations (including COA) as related to the clinical program
- Provided direct counseling services to modified caseload of children, adults and families

Therapist, Family Service of Kanawha Valley, Charleston, WV

- Provided counseling services to children and adults
- Provided counseling addressing issues of abuse -- both to victims/survivors and perpetrators
- Provided counseling in formats of individual, family and group therapy

Education

MA – Counseling, Marshall University Graduate College, Charleston, WV
BS – Chemistry, Bethany College, Bethany, WV

Additional Course Work and Certifications

West Virginia Licensed Professional Counselor, December 1993 (License [redacted]
Approved Licensed Professional Supervisor (ALPS)

APS Healthcare

Emily Proctor, LPC, AADC, CEAP

Contact Information

APS Healthcare - WV
100 Capitol Street, Charleston, WV
Phone: (304) 343-9663
Fax: (866-473-2354)
ebproctor@apshealthcare.com

Professional History

APS Healthcare, Inc.-WV, April 2001-Present
Team Leader

- Provide oversight of staff determining medical necessity for WV Medicaid behavioral health services.
- Develop, maintain and distribute utilization management guides, operational instructions, and provider reference documents.
- Interface with IT on customization of the APS CareConnection© including design, development and end-user testing.
- APS Physician Reviewer recruitment, education and coordination of the case review process.
- Provide clinical guidance regarding cases, establish and monitor performance measures and inter-rater reliability.
- Review and approve provider intensive service descriptions on behalf of the Bureau for Medical Services; participate in WV Medical manual work groups as requested by DHHR.
- Case review for prior authorization requests including data analysis for state level appeals.

Care Manager

- Integrate clinical information presented by providers to determine medical necessity for services provided under the West Virginia Medicaid Clinic, Rehabilitation, Targeted Case Management and Private Practitioner Options.
- Provide continual review of provider's utilization management systems, implement provider technical assistance and training, and encourage adherence with clinical best practice parameters for services.
- Renegotiate services requested utilizing current clinical parameters in the event medical necessity is not demonstrated.

Per Diem Social Worker, Thomas Memorial Hospital, South Charleston, WV

- Completed psychosocial assessments, develop therapeutic plans for treatment, and implemented discharge planning.
- Implemented intensive and educational groups for dual diagnosis population.
- Crisis on-call team member utilizing community/private referral sources.

Employee Assistance Program Counselor, REACH EAP, South Charleston, WV

- Performed EAP client assessments, therapy and referrals for REACH client companies in the State of West Virginia.
- Conducted training seminars, management consultations, critical incident stress debriefings and telephone on-call counseling services.
- Developed and maintained referral network with private practitioners/community programs.

Substance Abuse Therapist, Shawnee Hills, Extended Care Substance Abuse Unit, Charleston, WV

- Primary therapist for women's substance abuse residential facility. Provided therapeutic services through intensive group and individual therapy.
- Facilitated educational groups on addiction and related topics; developed and implemented treatment strategies, provided case management services and member of the crisis on-call staff.
- Developed referral network to maximize admissions, provided initial review of eligibility for prospective candidates and facilitated face-to-face interview with candidate and admissions team.

Substance Abuse Therapist, Shawnee Hills, Short-Term Substance Abuse Unit, Charleston, WV

- Primary therapist for short-term inpatient unit. Provided individual and group therapy, crisis intervention and case management services.
- Formulated and implemented treatment plans and client progress reviews.
- Facilitated family education groups and family therapy sessions.
- Completed Medicaid authorization requests.

Additional Trainings/Activities

- Completed telephone supervision series with Dr. David Mee-Lee, principle author of the ASAM PP-2 Placement Criteria.
- Basic Critical Incident Stress Debriefing Training and Workplace Critical Incident Stress Management Training.
- Member of Screening, Brief Intervention and Referral for Treatment (SBIRT) and Robert Wood Johnson WV Grant Teams as requested by DHHR.
- Member and Secretary of the WV Certification Board for Addiction Professionals.

Education

MA - Counseling and Rehabilitation, Marshall University, Huntington, WV

BA - Psychology, West Virginia Wesleyan College, Buckhannon, WV

Additional Course Work and Certifications

- WV Licensed Social Worker (currently inactive status)
- WV Licensed Professional Counselor #[redacted]
- WV Advanced Alcohol and Drug Counselor #[redacted]
- Certified Employee Assistance Professional [redacted]

APS Healthcare

Helen C. Snyder, MA, LPC, LCSW

Associate Director, West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Charleston, WV
Phone: (304) 343-9663
Fax: (304) 343-9010
email@apshealthcare.com

Professional History

Associate Director/Clinical Manager, APS West Virginia ASO, APS Healthcare, Inc.-WV
Oversight of the overall quality and appropriateness of care provided to Medicaid beneficiaries under the Medical contract for utilization management/ASO services. Supervision of medical and clinical staff, eligibility specialists, and network development staff and oversight of implementation of protocols and procedures related to utilization review and management of medical services. Responsible for oversight of clinical services provided by APS staff in the provision of UM services to Medicaid members.

- Assisted with customizing CareConnection and developing protocols for prior authorization of medical, behavioral health, socially necessary (BCF) and waiver services
- Development of Utilization Management Guidelines related to services included in the current contract expanded to include medical services as well as behavioral health services
- Consultation with DHHR on development of UMC services and a direct data entry system for medical prior authorization requests.
- Training and technical assistance for medical providers.
- Ongoing consultation with BMS and APS liaison on the BMS Policy Review committee and Procedure code work Group.

Additional Professional Experience

Director of Children's Mental Health Services, West Virginia Department of Health and Human Resources
Administration of budget allocations for Children's Mental Health Services, preparation of Federal Block Grant, allocation of Block Grant and participation in planning, coordination and developing a system of care for children with Serious Emotional Disturbances. Provision of technical assistance, training and consultation to the Comprehensive Behavioral Health Centers, inpatient psychiatric hospitals and Barboursville School (PRTF) contracted through the mental health bureau to serve SED children and their families. Maintain linkages with consumer groups, education, juvenile justice and social services. Represent Office of Behavioral Health Services on the local, state and national level.

Director of Youth and Adolescent Services, Shawnee Hills Mental Health/Mental Retardation Center, Inc.
Supervision of youth and adolescent mental health, early intervention and substance abuse programs (including outpatient programs, residential programs and Barboursville School (PRTF), clinical supervision of staff hiring and personnel management, program development, community relations, budget preparation and monitoring, grant writing, general administrative duties and program monitoring. 3/90-4/92

Grant writing includes: Phoenix House Substance Abuse Transitional Living Program (funded), Mobile Crisis Response Team (funded). Other grants submitted: Discovery House (residential mental health); Adolescent Crisis

Residential Unit (w/Robert Hansen).

Regional Youth Specialist, Shawnee Hills MH/MR Center, Inc.
Supervision of Model outpatient staff, community development and linkages, program development, Drug and Alcohol Assessment and intake, individual, family and group therapy, Student Assistance Programming, inpatient substance abuse referral, aftercare and care management. 10/88-3/90

Outpatient Therapist, Shawnee Hills MH/MR Center
Drug and Alcohol Assessment and Intake, individual, family and group therapy, Student Assistance Programming, inpatient substance abuse referral and case management. 6/88-10/88

Counselor/Administrator, Davis Child Shelter, South Charleston, West Virginia.
Counseling adolescents and their families, placement planning for youth, evaluation, coordination of medical, psychological and education planning, supervision of direct service staff, hiring and personnel management, responsible for ongoing staff training and development.

Social Service Worker, WV Department of Human Services
Individual and family counseling and case work, coordination of community services to clients, active involvement in personnel committee and liaison for Charleston Housing Authority.

Consultation
Ongoing consultation to DHHR related to UMC Contract implementation for medical services.

Consultation to the Bureau for Medical Services for Medicaid Behavioral Health ASO effort including development of training materials and training on program implementation. Ongoing technical assistance provided.

Consultation to the Bureau for Medical Services and the Bureau of Children and Families on development of rates and eligibility criteria for Residential Services, Treatment Foster Care and Family Preservation Services, implementation of Comprehensive Assessment and Planning protocol (CAP), development and implementation of Program Improvement Plan related to Child Welfare Services.

Consultation to the Bureau for Behavioral Health and Health Facilities related to Mental Health and Substance Abuse Block Grant data collection and reporting.

Education

M.A. – Counseling and Guidance, West Virginia College of Graduate Studies
B.A. Psychology, Douglass College – Rutgers University

Additional Course Work and Certifications

West Virginia Counseling License
License Number [redacted]

West Virginia Licensed Clinical Social Worker
Social Work License Number [redacted]

APS Healthcare

Rebecca Jamnick

Director, BBHHF Contract & Data Integration - West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Suite 600
Charleston, West Virginia 25301
Phone: (304) 343-9663
rajamnick@apshealthcare.com

Professional History

APS Healthcare -West Virginia DHHR Administrative Services Organization, Charleston, WV
2000 - Present

Director of the APS Bureau for Behavioral Health and Health Facilities Program & Data Integration

Responsible for the development and management of ASO activities for BBHHF, and the APS Contract data and reporting requirements. The Scope of BBHHF Program includes: consumer eligibility determinations for BBHHF Indigent Care, utilization management of indigent care funded services for eligible consumers, completion of specified block grant tables, receipt, validation and transfer to BBHHF of the Comprehensive Behavioral Health Centers' BBHHF Data Segment (BDS), Consumer Service Data Reports (CSDR) and all CareConnection records regardless of payer, and the coordination of mutual data updates and new activities. Scope of data activities includes monthly utilization management reports to contractors with various summary reports of ASO activities such as Provider Training, Technical Assistance and coordination/completion of ad hoc reporting and data requests from the Bureaus.

Shawnee Hills, Inc. (Community Mental Health Center) Charleston, West Virginia
1983 - 2000

Medical Necessity Assessment Unit Director

Lead Center-wide Implementation, Monitoring, Data Management of WV DHHR's New Directions Medical Necessity Assessment Program, Medicaid Service Coding Specialist, and direct supervision of support staff. Front Desk Functions Monitoring, Front Desk Training, MIS Report Writing.

Administrative Information Specialist

Assistant to the Chief Operations Officer and system-wide Report Writer for chief executive and management team for systems evaluation and data based decision-making.

Information Services Team Member

MIS Manager, Help Desk Coordinator, and MIS Report Writer

Outpatient Clinic – Operations Manager

Provide daily operational and administrative management of psychiatric outpatient clinic (six psychiatrists, six nurses, four transcriptionists, and three front desk staff). Responsibilities included the supervision of clinical and support staff, budget development and management, development and implementation of clinic processes for patient flow, documentation and consumer satisfaction.

Director of I/DD Adult Residential Services

Clinical and Administrative Management of eight group homes/supervised apartments serving Intellectually/Developmentally Disabled Adults. Direct supervision and leadership of five professional Residential Supervisors and Hiring Coordinator, with approximately 200 staff members rendering care and providing training to residents.

Director of Day Program for Adults with an Intellectual/Developmental Disability

Clinical and Administrative management of an average of 78 mentally retarded/developmentally disabled and/or mentally ill adult day program. Direct Leadership of approximately thirty staff members.

Shawnee Hills Industries - Director

Clinical and administrative management of Workshop and Day Program serving approximately 100 intellectually /developmentally disabled and/or mentally ill adults daily. Direct leadership of approximately twenty-five staff members.

Residential Supervisor

Direct clinical and administrative functions of approximately forty paraprofessional and four professional staff members providing direct supervision, skill acquisition training and behavior management programs to adult residents with I/DD in both a twenty-three unit apartment facility and a ten-bed ICF-MR group home.

Hansford Community Center/Multi-CAP, Inc. St. Albans, West Virginia
1980 - 1983

Assistant Director of Senior Citizens Program/Human Resource Worker II

Assisted in the daily operations and general management of the community-based day program for senior citizens with a federally funded nutrition program and administered CAP programs.

Education

MSW: Social Work, *West Virginia University*, Morgantown, West Virginia

BA: Psychology and Sociology, Minor - Computer Science, *Concord University*, Athens, West Virginia

Certifications

WV Board of Social Work - License Eligible

Jennifer W. Britton, Ph.D.

Vice President, West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Charleston, WV
Phone: (304) 343-9663
Fax: (304) 343-9010
jwbritton@apshealthcare.com

Professional History

Vice President, APS West Virginia ASO, APS Healthcare, Inc.-WV (2000-2015)

Responsible for the overall administration of the WV Medicaid ASO Program including: ASO for Medicaid Behavioral Health, ASO for BHHF Care & Federal Block Grant Data, ASO for Children's Social Services, ASO MR/DD Waiver, TBI Waiver, A&D Waiver, UM Medical (including NH & PC) and Health Homes .

- Provides leadership and supervision for all local staff.
- Manages all day-to-day operations.
- Oversees the design, development and implementation of all services and products related to the ASO functions.
- Primary contact for all the Department Bureaus.
- Responsible for executive-level provider, consumer and state relationships and problem solving on issues.
- Responsible for state, regional and community relations.
- Responsible for all contractual obligations related to the WV ASO Contract.
- Responsibility for financial management related to the WV Contract.
- Provides consultation to DHHR on issues and direction for healthcare.

Vice President of Government Relations, ValueOptions, Inc/FHC Health Systems, Inc.

- Designed and implemented the Government Relations functions for both companies.
- Provided the oversight and direction of all government relation's functions as they related to strategic planning, business development and implementations, and business maintenance of all public sector, commercial, health plans and federal products.
- Provided supervision and leadership for Government Relations staff and contractors.

Vice President of Public Sector Development, ValueOptions, Inc. (post merger)

- Developed new behavioral health care programs and services for public and private sector companies
- Identified and proposed business opportunities.
- Lead development efforts within an assigned region.
- Conducted forums and provided marketing presentations.
- Assisted with strategic planning.
- Collaborated with corporate and regional staff to develop products and improve existing operations.

- Conducted research and analysis of political and competitive environments, legislative/regulatory mandates, and health/social systems.

Vice President of Development, OPTIONS, Inc.

- Developed new behavioral health care programs and services for public and private sector companies
- Identified and proposed business opportunities.
- Lead development efforts within an assigned region.
- Conducted forums and provided marketing presentations.
- Assisted with strategic planning.
- Collaborated with corporate and regional staff to develop managed care products and improve existing operations.
- Conducted research and analysis of political and competitive environments, legislative/regulatory mandates, and health/social systems.

Vice President of Corporate Services, Shawnee Hills, Inc.

- Responsibilities included: coordination and management of the marketing, clinical, and operations functions of First Choice Health Systems, Inc. (a statewide, horizontal behavioral healthcare company).
- Designed and coordinated Outcomes Evaluation Programs for First Choice and Aspire, Inc. (a regional, vertical Behavioral Healthcare network).
- Directed Shawnee Hills' Research and Development Department.
- Designed, piloted and implemented a functionality assessment for consumers with MI/SA/DD.
- Coordinated the center's quality improvement efforts.
- Provided center-wide and national training on Managed Care and Total Quality Management.

Vice President of Quality Planning and Development Services, Shawnee Hills, Inc.

- Quality Planning: developed and provided oversight of the Center's Total Quality Management plan; developed and monitored the Center's Strategic Plan; monitored JCAHO and other regulatory requirements; developed, implemented and monitored the Staff Development and Orientation programs; provided training and technical assistance for external training contracts.
- Development Services: implemented and monitored the Medicaid Waiver Program for developmentally delayed individuals; provided senior leadership for the Early Intervention/Family Support Division.

Summary of previous leadership / clinical experiences at Shawnee Hills:

Associate Director of Residential Services

- Provided direction and management for various residential programs serving persons with mental illness, mental retardation and dual diagnosis – over 250 beds.

Associate Director of Youth and Adolescent Services

- Provided direction and management for all outpatient and residential programs serving children and youth with emotional disturbance and developmental disabilities.

Director of Day Programs

- Provided direction and management for day treatment, sheltered work and supportive work programs serving persons with mental illness, developmental disabilities and substance abuse.

Additional Professional Experience

Adjunct Associate Professor of Special Education, Marshall University Graduate College
Taught core graduate courses and the masters thesis research for all exceptionalities.

Assistant Professor of Special Education, University of Charleston

Special Education Public School Teacher
Taught a variety of exceptionalities and levels at various schools.

Education

Ph.D. – Education, The Ohio State University, Columbus, Ohio
Major: Low Incidence Handicapping Conditions
Minor: Educational Administration

MA – Special Education, West Virginia University, Morgantown, WV

BA – Speech and English, University of Charleston, Charleston, WV

Additional Course Work and Certifications

Wright State University, Dayton, OH
Marshall University Graduate College, South Charleston, W.Va.
Permanent Teaching Certificates for Mental Retardation and Behavior Disorders

APS Healthcare

Lori McGurty MS, LSW

Director of Waiver Programs, West Virginia ASO, APS Healthcare

Contact Information

APS Healthcare
100 Capitol Street, Charleston, WV
Phone: (866) 385-8920
Fax: (866) 521-6882
lmcgurty@apshealthcare.com

Professional History

Director of Waiver Programs, APS West Virginia ASO, APS Healthcare, Inc.-WV (12/11-present)

- Manage department of more than 50 staff across 5 WV Medicaid programs to ensure smooth daily operations with the expectation of excellence, quality assurance/improvement, consistency and customer service; Daily processes include: Eligibility assessments, individualized budgeting (I/DD), authorization reviews, provider utilization and quality reviews, inter-rater reliability, developing and implementing quality measures for internal and external deliverables, data collection/analysis for state, federal and ad hoc reporting, training development/implementation and technical assistance
- Design system requirements, perform user access testing and provide approval for implementation of web-based information systems pertaining to WV Waiver and Personal Care programs
- Collaborate with contract holder and other stakeholders to recommend policy, procedures and forms
- Assist in procuring new business - Assist in writing response to RFP for West Virginia Medicaid ASO contract; provide expertise and recommendation to other APS programs when requested pertaining to their states' RFPs; perform demonstration and trainings of web-based systems

Lead Provider Educator, APS West Virginia ASO, APS Healthcare, Inc.-WV (02/10-12/11)

- Managed Provider Educator staff to ensure timely and accurate completion of on-site I/DD Provider reviews
- Developed WV I/DD Waiver Provider Review Tool, Provider Self-Review Tool, reports and processes to promote I/DD Waiver provider compliance within WV Medicaid policy
- Coordinated data trending, analysis and reporting related to Federal CMS quality assurances and WV's I/DD Quality Plan and Discovery and Remediation Report
- Coordinated WV's I/DD Waiver Quality Improvement Advisory Council activities and quarterly statewide provider meetings

Provider Educator, APS West Virginia ASO, APS Healthcare, Inc.-WV (07/06-02/10)

- Developed and implemented statewide training programs, materials and protocols for I/DD Waiver providers related to utilization management, compliance with federal and state regulation, electronic records, Person-Centered Planning, individualized budgeting and prior authorization
- Developed the process for and conducted retrospective reviews for I/DD Waiver service providers to ensure compliance with federal and state documentation requirements

- Electronic Records; part of the team which identified required data elements, functionality, user rights, and synergies between the provider, APS prior authorization agent, the Bureau for Behavioral Health and Health Facilities, and the WV MMIS claims payer; developed accompanying Web User Guide to detail instructions on system use

Service Support Facilitator, APS West Virginia ASO, APS Healthcare, Inc.-WV (07/05-07/06)

- Part of the development team tasked with designing operations and implementing APS Healthcare's functions within the WV I/DD Waiver program
- Developed promotional and training/educational materials for dissemination to all stakeholders about the state's individualized budgeting process, member functional assessments, Person-Centered Planning, rights and responsibilities, prior authorization and other topics

Family Support Educator, Socially Necessary Services, APS West Virginia ASO, APS Healthcare, Inc.-WV (10/04- 07/05)

- Provided training and education to assist families and providers with accessing WV Medicaid Socially Necessary Services (quality, referrals, prior authorization, service provision)
- Developed marketing materials to improve stakeholder understanding of available services
- Implemented Focus Groups to obtain member input about services and quality improvement
- Assisted in facilitation of Consumer Quality Improvement Council

Service Coordinator, I/DD Waiver, **Community Services, Inc.** (07/04- 07/05)

- Title XIX Waiver services to assist I/DD population
- Case management including: Coordinating, convening, and chairing the IDT process, advocacy, linkage/ referral, crisis response planning, and service plan evaluation
- Implemented service designed to ensure accessibility, accountability, and continuity of support and services to program participants
- Provided [formerly known as] QMRP services to develop, monitor, and update habilitation training plans; trained direct- service staff to implement plans

Service Coordinator, I/DD Waiver, **REM Community Options** (05/02-07/04)

Same duties as Service Coordinator above

Truancy Diversion Social Worker, **Burlington United Methodist Family Services** (10/00-05/02)

Worked to prevent truancy in Putnam County, WV elementary and middle schools by implementing a child-focused, family-centered philosophy; Assessment, service planning, referral, skills training, parent education, advocacy, tutoring and supportive counseling to truant students

Family Service Specialist, **Action Youth Care** (02/00- 10/00)

Assisted at-risk children and families through assessment, service planning, supportive counseling, linkage/referral and behavior support programming

Education

MS, Health Care Administration, Marshall University Graduate College; South Charleston, WV

BA, Communication Disorders, Minor in Psychology, Marshall University; Huntington, WV

Additional Course Work, Certifications and Skills

West Virginia Board of Social Work Examiners, Licensed Social Worker

Collaborative Institutional Training Initiative (CITI) Institutional Review Board Approved for MS program research

Knowledge of WV Medicaid services and reporting requirements

Experience with Microsoft programs

Excellent verbal and written communication skills

Leadership and management training and experience

Experience with designing requirements for and testing electronic medical records systems

Quality assurance/improvement monitoring and planning

Strong work ethic, high achievement expectations for self and others

Ability to assess, plan and implement with effectiveness and efficiency

State of West Virginia
Board of Social Work

This is to certify that

CAROLINE G. DUCKWORTH, MSW

has met the requirements of this Board and regulations set forth in the West Virginia Code and is hereby licensed in the professional practice of

Social Work

at the following level:

CERTIFIED SOCIAL WORKER

subject to provisions of renewal and revocation

License Number	Effective Date	Expiration Date
[redacted]	01-Jan-15	01-Jan-17

sealed and attested

Kyta M. Brown
CHAIR

Lucy C. Estes
SECRETARY

IN WITNESS WHEREOF, The WEST VIRGINIA STATE BOARD OF SOCIAL WORK, by virtue of the authority vested in it by Article 30 of the West Virginia Code of March 18, 2011, has caused a license to be issued with its seal imprinted on the date shown above.

Hayes, Catherine

From: reciprocity1948@aol.com
Sent: Wednesday, May 20, 2015 7:22 PM
To: Hayes, Catherine
Subject: Fwd: 2015 LPC Renewal Approved-5/1/2015

-----Original Message-----
From: WVBEC, Roxanne Clay <rclay27@msn.com>
To: reciprocity1948 <reciprocity1948@aol.com>
Sent: Wed, May 20, 2015 11:06 am
Subject: 2015 LPC Renewal Approved-5/1/2015

West Virginia Board of Examiners in Counseling

815 Quarrier Street, Suite 212, Charleston, WV 25301

304.558.5494 www.wvbec.org[r20.rs6.net]

Please read this email in its entirety as it contains important information regarding your 2015 renewal.

DEAR LPC,

Your 2015 Renewal Application has been approved. Your license is current through June 30, 2017.

- Your license is valid from **5/1/2015** through 6/30/2017. Your **renewal date** for your license is documented in our LPC database as **5/1/2015.** Approved CE offerings you attend on/after this date can be counted toward the required 35 contact hours when you renew your license in 2017.
- Your renewal sticker will be mailed to your home address this week. In the meantime, all verifications of your license through the board will include the expiration date of 6/30/2017. When you receive your renewal sticker please place the sticker on your current license certificate over the

sections: "Current Renewal Date and Valid Until".

- If you haven't already done so, YOU MAY REQUEST A NEW LICENSE CERTIFICATE TO INCLUDE THE NEW EXPIRATION DATE of 6/30/2017 FOR A REPLACEMENT FEE OF $10, per Series 2, Fee Rule. If you would like a new certificate you may pay the fee via credit card on our website. You will need to forward me your email of payment confirmation and include in the email your request for a replacement certificate. If you will be mailing a $10 check or money order to the board address, please include a note that you are requesting the replacement certificate. Please allow 6-8 weeks to receive the certificate as signatures of two board members are needed for your license.

- The board uses email as the primary means of communication with the LPCs, Applicants and ALPS. If there are any changes to your email or other contact information, including employment information, please complete and forward the 'Update Form' located on our website at the 'Change Address/Name' tab. You may email your completed form to RClay27@msn.com. Thank you.

- Please take note, Per LPC Renewal Rules, Series 3, section 5, Beginning on the third renewal cycle for each licensee, the board will monitor a licensee's compliance with continuing education requirements by the use of random audit. Those selected for the random audit will be notified and required to submit a copy of their completed renewal, recording form AND copies of certificates of completion. Please review this section of Series 3 for more information. The rule can be found on our website at the 'LPC Legislatives Rules' tab.
- Please check the home page of our website for important announcements and updates.

Thank you and have a great summer!

Thank you,

Roxanne

Roxanne Clay
Assistant Executive Director
West Virginia Board of Examiners in Counseling
815 Quarrier Street, Suite 212

Charleston, WV 25301
800-520-3852
www.wvbec.org[r20.rs6.net]

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WVBEC 815 Quarrier Street · Suite 212 Charleston WV 25301

West Virginia Board of Examiners in Counseling
815 Quarrier Street, Suite 212 Charleston, WV 25301 www.wvbec.org rclay27@msn.com 800-520-3852

PLEASE READ THIS LETTER IN ITS ENTIRETY. THANK YOU.

Your 2015 renewal application has been approved. Your license is current through June 30, 2017.

Your license is valid from May 1, 2015 through June 30, 2017.
(2015 *RENEWAL DATE)

WVBEC
Valid Until
June 30, 2017

- Attached is your renewal sticker. Please place the sticker on your current licensure certificate over the sections "Current Renewal Date and Valid Until". Once the sticker is placed on the certificate the only items showing should be "License Issued" and the information on the sticker. Individuals licensed in the last two years only need to cover the section "Valid Until" with the new sticker.

- Your ***RENEWAL DATE** (shown above) for your license is documented in our LPC database. All approved offerings you attend after this date can be counted toward the required **35** contact hours when you renew your license in **2017**. **Please keep this letter for your records and include it with your 2015-2017 renewal materials.**

- The board uses email as the primary means of communication with the LPCs & Applicants. If there are any changes to your email or other contact information, including employment information, please complete and forward the **'Update Form'** located on our website at the **'Change Address/Name'** tab. You may email your completed form to RClay27@msn.com.

- Please take note, per LPC Renewal Rules, Series 3, Section 5, beginning on the third renewal cycle for each licensee, the board will monitor a licensee's compliance with the continuing education requirements by the use of a **random audit**. Those selected for the random audit will be notified and required to submit a copy of their completed renewal, recording form AND copies of certificates of completion. Please review this section of Series 3 for more information. The rule can be found on our website at the 'LPC Legislative Rules' tab.

- Please check the home page of our website periodically for important announcements and updates at **www.wvbec.org**

Thank you and have a great summer!

West Virginia Board of Examiners in Counseling

Advises all who shall read this document, that reposing special trust and confidence in the knowledge, dedication and competence of

Catherine Ann Hayes

License Number [redacted]

And in recognition of which, the Board has determined by the authority vested in it, to title the above named as a

Licensed Professional Counselor (LPC)

Approved Licensed Professional Supervisor (ALPS)

For practice in the field of Counseling as such upon enrollment thereof as provided in the West Virginia Code 30-31-5

License Issued
12/3/1993

WVBEC

Valid Until
June 30, 2017

John J. Charonko

John J. Charonko, Chair

John H. Niles

John H. Niles, Secretary

West Virginia Certification Board for Addiction and Prevention Professionals, Inc.

Emily Proctor

having given satisfactory evidence and demonstration of knowledge, skills and competency and having met all other criteria subject to the provisions of the established standards and procedures in the State of West Virginia, is hereby authorized to use the designated credential

Advanced Alcohol and Drug Counselor

given under the hands and seal by the West Virginia Certification Board for Addiction and Prevention Professionals, Inc.

this 30th *day of* September *A.D.* 2004

Angela R. Bartle
Certification Board President

Tammi Lewis
Certification Committee Chairperson

Robert Metzger
Certification Board Secretary

Certification Board Director

EXPIRES 9/30/16

Certificate No. 04-301

West Virginia Board of Examiners in Counseling

Advises all who shall read this document, that reposing special trust and confidence in the knowledge, dedication and competence of

Emily Beth Proctor

License Number [redacted]

And in recognition of which, the Board has determined by the authority vested in it, to title the above named as a

Licensed Professional Counselor (LPC)

For practice in the field of Counseling as such upon enrollment thereof as provided in the West Virginia Code 30-31-5

License Issued
1/18/2000
WVBEC
Valid Until
June 30, 2017

John J. Charonko, Chair

John H. Niles, Secretary

State of West Virginia
Board of Social Work

This is to certify that

HELEN C. SNYDER

has met the requirements of this Board and regulations set forth in the West Virginia Code and is hereby licensed in the professional practice of

Social Work

at the following level:

CERTIFIED SOCIAL WORKER

subject to provisions of renewal and revocation

License Number	Effective Date	Expiration Date
[redacted]	01-Jan-15	01-Jan-17

sealed and attested

Lita M. Brown
CHAIR

Lucy C. Estes
SECRETARY

IN WITNESS WHEREOF, The WEST VIRGINIA STATE BOARD OF SOCIAL WORK, by virtue of the authority vested in it by Article 30 of the West Virginia Code of March 18, 2011, has caused a license to be issued with its seal imprinted on the date shown above.

West Virginia Board of Examiners in Counseling

Advises all who shall read this document, that reposing special trust and confidence in the knowledge, dedication and competence of

Helen C. Snyder

License Number [redacted]

And in recognition of which, the Board has determined by the authority vested in it, to title the above named as a

Licensed Professional Counselor (LPC)

For practice in the field of Counseling as such upon enrollment thereof as provided in the West Virginia Code 30-31-5

License Issued
3/14/1988

WVBEC
Valid Until
June 30, 2017

John J. Charonko, Chair

John H. Niles, Secretary

State of West Virginia
Board of Social Work Examiners

This is to certify that

LORI A. MCGURTY

has met the requirements of this Board and regulations set forth in the West Virginia Code and is hereby licensed to the practice of the profession

Social Work

at the following level

SOCIAL WORKER

subject to provisions of rules and regulations

License Number	Effective Date	Expiration Date
[redacted]	01-Mar-14	01-Mar-16

sealed and attested

[redacted]
CHAIR

[redacted]
SECRETARY

IN WITNESS WHEREOF, The WEST VIRGINIA STATE BOARD OF SOCIAL WORK EXAMINERS, by virtue of the authority vested in it by Article 30 of the West Virginia Code of March 19, 2013, has caused a license to be issued with its seal impressed on the date shown above.

WEST VIRGINIA
STATE TAX DEPARTMENT
BUSINESS REGISTRATION CERTIFICATE

ISSUED TO:
APS HEALTHCARE QUALITY REVIEW, INC.
DBA KEPRO
100 CAPITOL ST 600
CHARLESTON, WV 25301-2674

BUSINESS REGISTRATION ACCOUNT NUMBER: **2319-7915**

This certificate is issued on: **10/14/2015**

This certificate is issued by
the West Virginia State Tax Commissioner
in accordance with Chapter 11, Article 12, of the West Virginia Code

The person or organization identified on this certificate is registered to conduct business in the State of West Virginia at the location above.

This certificate is not transferrable and must be displayed at the location for which issued

This certificate shall be permanent until cessation of the business for which the certificate of registration was granted or until it is suspended, revoked or cancelled by the Tax Commissioner.

Change in name or change of location shall be considered a cessation of the business and a new certificate shall be required.

TRAVELING/STREET VENDORS: Must carry a copy of this certificate in every vehicle operated by them. CONTRACTORS, DRILLING OPERATORS, TIMBER/LOGGING OPERATIONS: Must have a copy of this certificate displayed at every job site within West Virginia.

atL006 v.4
L0107212096

State of West Virginia

Certificate

I, Natalie E. Tennant, Secretary of State of the State of West Virginia, hereby certify that

APS HEALTHCARE QUALITY REVIEW, INC.

has filed a "Certificate of Registration of Trade Name" in my office according to the provisions of Chapter 47 of the West Virginia Code and was found to conform to law.

Therefore, I hereby issue this

CERTIFICATE OF REGISTRATION OF TRADE NAME

authorizing it to transact business in West Virginia under the assumed name of

KEPRO

Given under my hand and the Great Seal of the State of West Virginia on this day of September 17, 2015

Natalie E Tennant

Secretary of State

Natalie E. Tennant
Secretary of State
1900 Kanawha Blvd E
Bldg 1, Suite 157-K
Charleston, WV 25305

FILED
SEP 17 2015
IN THE OFFICE OF
SECRETARY OF STATE

Penney Barker, Manager
Business & Licensing Division
Tel: (304)558-8000
Fax: (304)558-8381
Website: www.wvsos.com
E-mail: business@wvsos.com

Office Hours: Monday – Friday
8:30 a.m. – 5:00 p.m. ET

FILE ONE ORIGINAL
(Two if you want a filed date stamped copy returned to you)
FEE: $25.00

APPLICATION FOR TRADE NAME (DBA)

1. The **name of the company** applying to register a **Trade Name (DBA)** is: APS Healthcare Quality Review, Inc.

2. The above company is applying to do business within West Virginia under the following **Trade Name (DBA):** APS Healthcare Quality Review, Inc. d/b/a KEPRO

3. The **address** of the **principal office:**
   Address 1: 777 East Park Drive
   Address 2:
   City/State/Zip: Harrisburg, PA 17111

4. The **name, address, signature** and **title** of the person having authority to make application:
   Name: Joseph A. Dougher
   Street: 777 East Park Drive
   City/State/Zip: Harrisburg, PA 17111

5. Is the company operating as a **franchise?** ☐ **Yes** (If "Yes," attach page one of the Franchise Agreement.) ☑ **No**

6. Contact Person Name: Joseph A. Dougher Contact Phone #: (717) 564-8288

7. **Signature***: _____ **Title:** President & CEO **Date:** 9/14/2015

Important Legal Notice Regarding Signature:
Corporations/Voluntary Associations/Business Trusts/Unincorporated Nonprofit Associations/Limited Partnerships - Per West Virginia Code §31D-1-129. Penalty for signing false document. Any person who signs a document he or she knows is false in any material respect and knows that the document is to be delivered to the Secretary of State for filing is guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than one thousand dollars or confined in the county or regional jail not more than one year, or both. **Limited Liability Companies/Limited Liability Partnerships - Per West Virginia Code §31B-2-209. Liability for false statement in filed record.** If a record authorized or required to be filed under this chapter contains a false statement, one who suffers loss by reliance on the statement may recover damages for the loss from a person who signed the record or caused another to sign it on the person's behalf and knew the statement to be false at the time the record was signed.

BEFORE you fill out the application: The name you select will be approved **only** if it is available—that is, if the name is not the same as and is distinguishable from any other name which has been reserved or filed with the Secretary of State. Before you prepare this application, call the Business & Licensing Division at (304)558-8000 to find out if the name you have chosen is available. A telephone check on availability of a name is not a guarantee, but it will help find a name you can use. As required by §47-8-4 of the West Virginia Code, corporations, associations, limited partnerships, limited liability partnerships, business trusts, and limited liability companies may not conduct business under a trade name or assumed name without first filing an application for registration of trade name with the Secretary of State.

Franchises: If filing as part of a Franchise, you must include a copy of the first page of the Franchise Agreement with this application. The application will be returned to you as incomplete if page one of the Franchise Agreement is not attached.

Important Note: This form is a public document. Please do **NOT provide any personal identifiable information on this form** such as social security number, bank account numbers, credit card numbers, tax identification or driver's license numbers.

SEND THE APPLICATION TO THE ADDRESS AT THE TOP OF THE APPLICATION
FILING FEE -- $25 Make checks payable to *West Virginia Secretary of State.*

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
March USA Inc. Six PPG Place, Suite 300 Pittsburgh, PA 15222 Attn: Pittsburgh.certificates@marsh.com	PHONE (A/C, No, Ext): FAX (A/C, No):
1223-20148-Prop-15-16	E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE / NAIC #
	INSURER A: Hartford Accident and Indemnity Company
INSURED Keystone Peer Review Organization, Inc. Attention: Barb Strange 777 E Park Dr Harrisburg, PA 17111	INSURER B: N/A / N/A
	INSURER C: Hartford Underwriters Insurance Company / 30104
	INSURER D:
	INSURER E:
	INSURER F:

COVERAGES CERTIFICATE NUMBER: 15-16 Master 6 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:			10 UUN AT 2015	01/01/2015	01/01/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG $	$ 1,000,000 $ 300,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS			10 UUN AT 2015	01/01/2015	01/01/2016	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ 1,000,000 $ $ $ $
	UMBRELLA LIAB EXCESS LIAB DED RETENTION $						EACH OCCURRENCE AGGREGATE $	$ $ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N N	N/A	10 WE AU2 2015	01/01/2015	01/01/2016	X STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
A	Property			10 UUA XD1208 Deductible $2,000	01/01/2015	01/01/2016	Business Income Rented Personal Property	$250,000 $ 1,500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Per request re: Property other deductibles may apply as per policy terms and conditions.

CERTIFICATE HOLDER

Keystone Peer Review Organization, Inc.
777 E. Park Drive
Harrisburg, PA 17111

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Maureen Wahrenjee

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AGENCY CUSTOMER ID: 102336743

LOC #: Pittsburgh

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAIC CODE
Marsh USA Inc.	
POLICY NUMBER	

NAMED INSURED

Keystone Tax Exempt Organization, Inc.
Attention: Mark Wagner
1717 S Park Dr.
Harrisburg, PA 17104

EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM.

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Additional Named Insureds include the following:

Keystone Tax Exempt Organization, Inc.
AHS Healthcare Holdings, Inc.
AHS Healthcare, Inc.
Innovative Resource Group, LLC
AHS Healthcare Quality Assurance, Inc.
AHS TSC Acquisition, Inc.

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

Center for Clinical Standards and Quality

JUL 08 2014

Stephen J. Schlager
Senior Vice President
APS Healthcare
44 South Broadway, Suite 1200
White Plains, New York 10601

Dear Mr. Schlager:

We have reviewed your application of June 25, 2014, requesting that the Centers for Medicare & Medicaid Services certify APS Healthcare as a Quality Improvement Organization (QIO)-like entity for the State of New York. As a result of this review, we have determined that APS Healthcare meets the requirements to be a QIO-like entity, namely:

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

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

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

Your certification is granted for a period of 5 years and will expire on June 25, 2019.

This certification of eligibility permits your organization to seek a contract with the states for review activities within the requirements. In addition, states have specific qualifications and performance requirements depending upon the scope of work they desire to procure. This certification does not reflect a determination as to whether your organization has the ability to meet those requirements. The state is responsible for making that determination. We have certified your organization to review cases and analyze patterns of care related to medical necessity and quality review. We have not certified the organization as meeting the State Medicaid Agency's requirements for external quality review or related functions such as utilization review specified in 1903 (a) (3) (c) and 1932 (c)(2) of the Act. In addition, we have not evaluated the organization to perform the same functions as a QIO under contract with CMS.

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

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

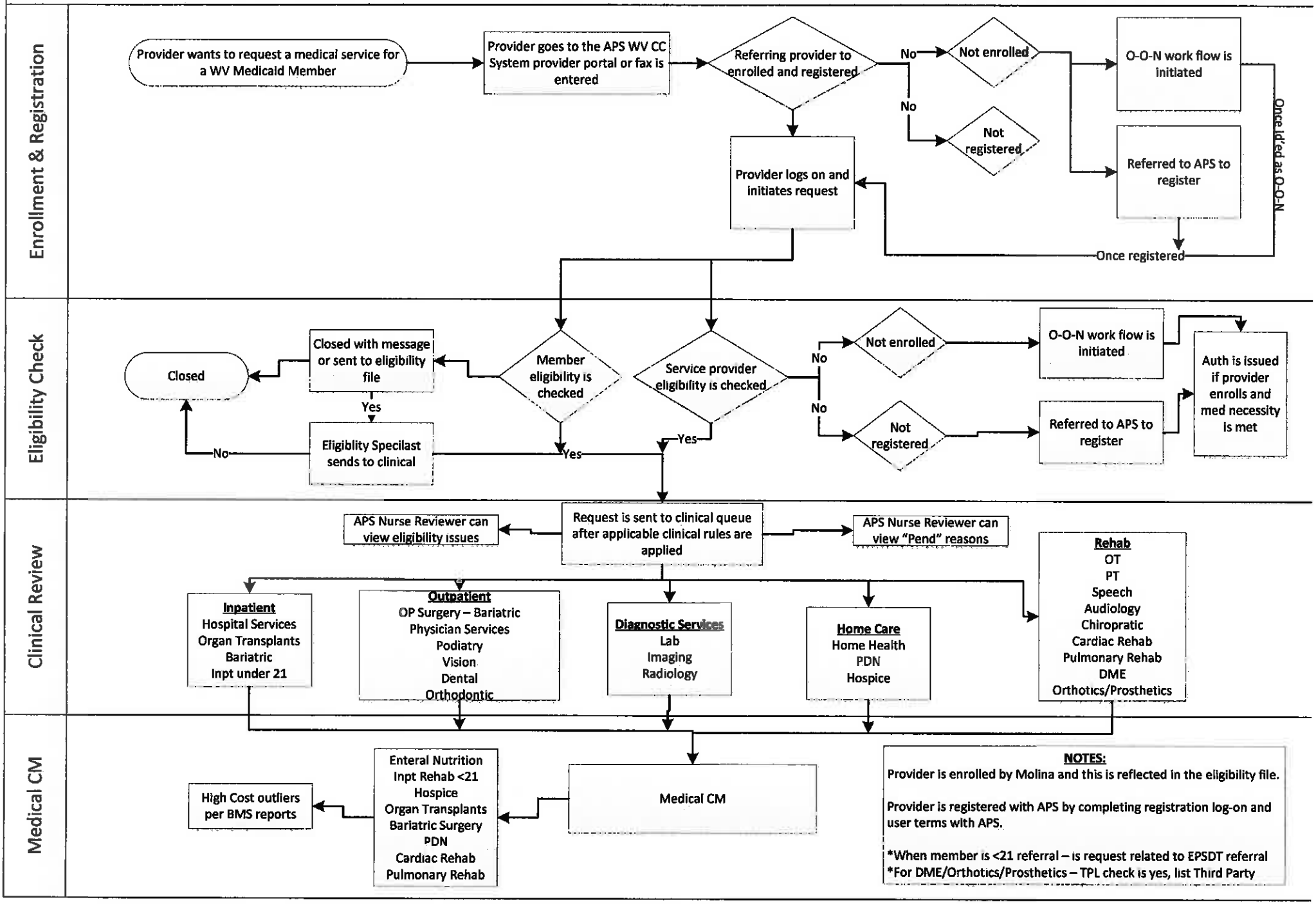
If you have questions, please contact Malinda Greene of my staff on (410) 786-7829 or Email, malinda.greene@cms.hhs.gov.

Sincerely,

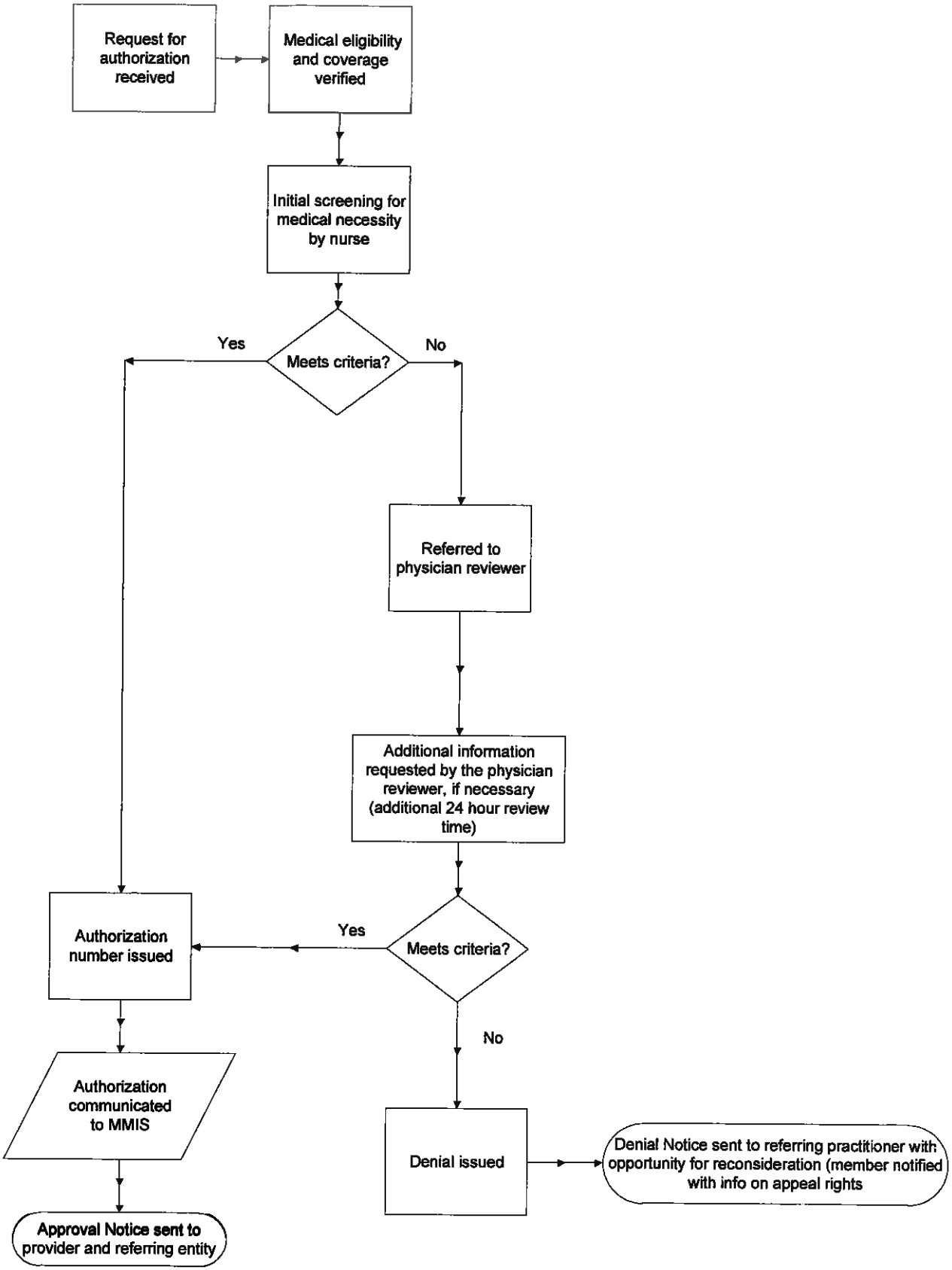
For

Jean Moody-Williams, RN, MPP
Director
Quality Improvement Group
Center for Clinical Standards and Quality

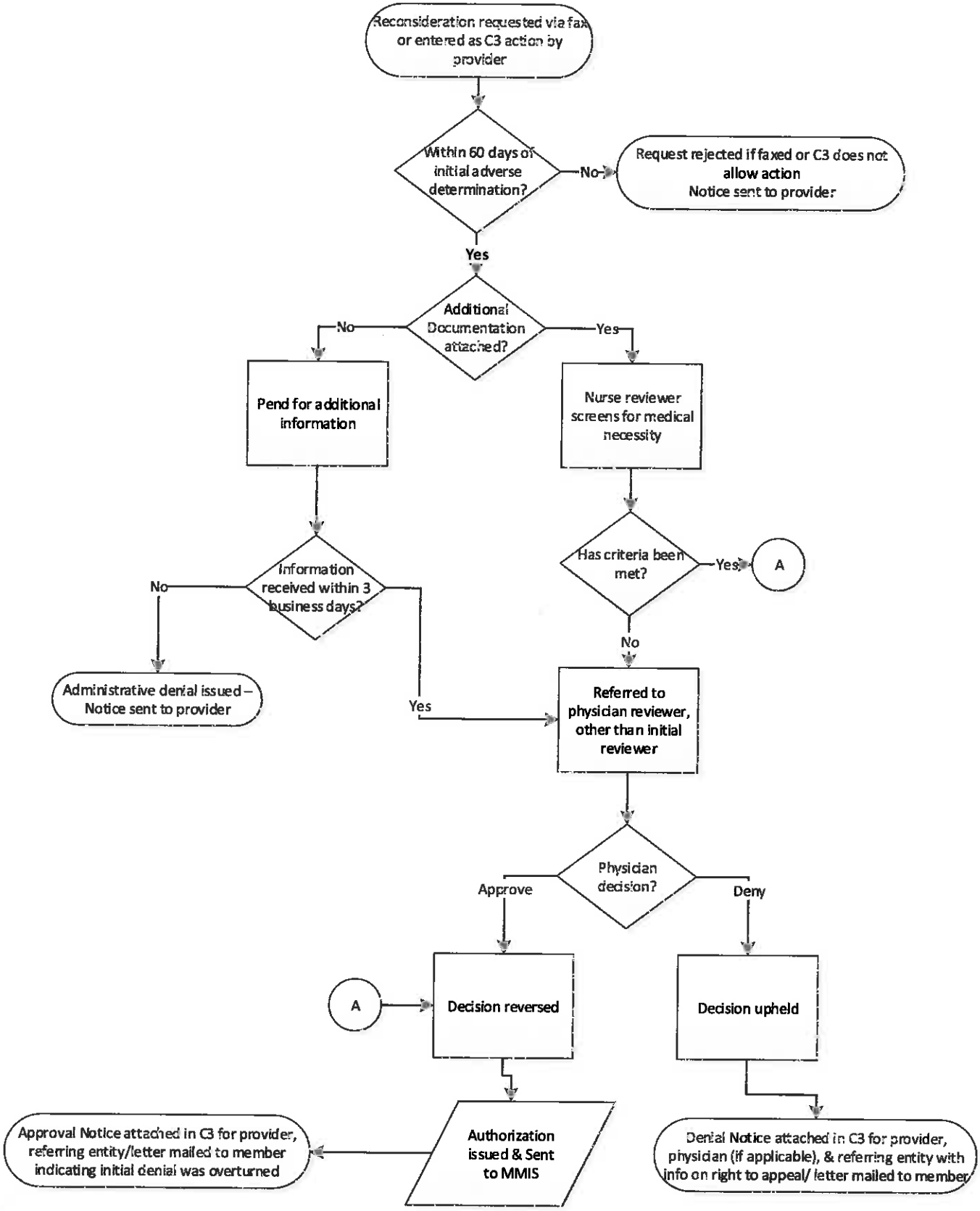
Medical Utilization Managment



Authorization/Denial Process



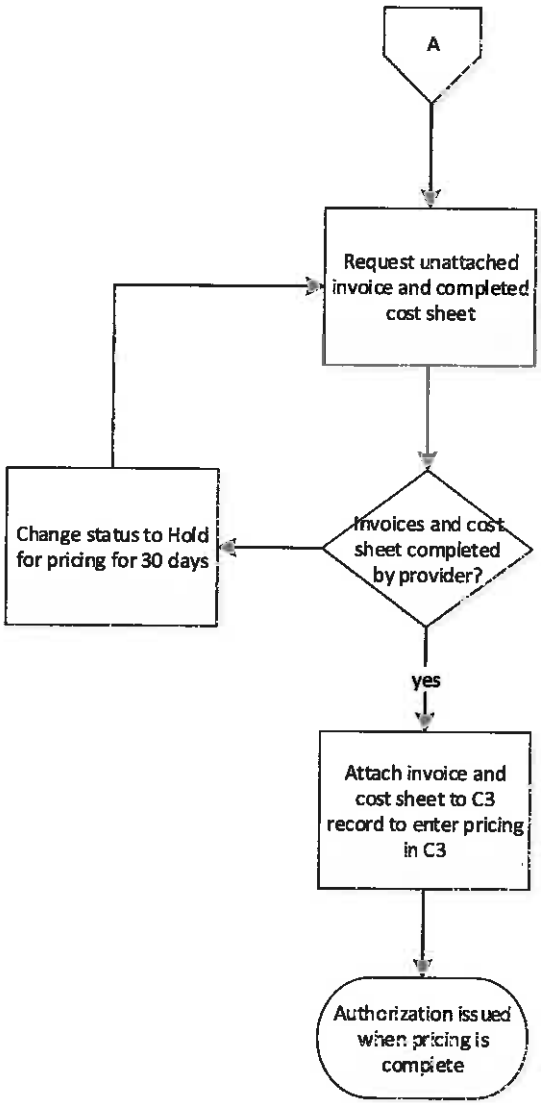
Inpatient Reconsideration Process (Level II)



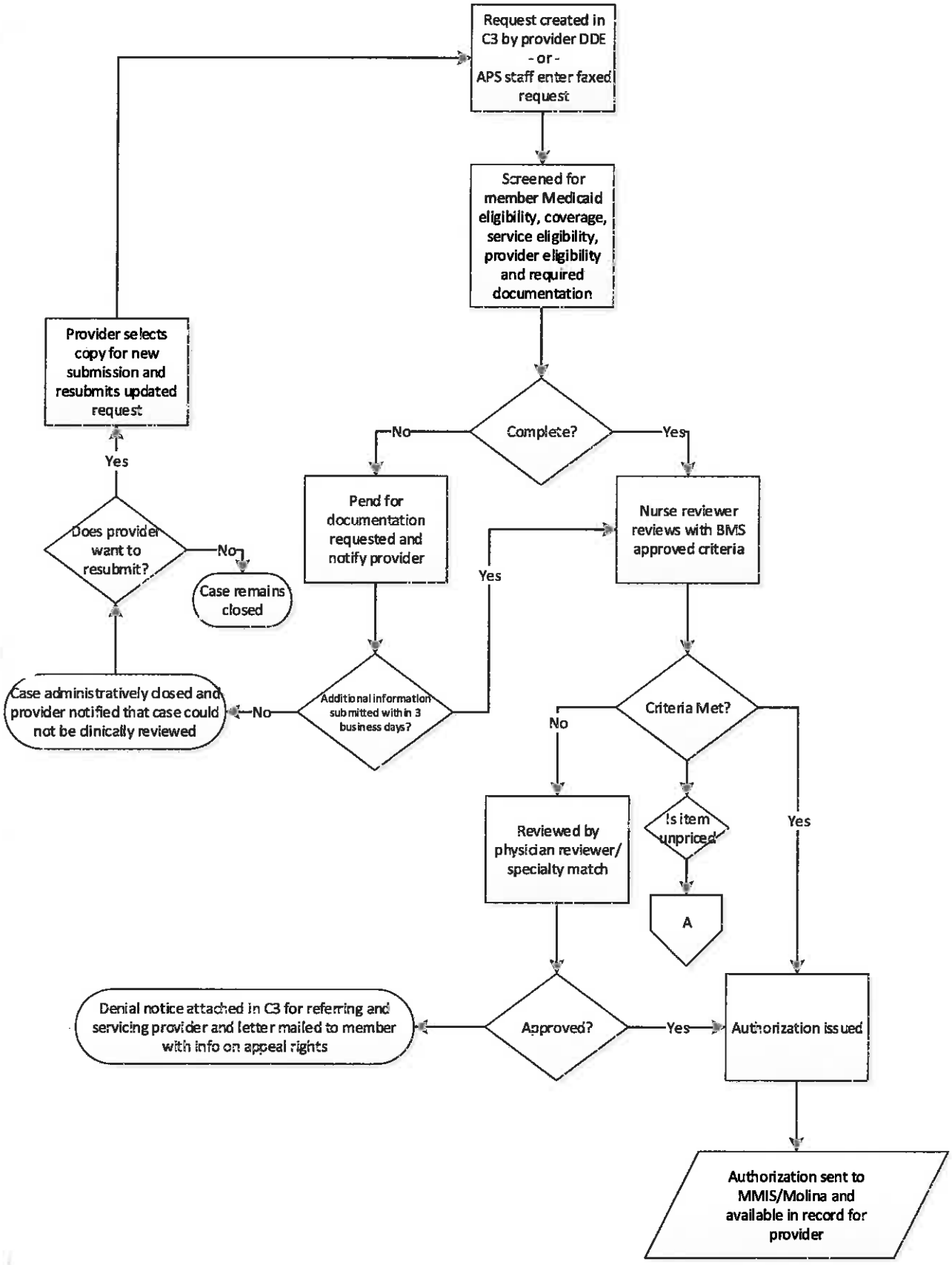
Retrospective Review Submission Policy

- In general, providers have 10 business days from the date of admission/first date of service to submit a prior authorization request;
- There are EXCEPTIONS to this policy (e.g. DME Policy Chapter indicates equipment/supplies CANNOT be place before prior authorization is obtained). In these instances the provider must obtain prior authorization before service is rendered;
- After the 10 business day period has elapsed from the selected service start date prior authorization is NOT available as a selection and retrospective review must be selected. The Retrospective Review Policy will be applied to requests submitted after this time period and any request not meeting policy will be administratively closed and will NOT be medically reviewed.
- For any Medicaid member retrospective review is allowed when:
    - Retroactive Medicaid- requests may be submitted for services rendered previously if Medicaid coverage is backdated to include the date of the service;
    - TPL- an EOB or certificate of non-coverage must be submitted with the request in instances where the service is denied by the primary payer for a Medicaid covered service;
    - In instances where the APS system is inaccessible (this would be announced to all providers) or the provider has approved leniency from BMS due to a systems issue (e.g. computer system failure, fire etc.).

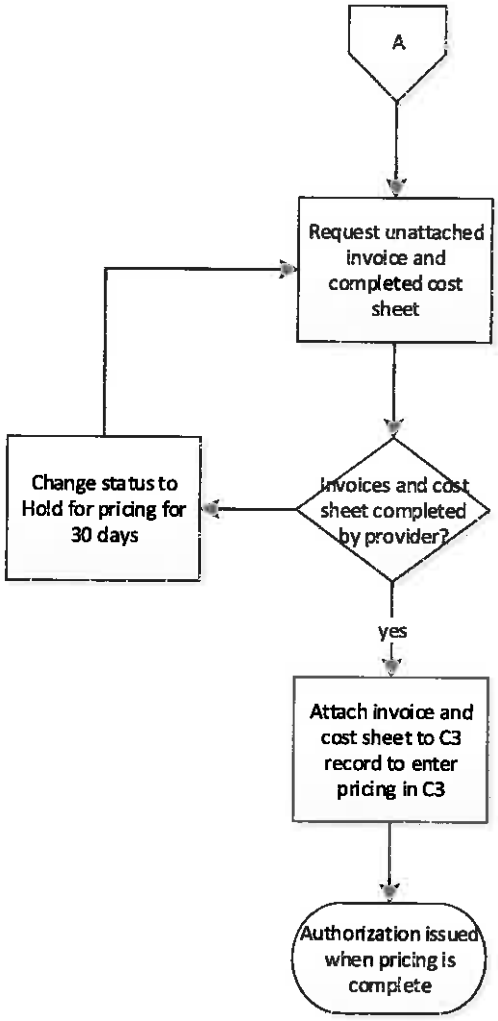
DME/Orthotic & Prosthetic (DMEPOS) Pricing



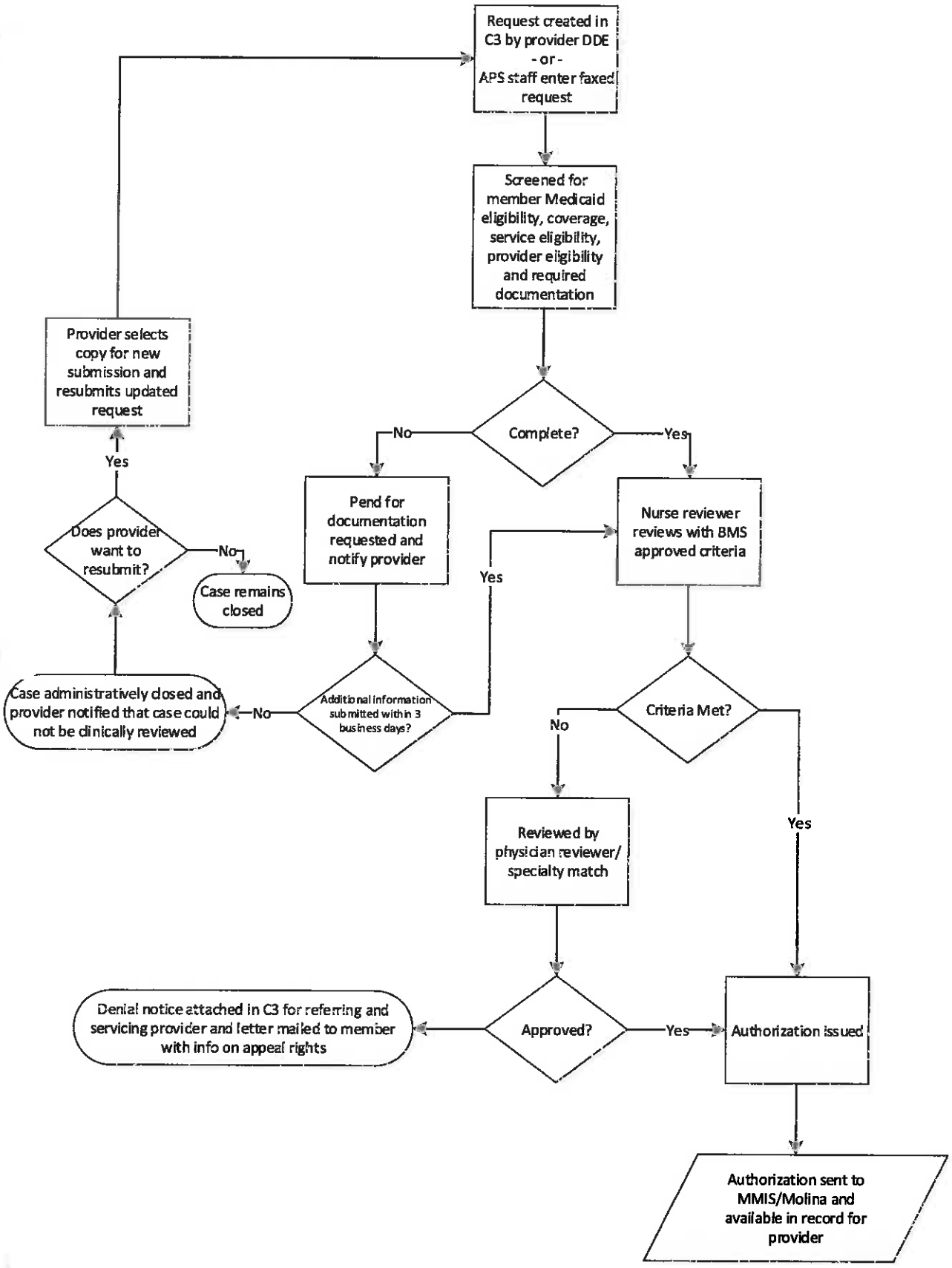
DME/Orthotics & Prosthetics (DMEPOS)
Orthotic and Prosthetics



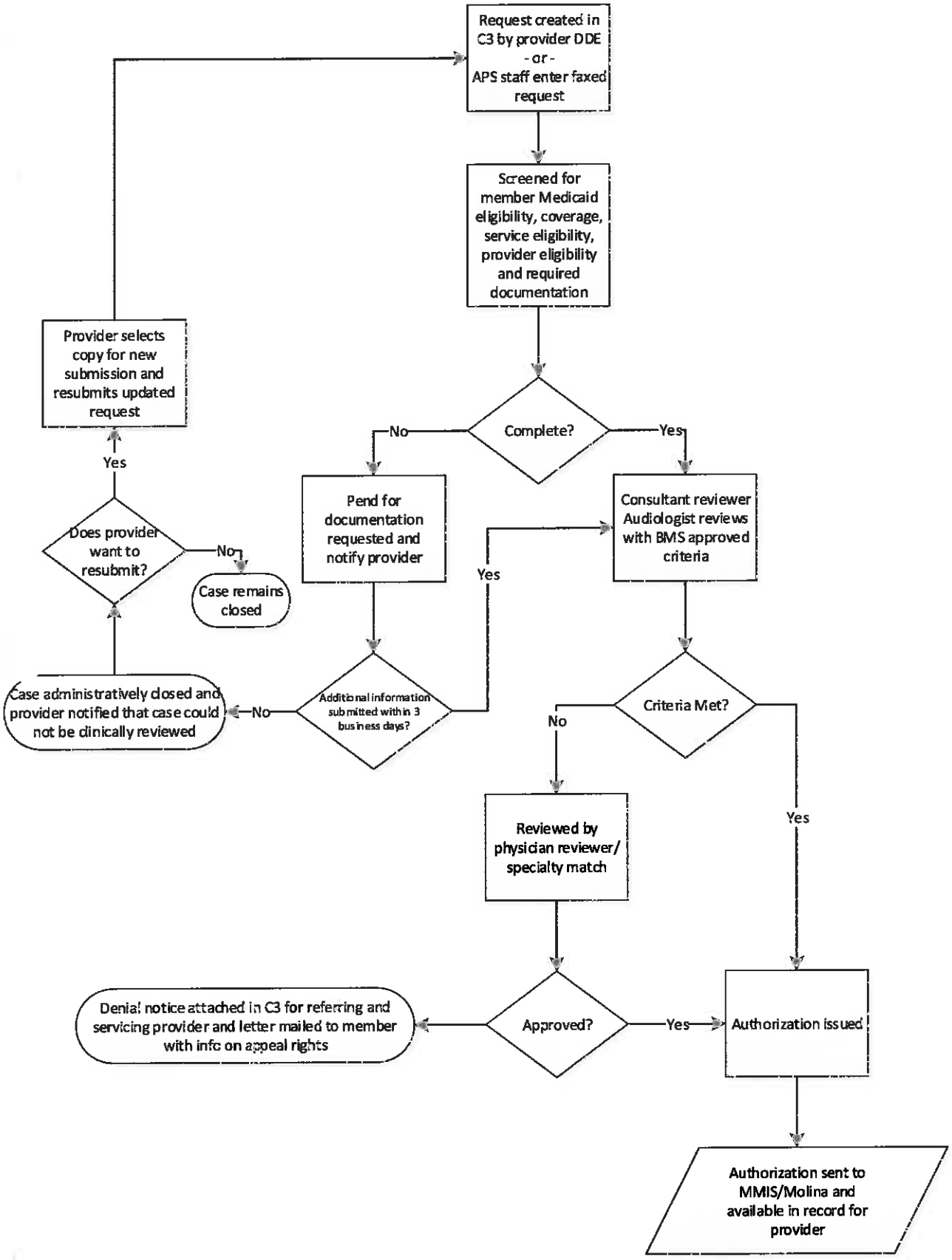
DME/Orthotic & Prosthetic (DMEPOS) Pricing



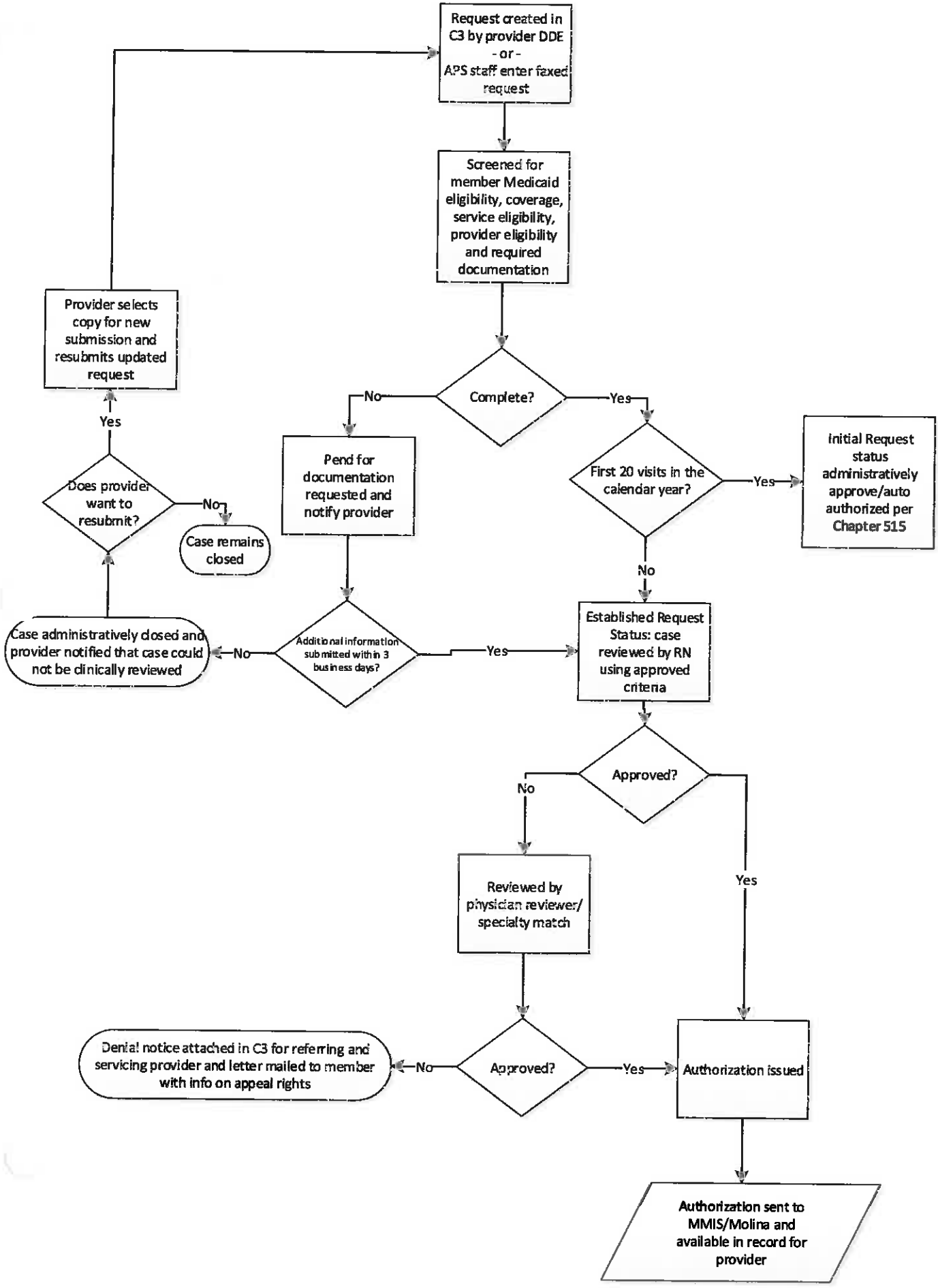
Vision Services



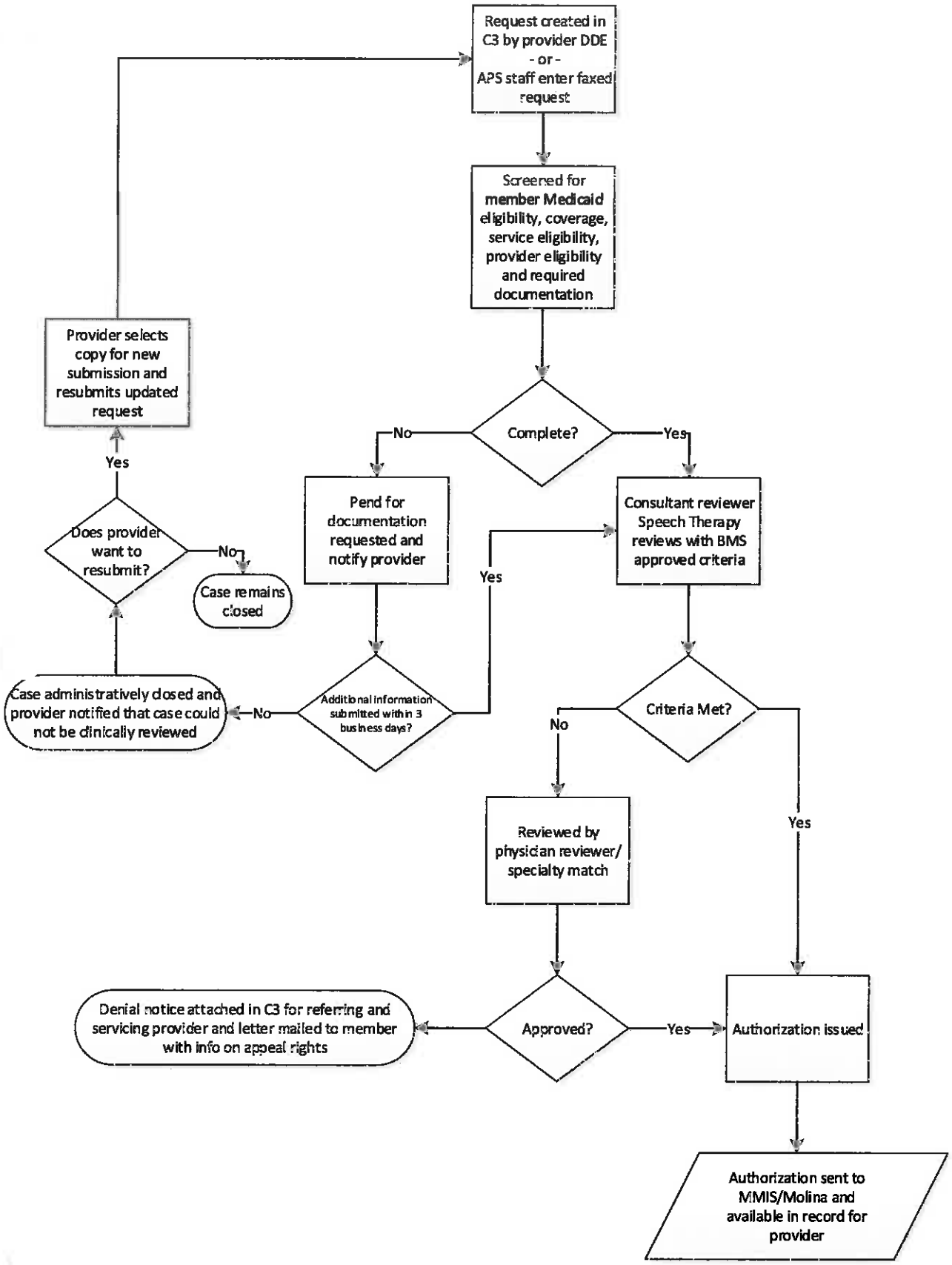
Audiologist Services



Physical, Occupational, Speech Therapy
Physical Therapy/Occupational Therapy (PT/OT)

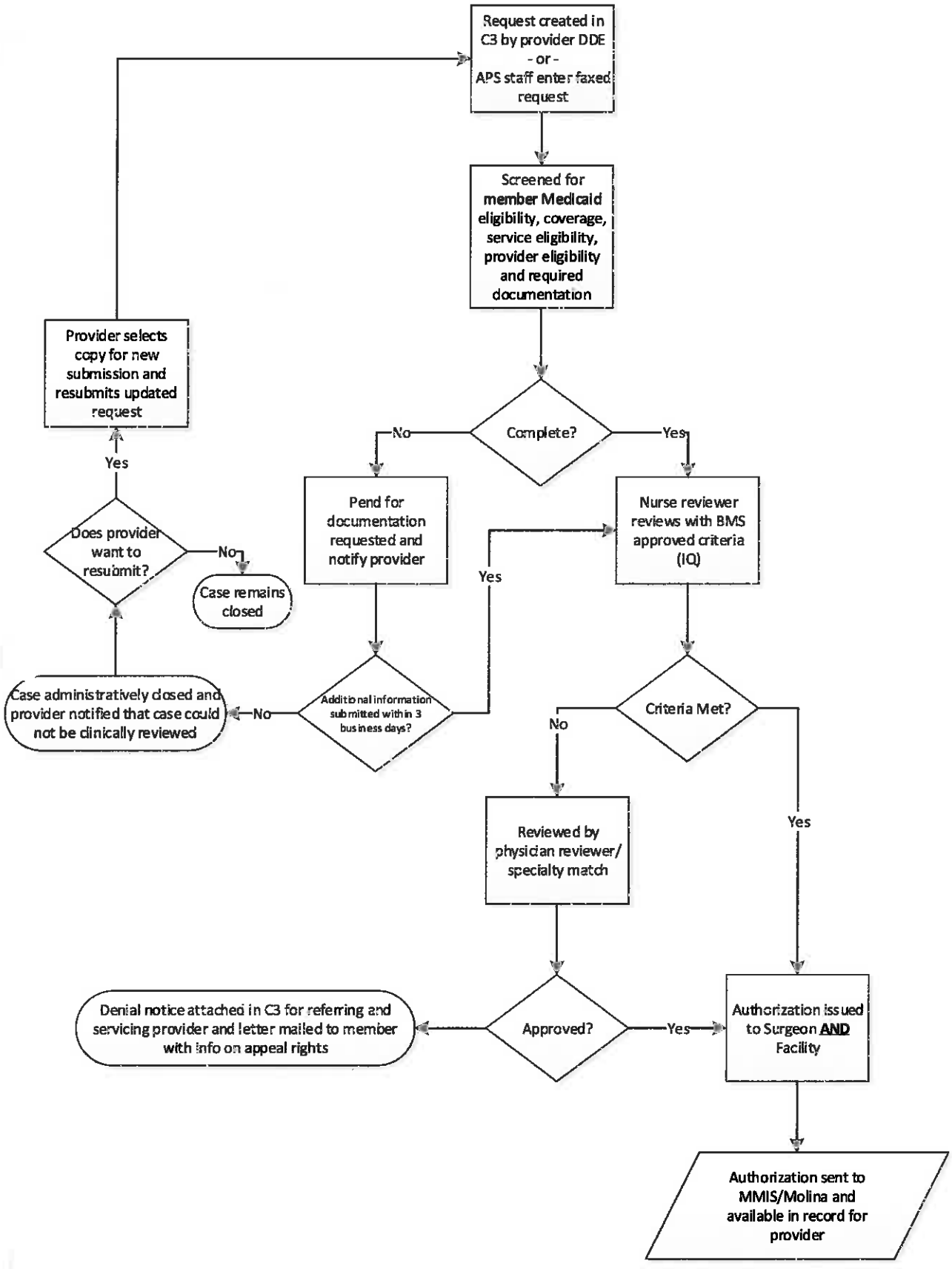


Physical, Occupational, Speech Therapy
Speech Therapy

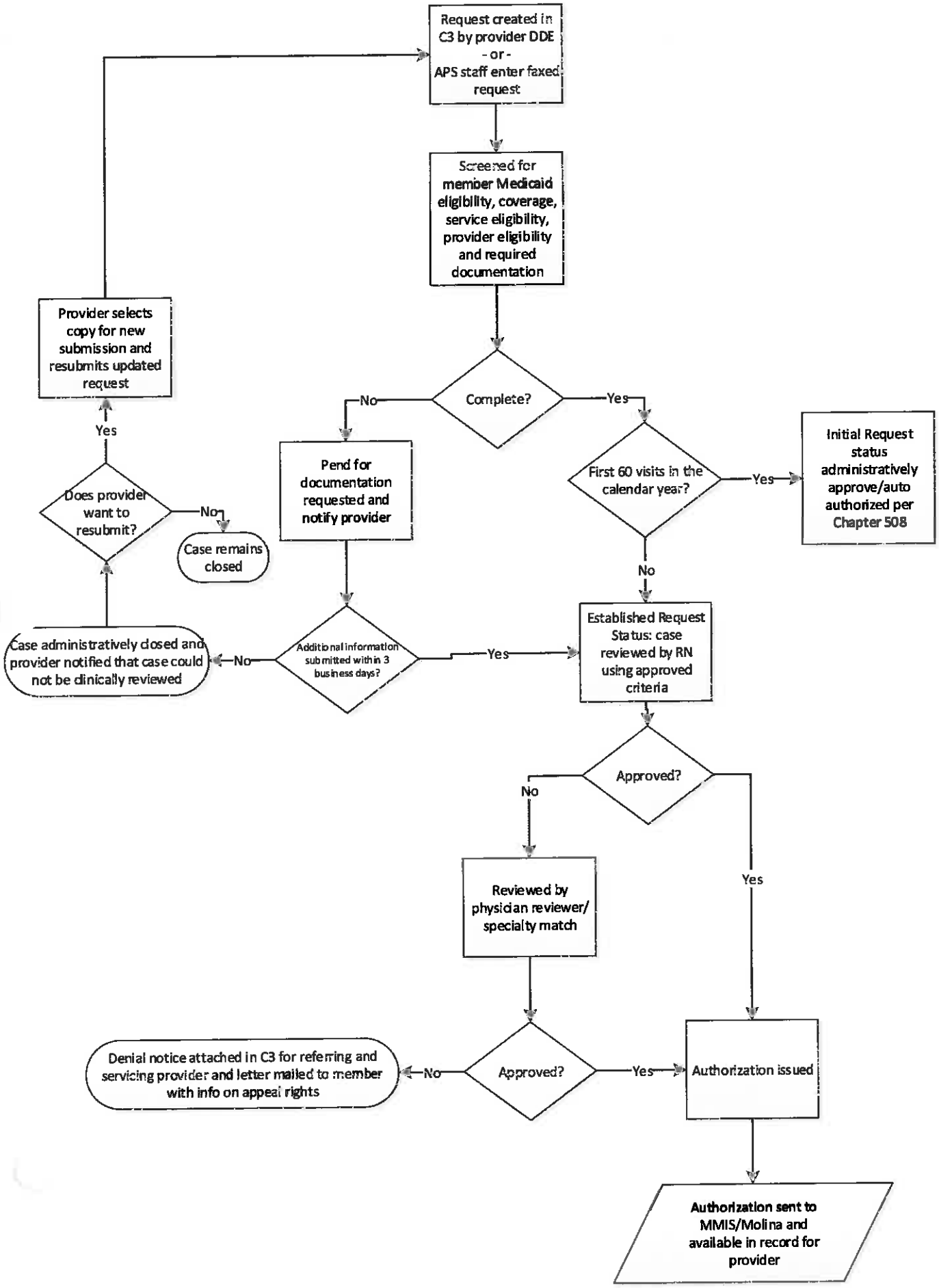


Physician & Non-Physician Practitioner Services

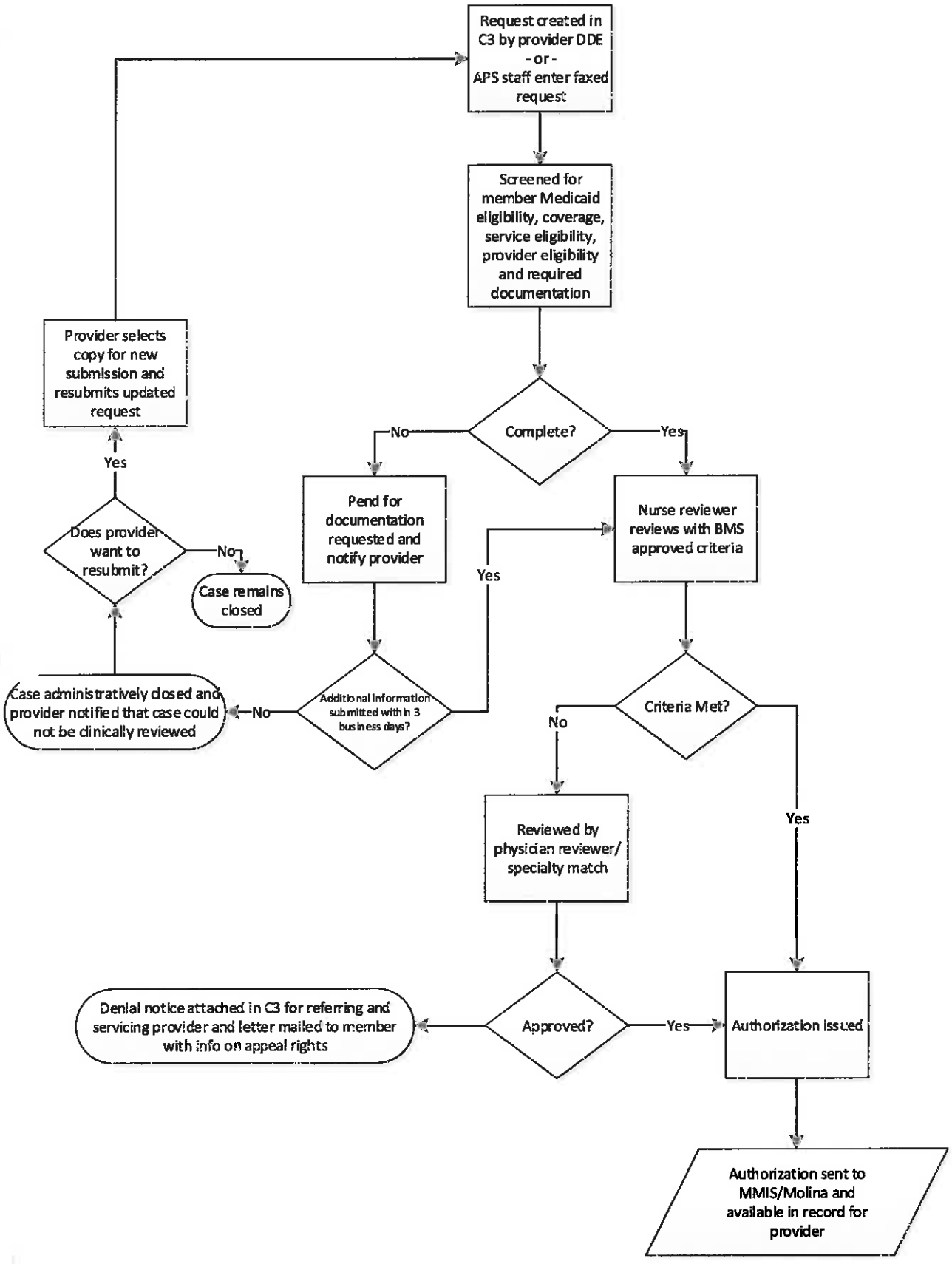
Currently Practitioner Services (OP Surgery & Bariatric Procedures 519.4)



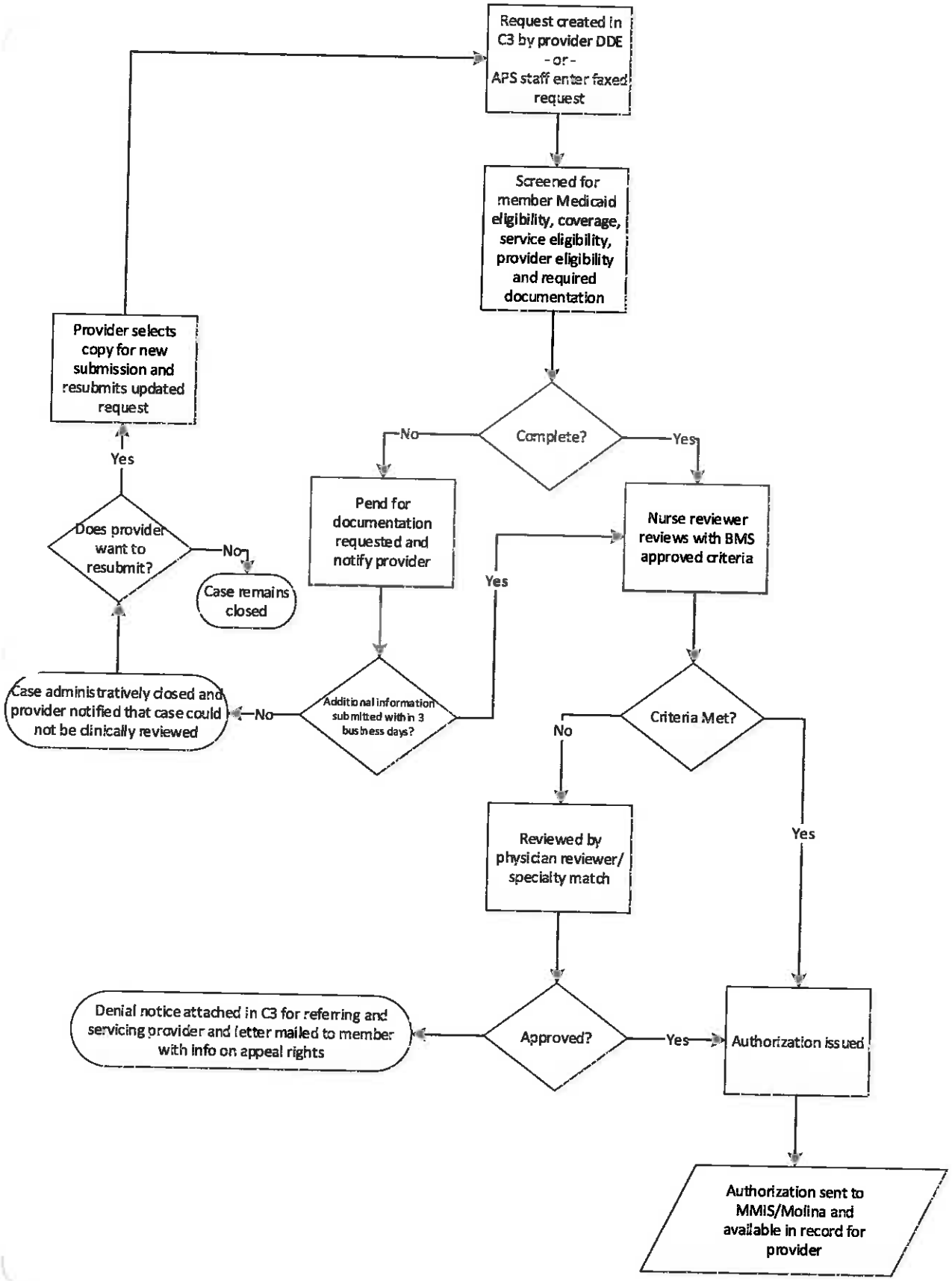
Home Health Services



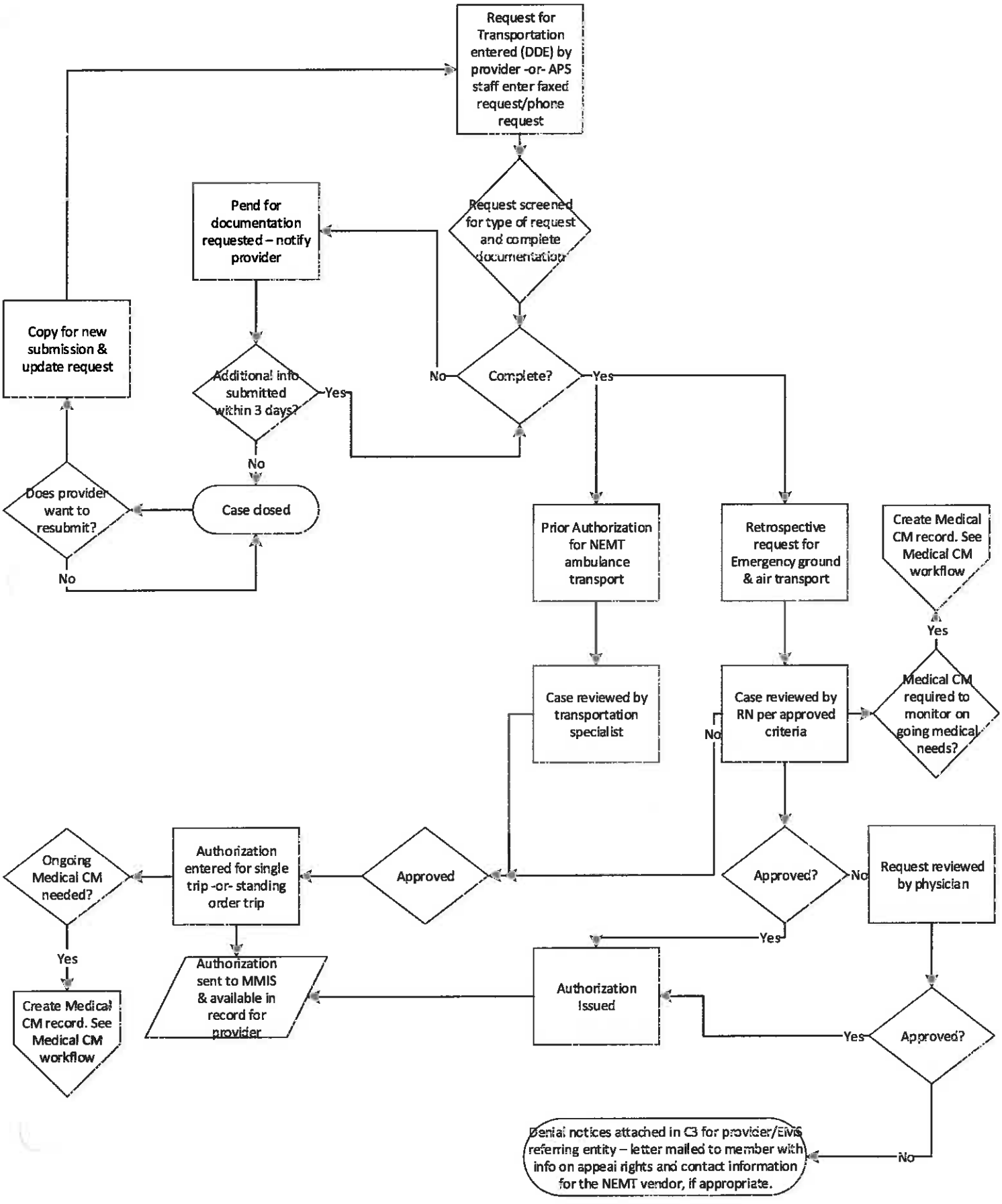
Private Duty Nursing Services



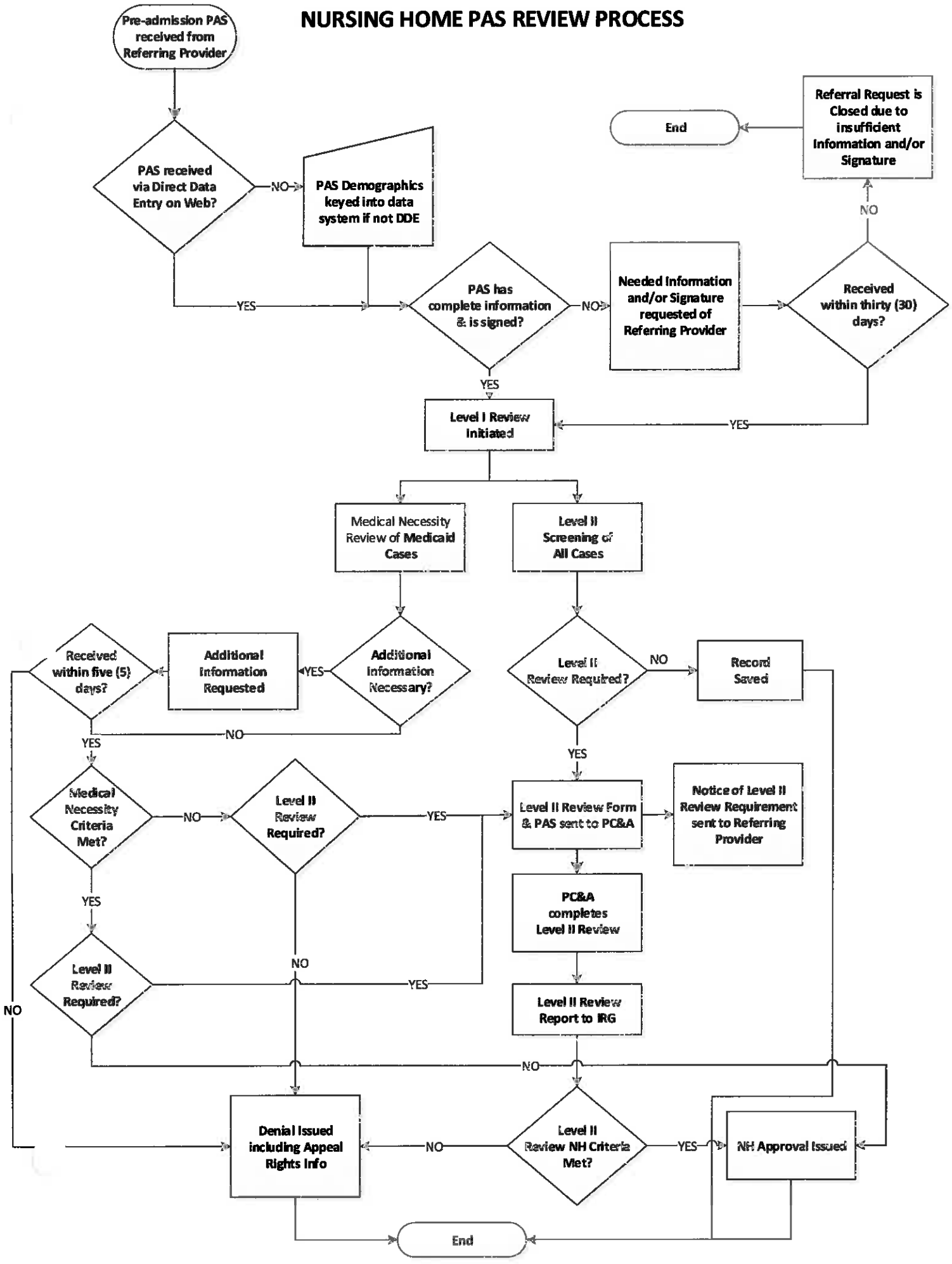
Diagnostic Imaging/Radiology Services



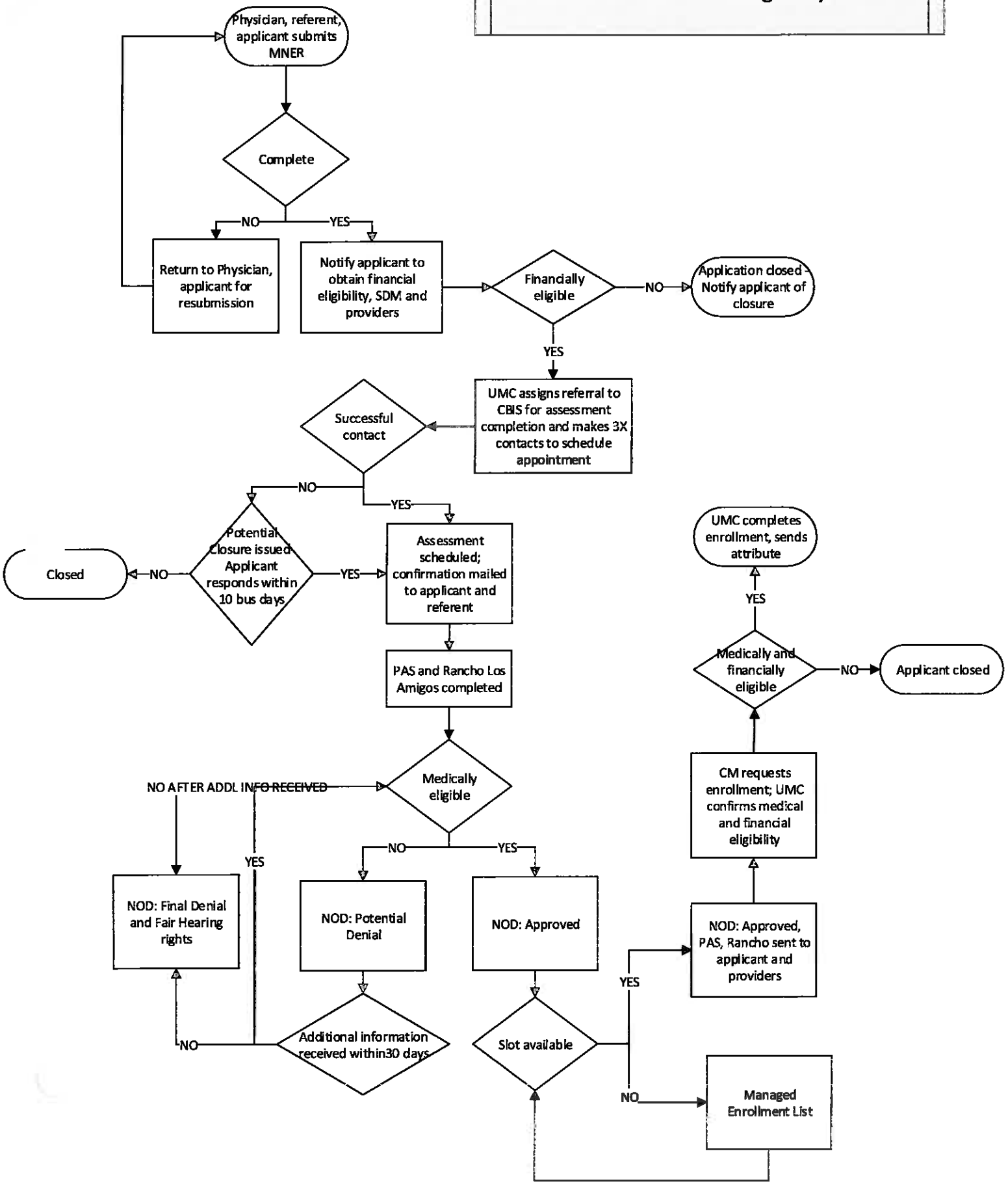
Transportation
(NEMT Ambulance/Emergency Ground & Air Transport)



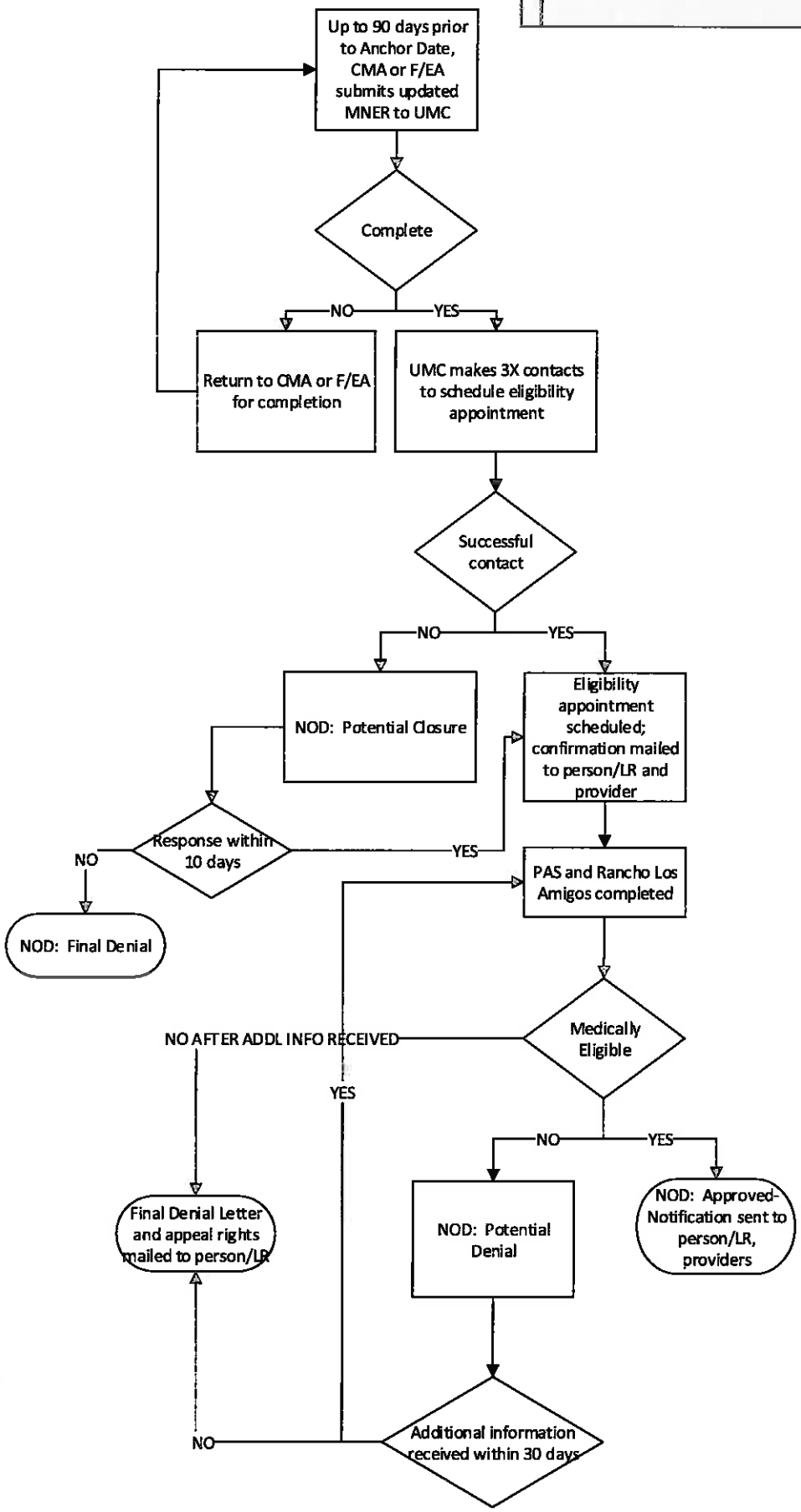
NURSING HOME PAS REVIEW PROCESS



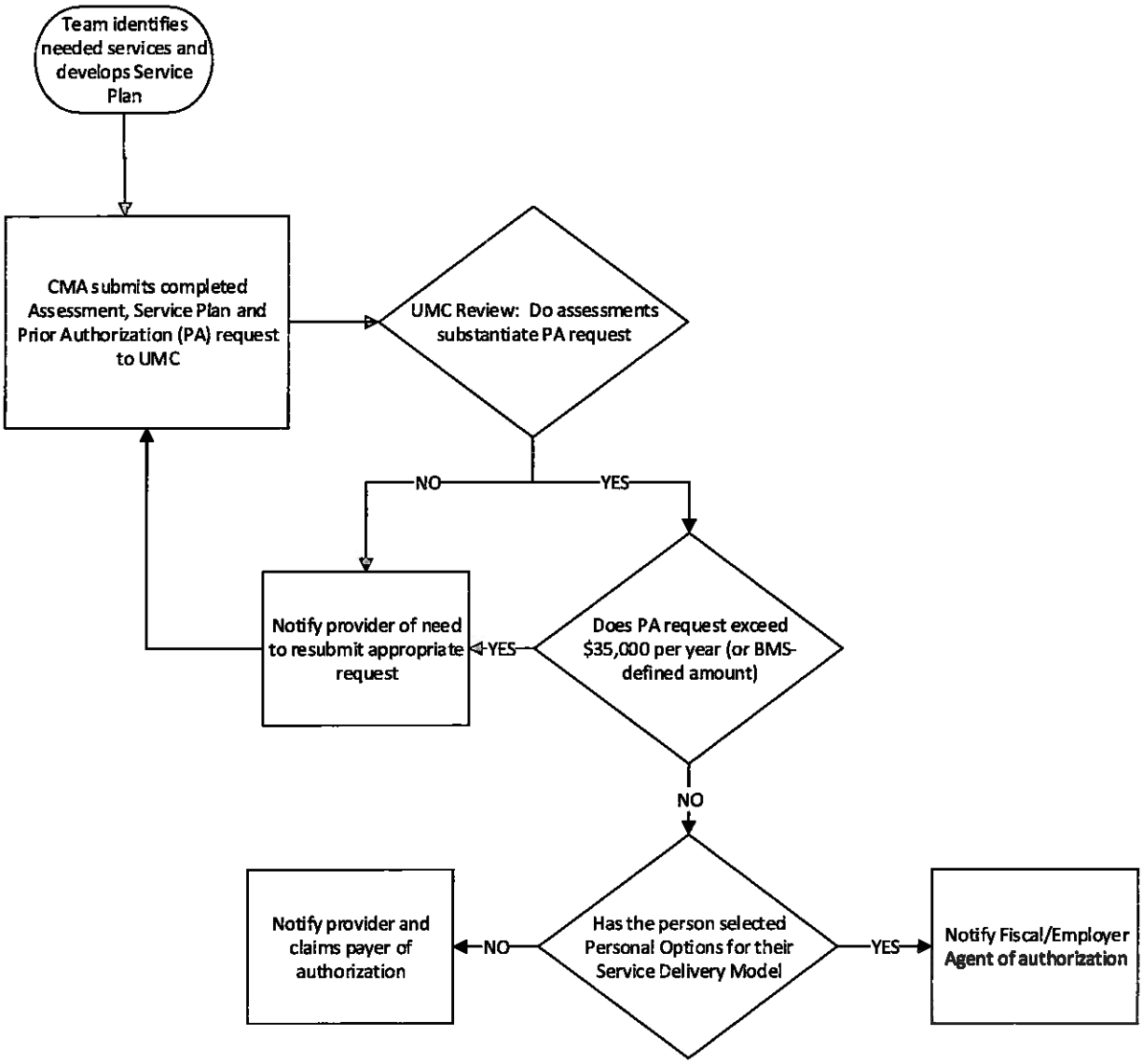
Traumatic Brain Injury Waiver
Initial Medical Eligibility



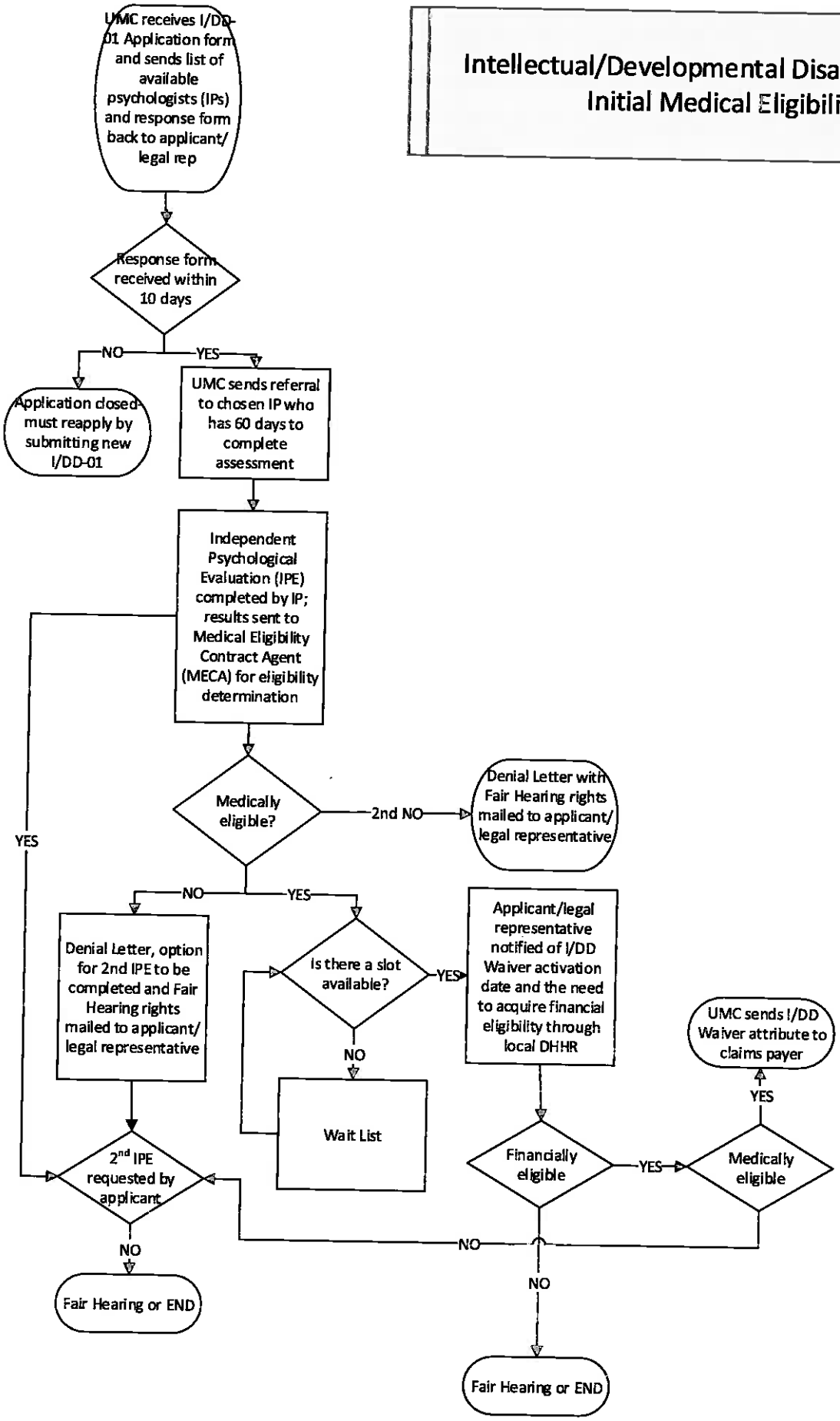
Traumatic Brain Injury Waiver
Reevaluation of Medical Eligibility



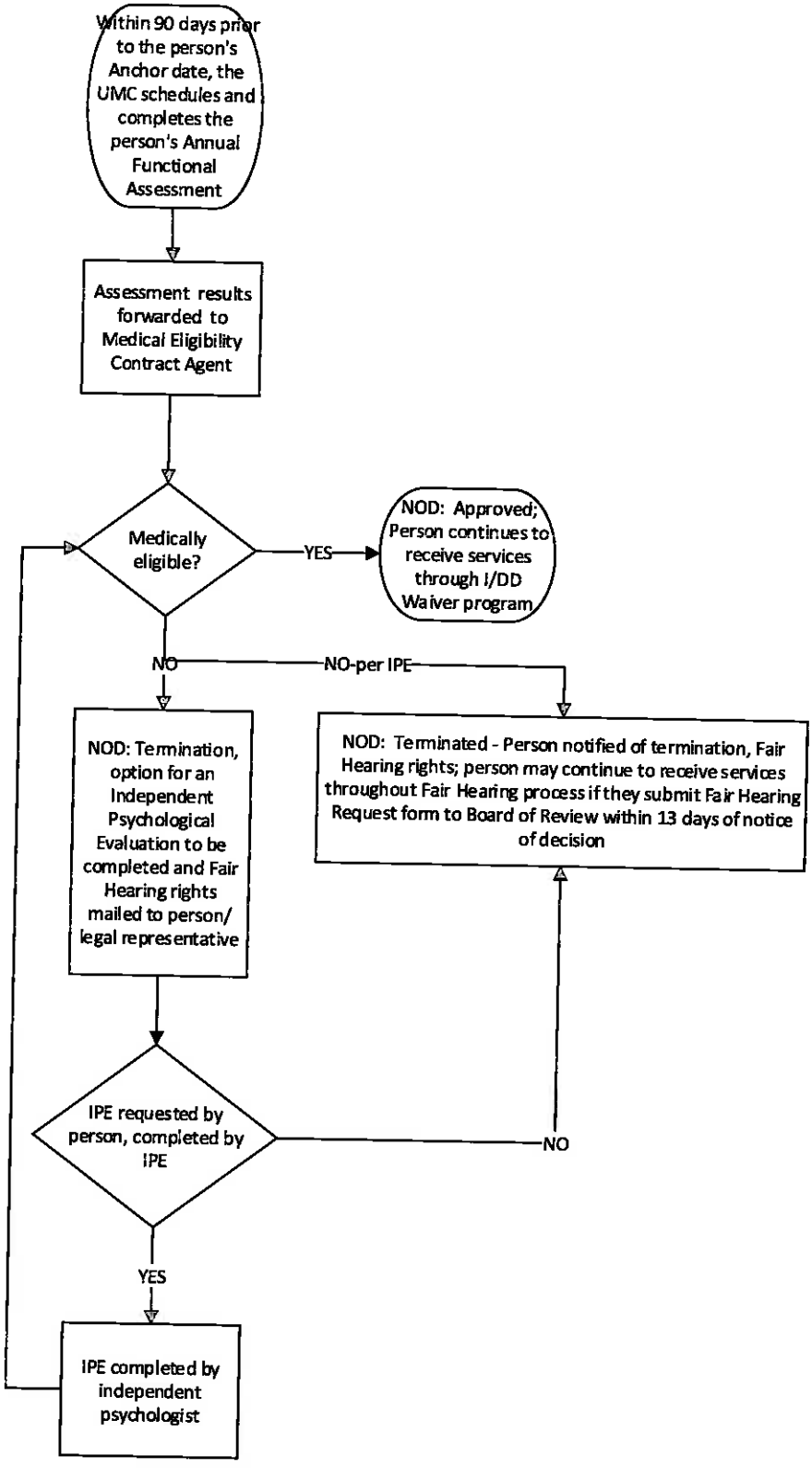
Traumatic Brain Injury Waiver Prior Authorization



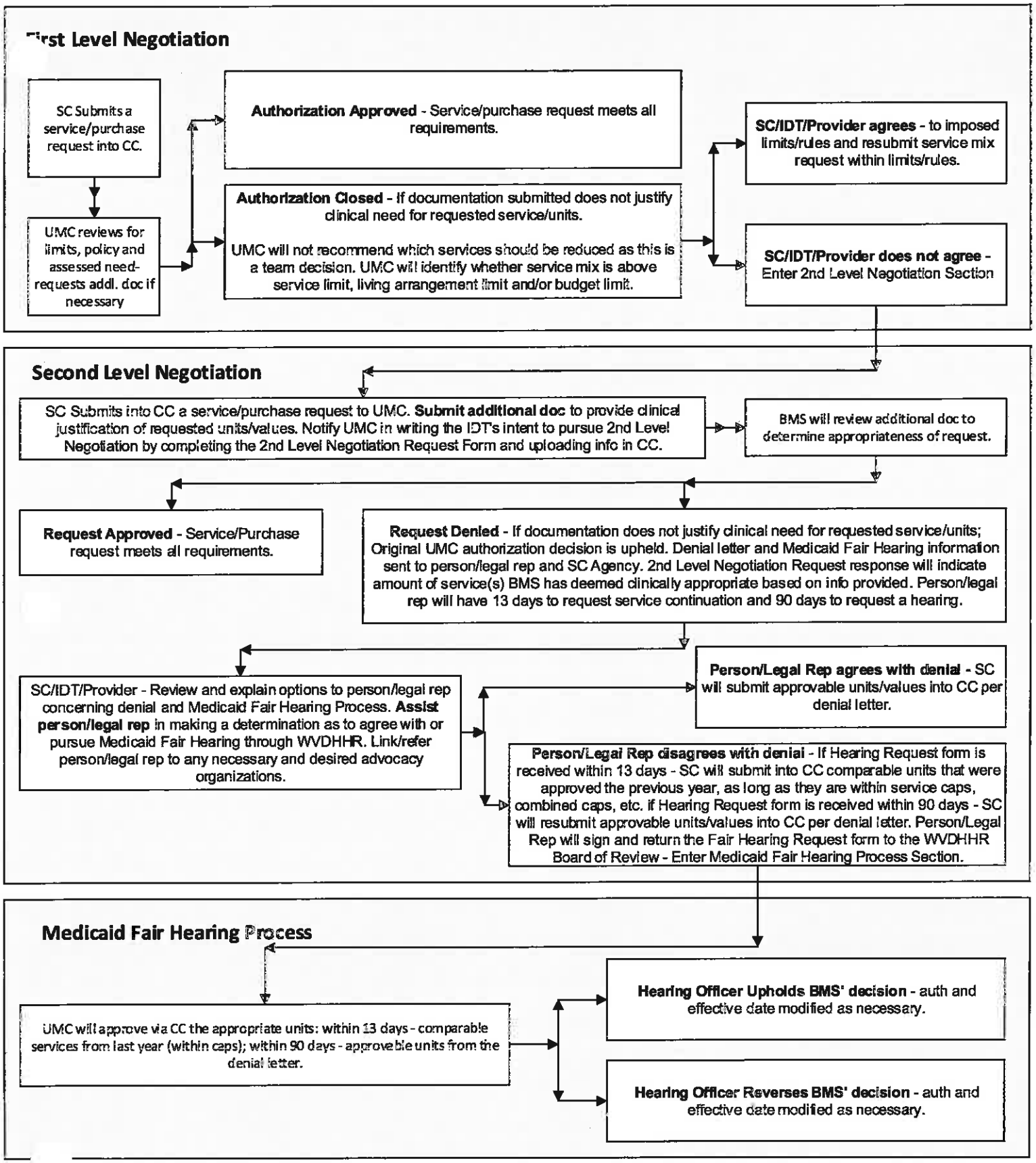
Intellectual/Developmental Disability Waiver
Initial Medical Eligibility



Intellectual/Developmental Disability Waiver Reevaluation for Medical Eligibility

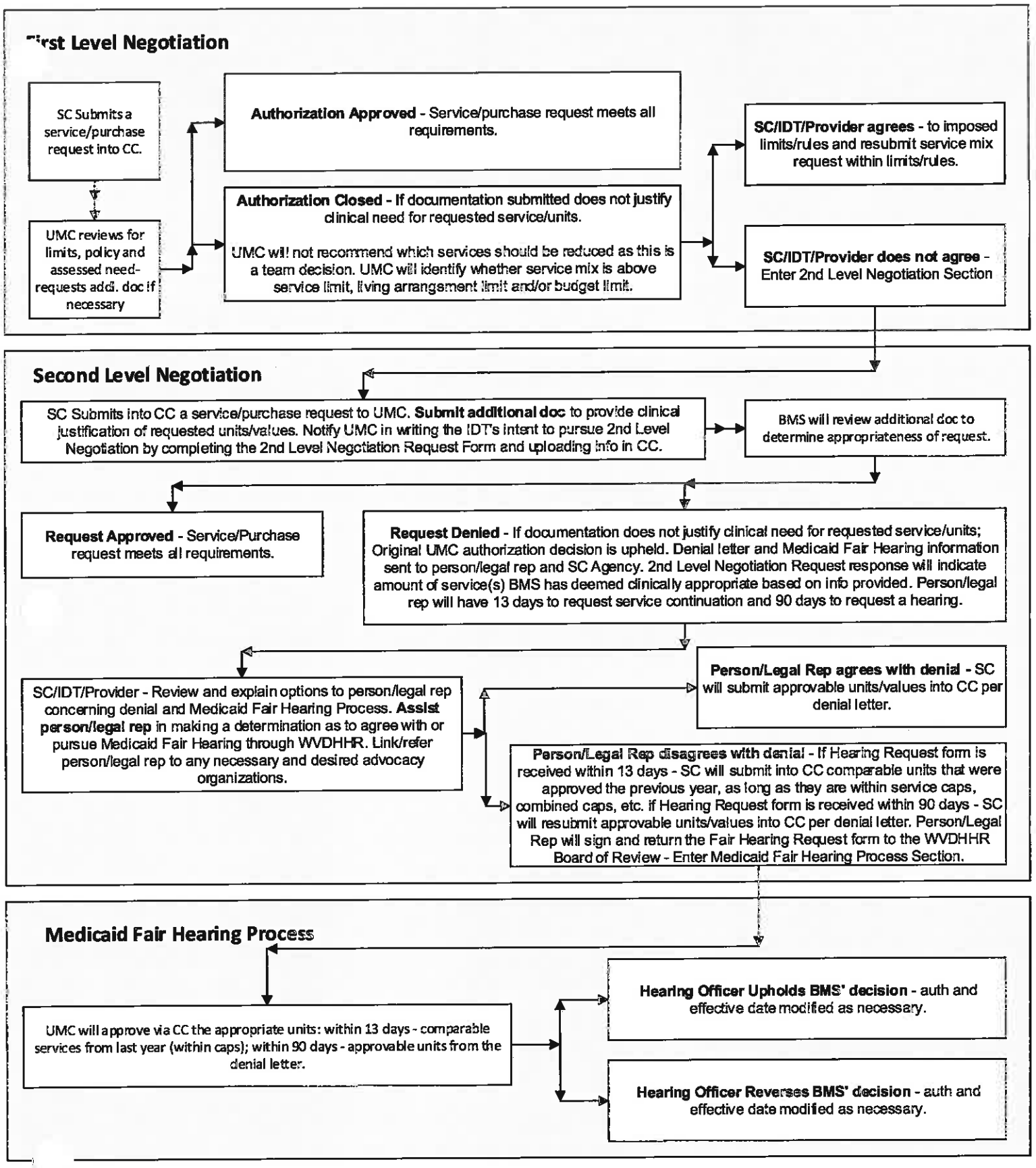


Intellectual/Developmental Disability Waiver
Service Authorization and Negotiation Process



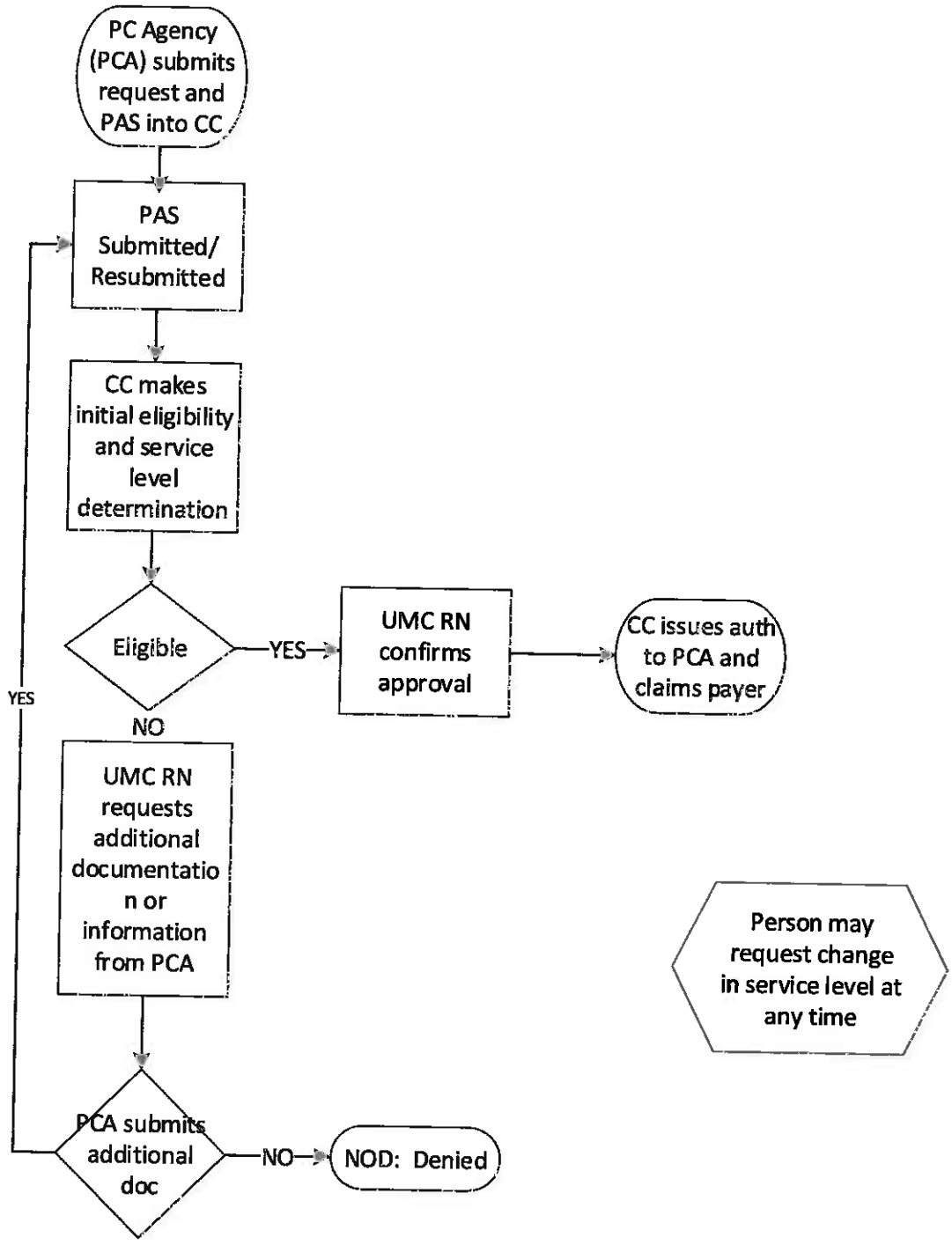
NOTE: If a service is in 2nd Level Negotiation or Fair Hearing process, the team can not request any change or modification on that service until the process has been completed and either a hearing decision has been made, negotiation has been successful or the request is withdrawn.

Intellectual/Developmental Disability Waiver
Service Authorization and Negotiation Process

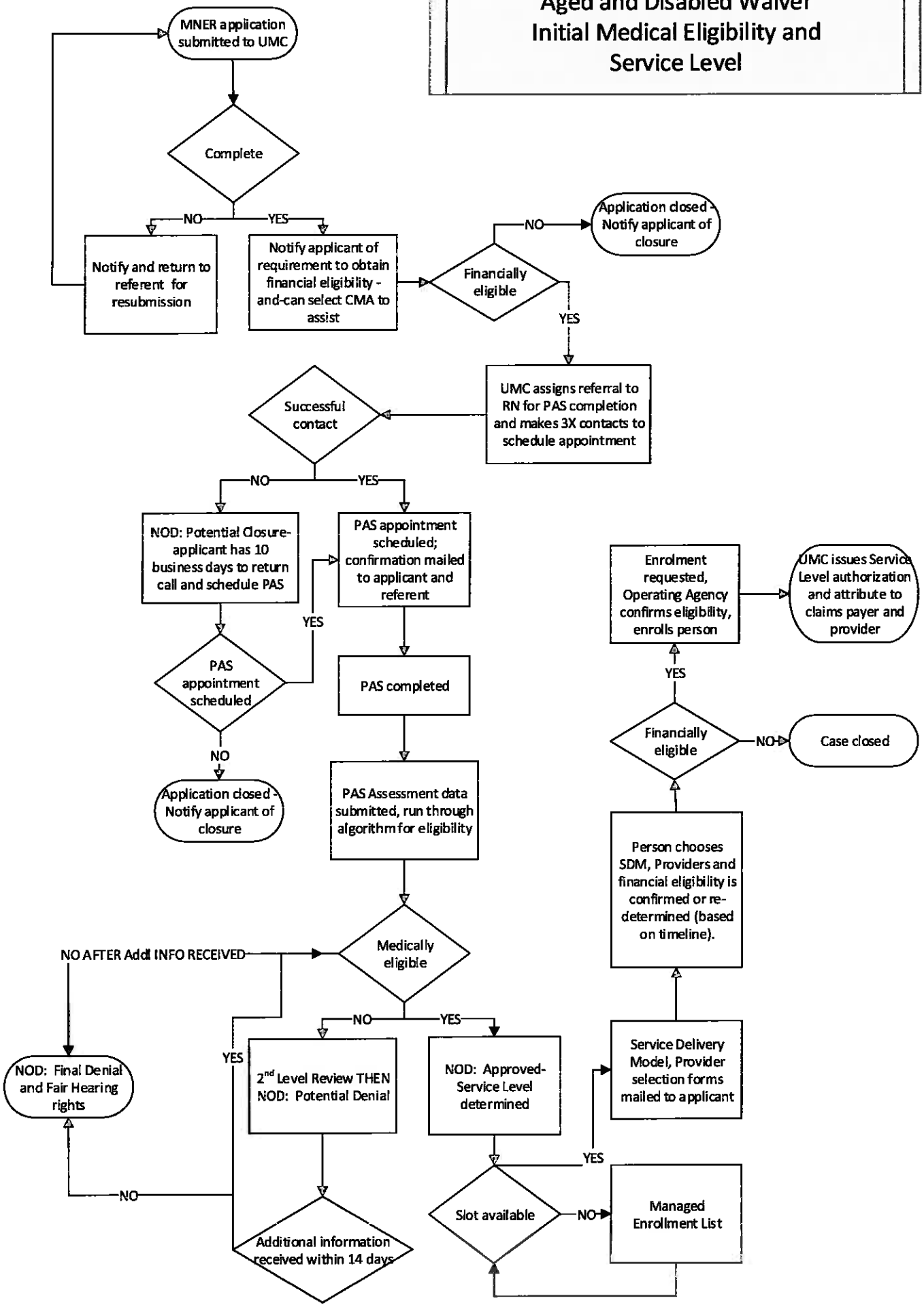


NOTE: If a service is in 2nd Level Negotiation or Fair Hearing process, the team can not request any change or modification on that service until the process has been completed and either a hearing decision has been made, negotiation has been successful or the request is withdrawn.

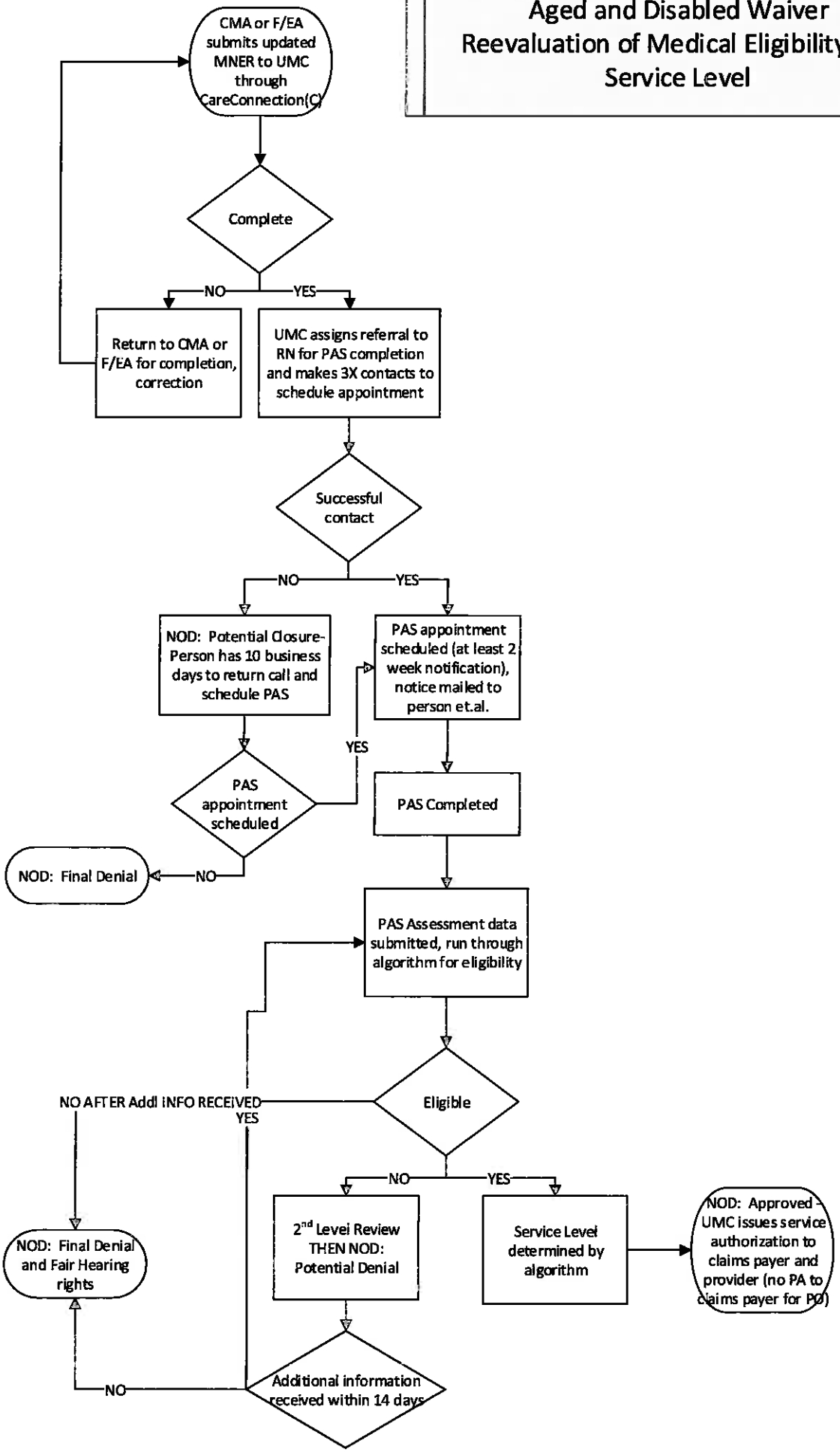
Personal Care Prior Authorization



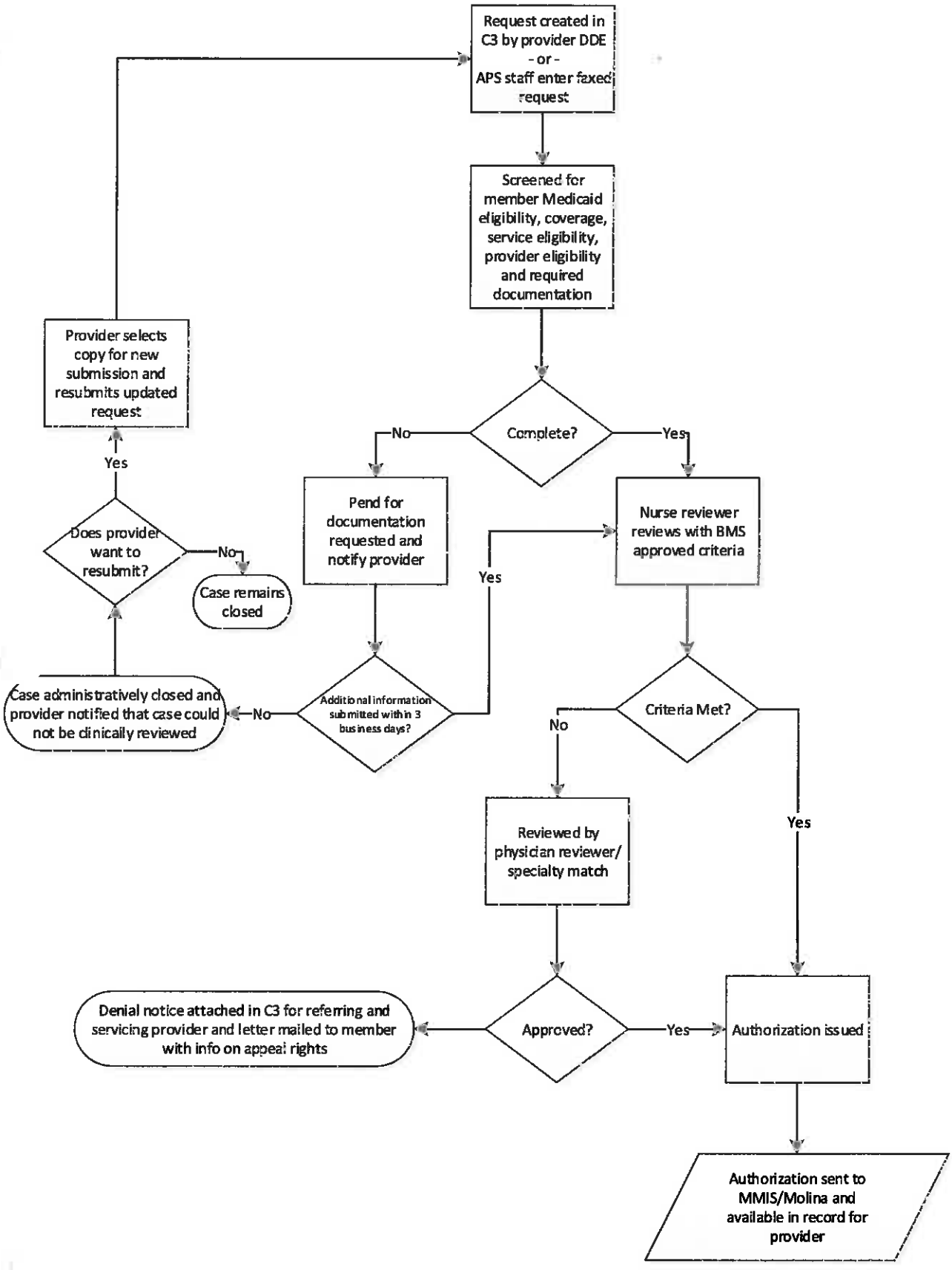
Aged and Disabled Waiver Initial Medical Eligibility and Service Level



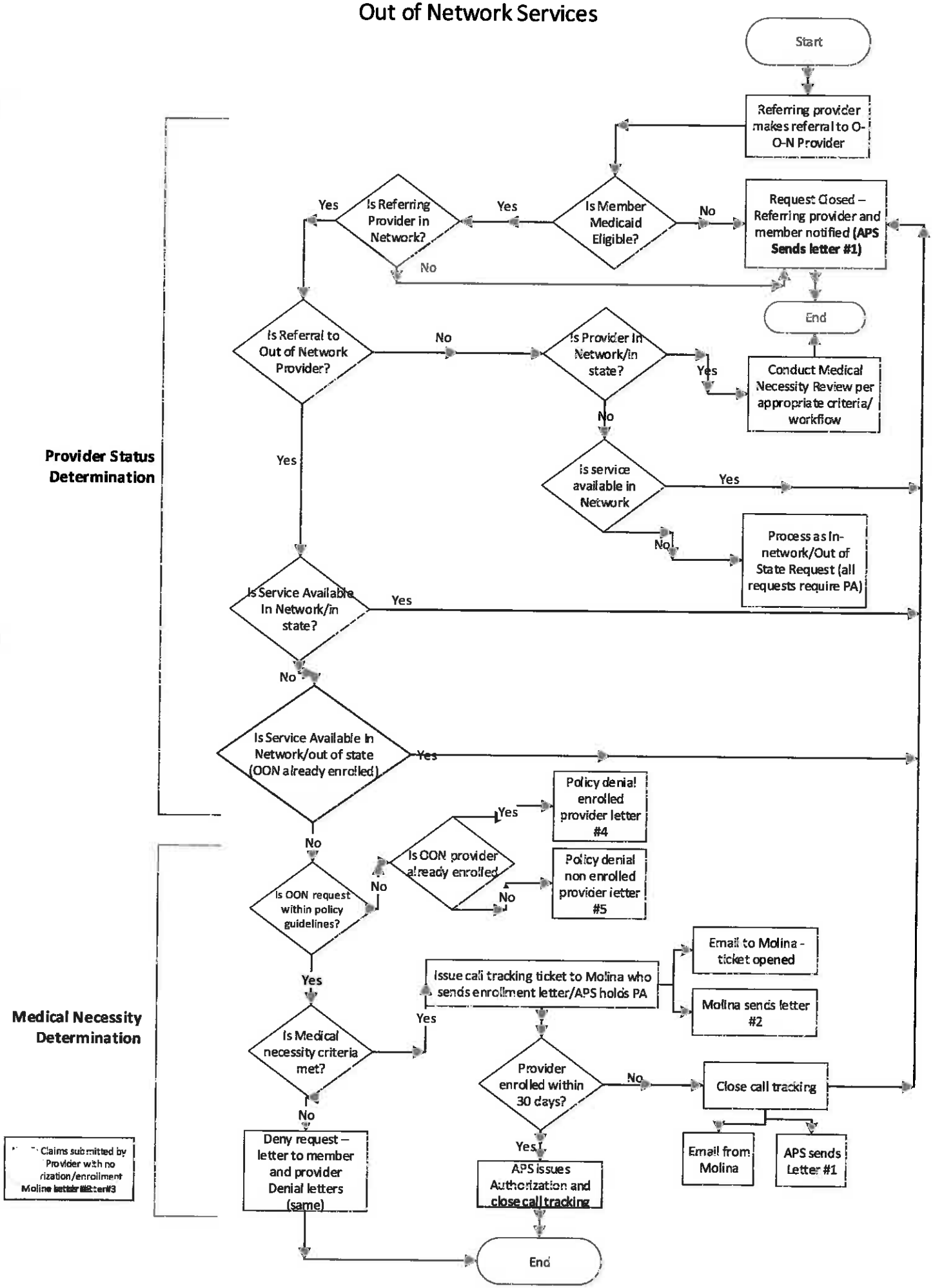
Aged and Disabled Waiver Reevaluation of Medical Eligibility and Service Level



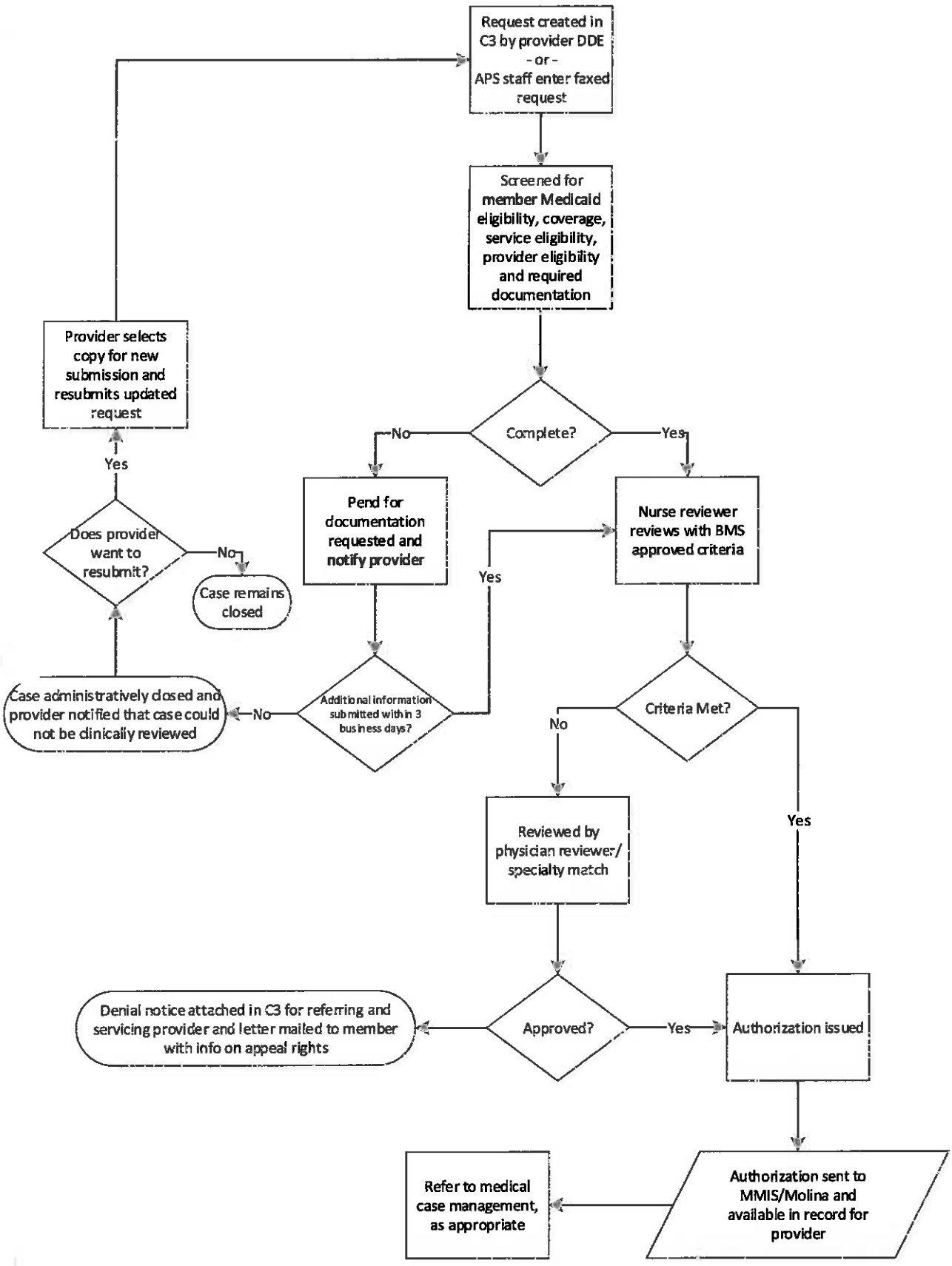
Laboratory/Genetics Services



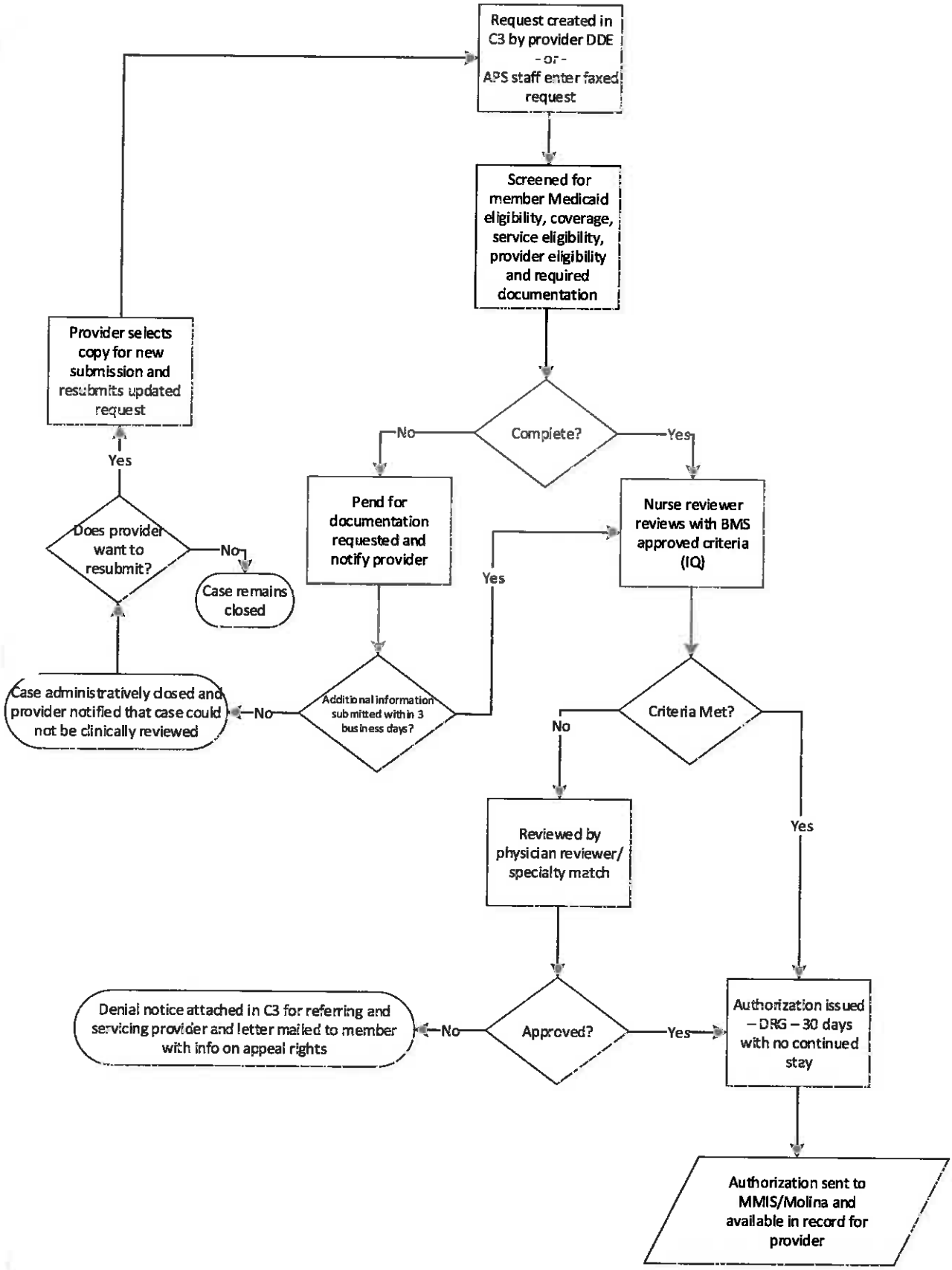
Out of Network Services



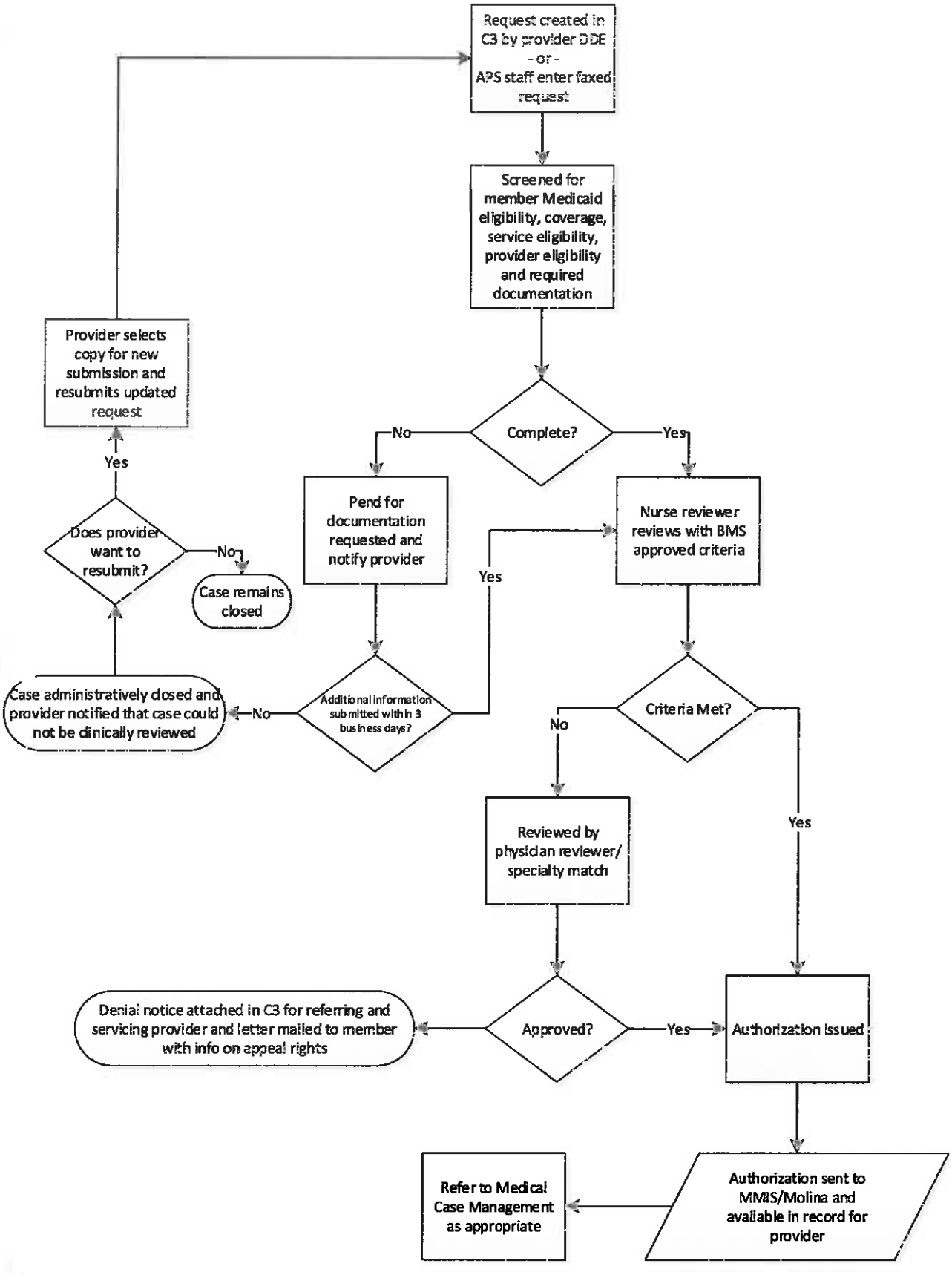
Cardiac Rehabilitation



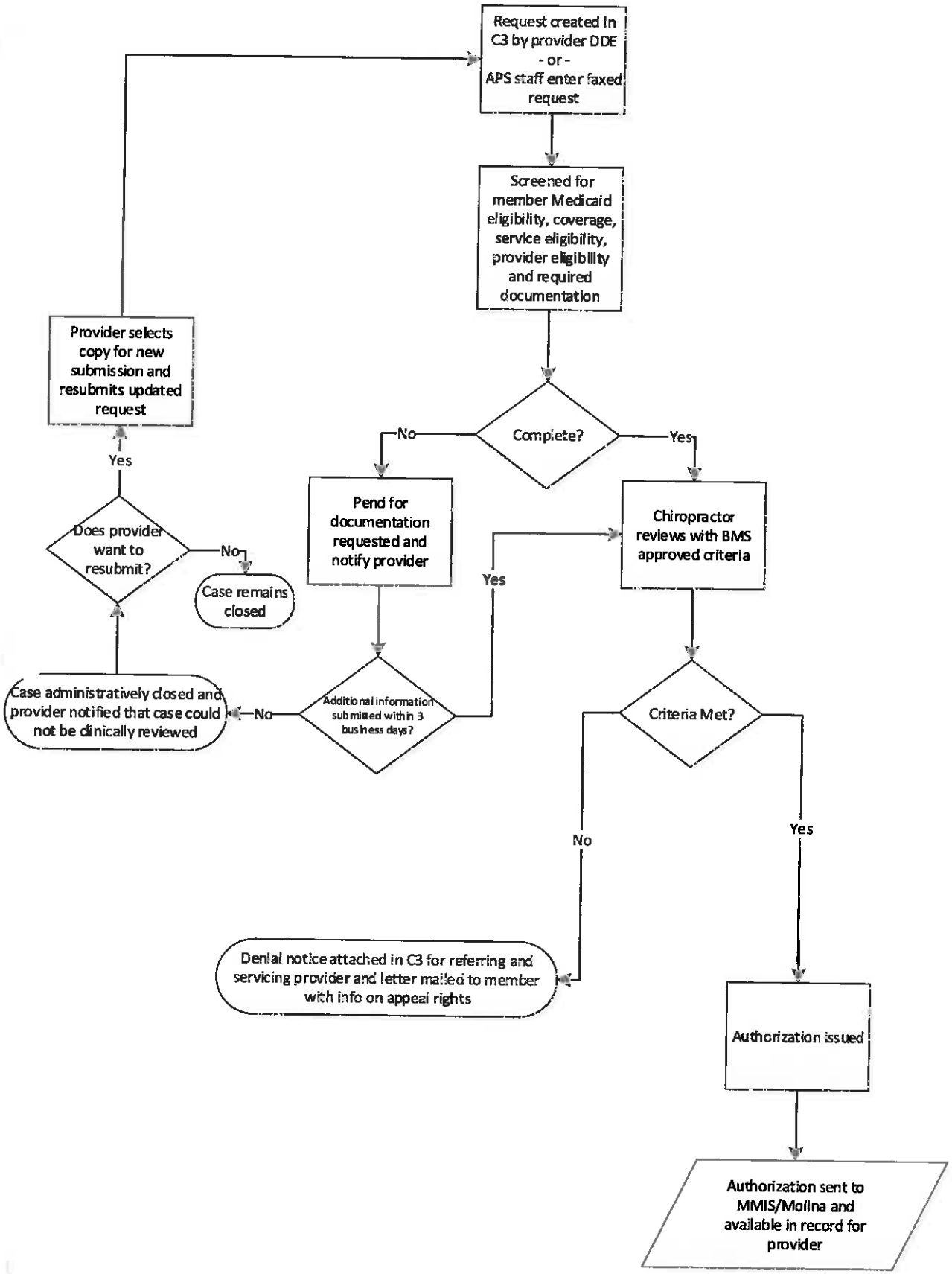
General and Acute Inpatient Hospital Admissions



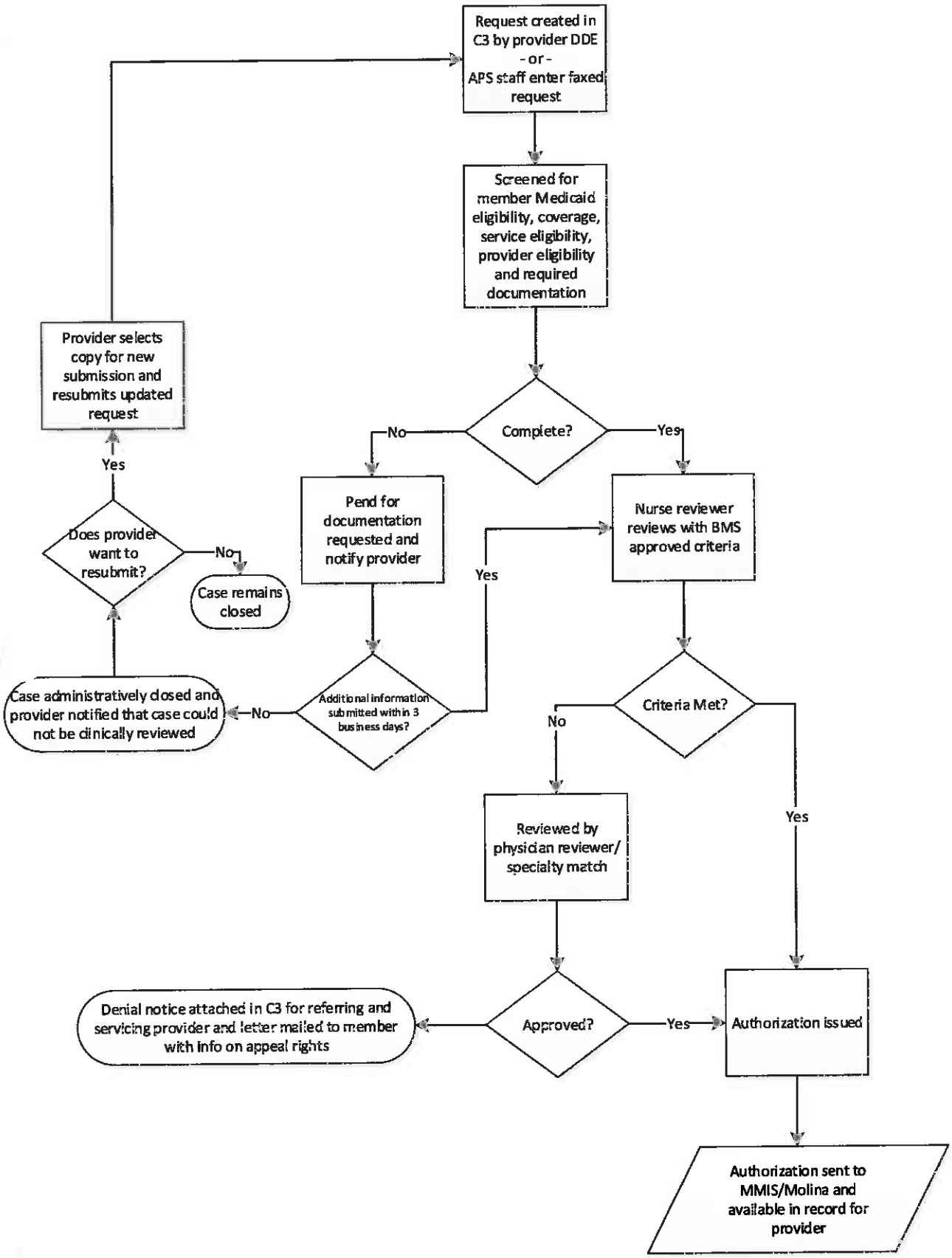
Pulmonary Rehabilitation Services



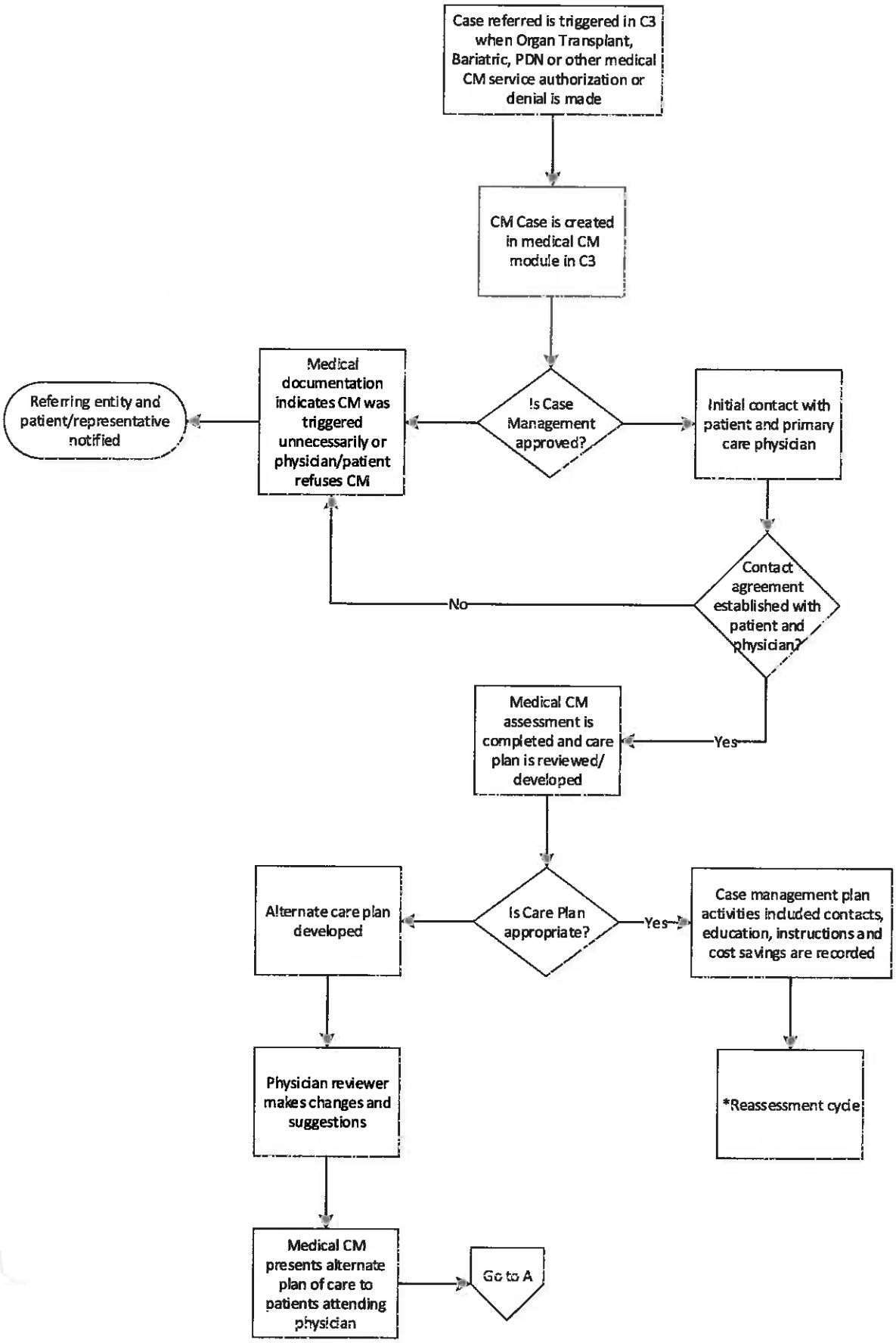
Chiropractic Services



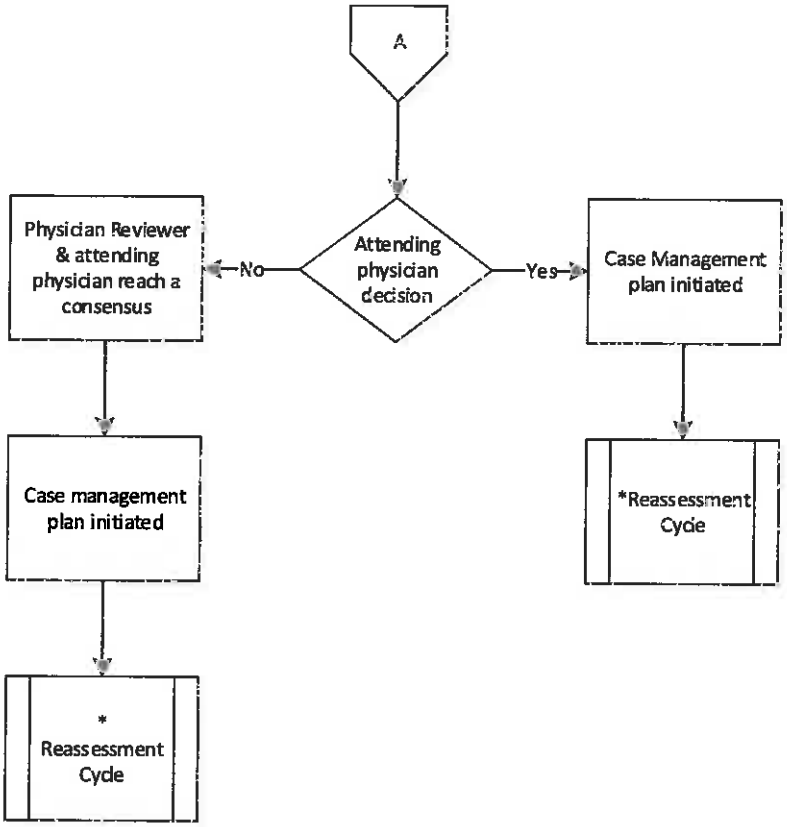
Podiatry Services

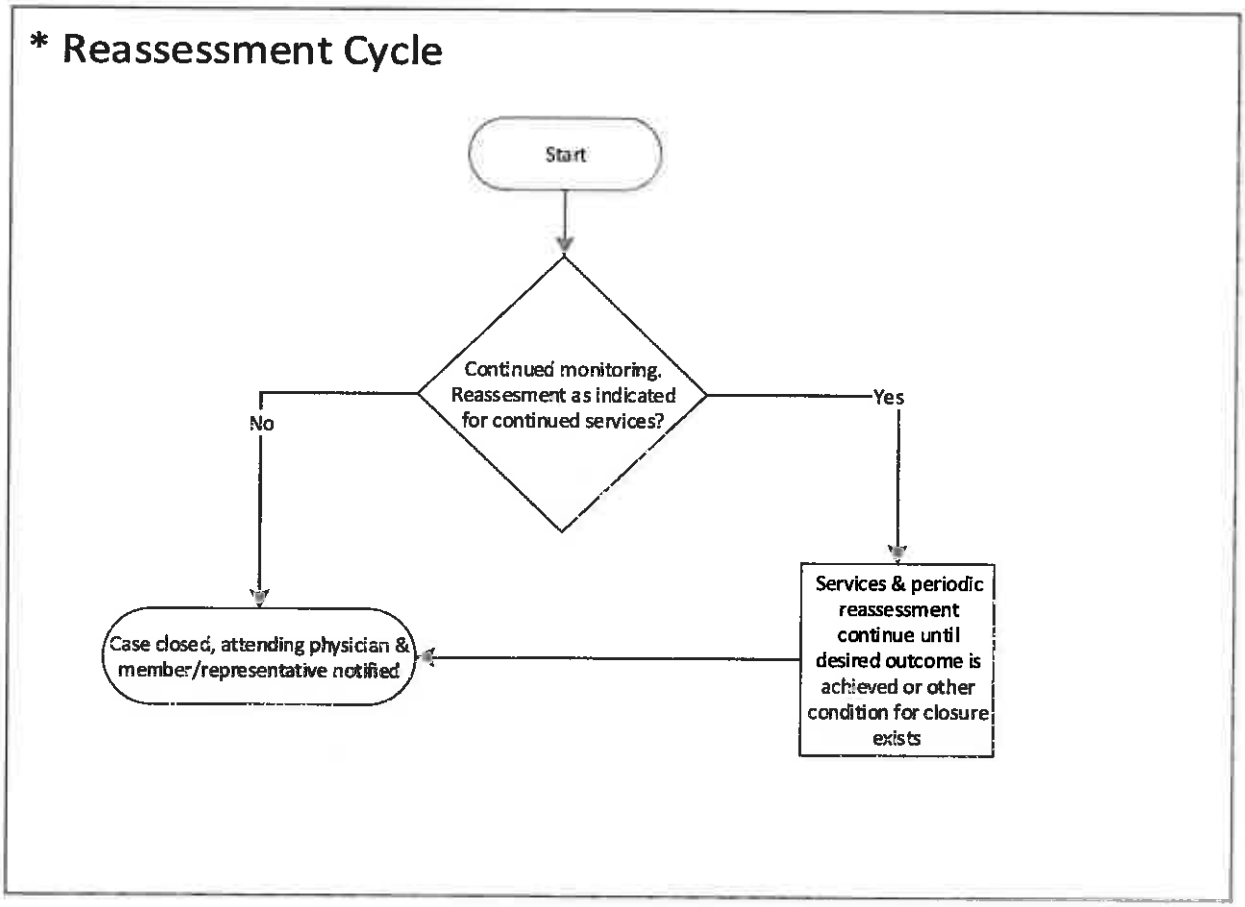


Medical Case Management

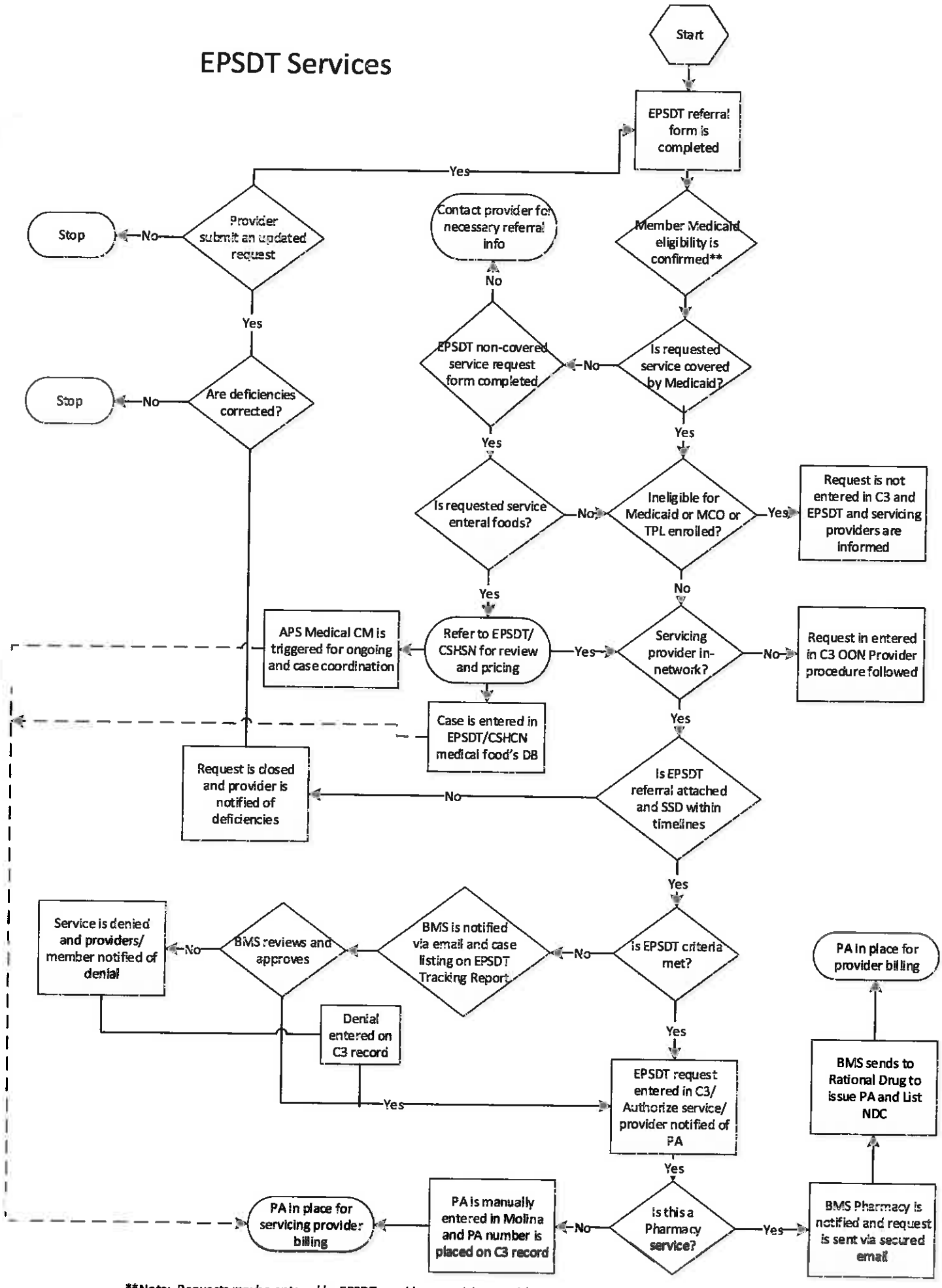


Medical Case Management





EPSDT Services

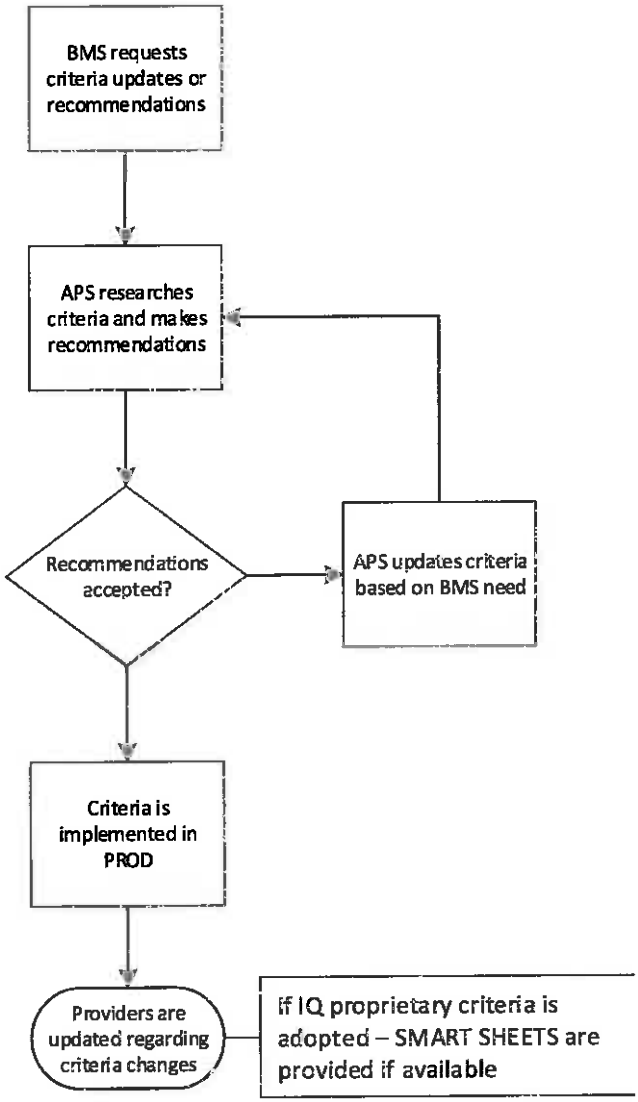


**Note: Requests maybe entered by EPSDT providers, servicing providers or APS staff è EPSDT cannot be enabled unless a member is <21. Referring provider must be Medicaid enrolled to be selected in C3.

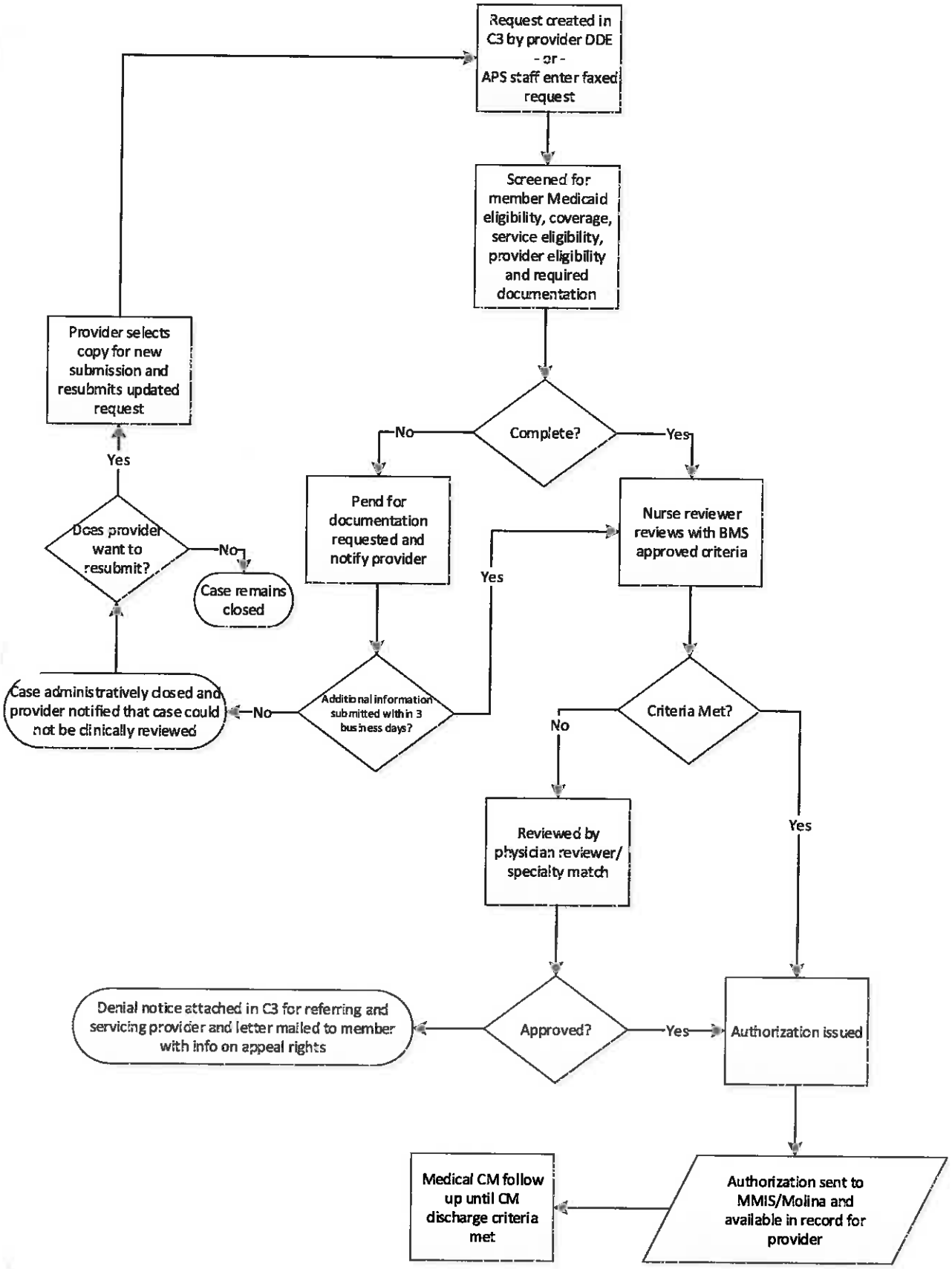
Definition of "Medically Urgent" Case Review

- a) a delay could seriously jeopardize the life or health of the consumer or,
- b) the ability of the consumer to regain maximum function or,
- c) in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.
- NOTE: Some review areas do not recognize medically urgent requests. In these instances it is not a choice in the admission type dropdown. For those review areas that recognize medically urgent (e.g. inpatient) each admission type has a medically urgent choice (e.g. direct admission OR direct admission-medically urgent). Requests not meeting the medically urgent definition WILL NOT be clinically reviewed as medically urgent.

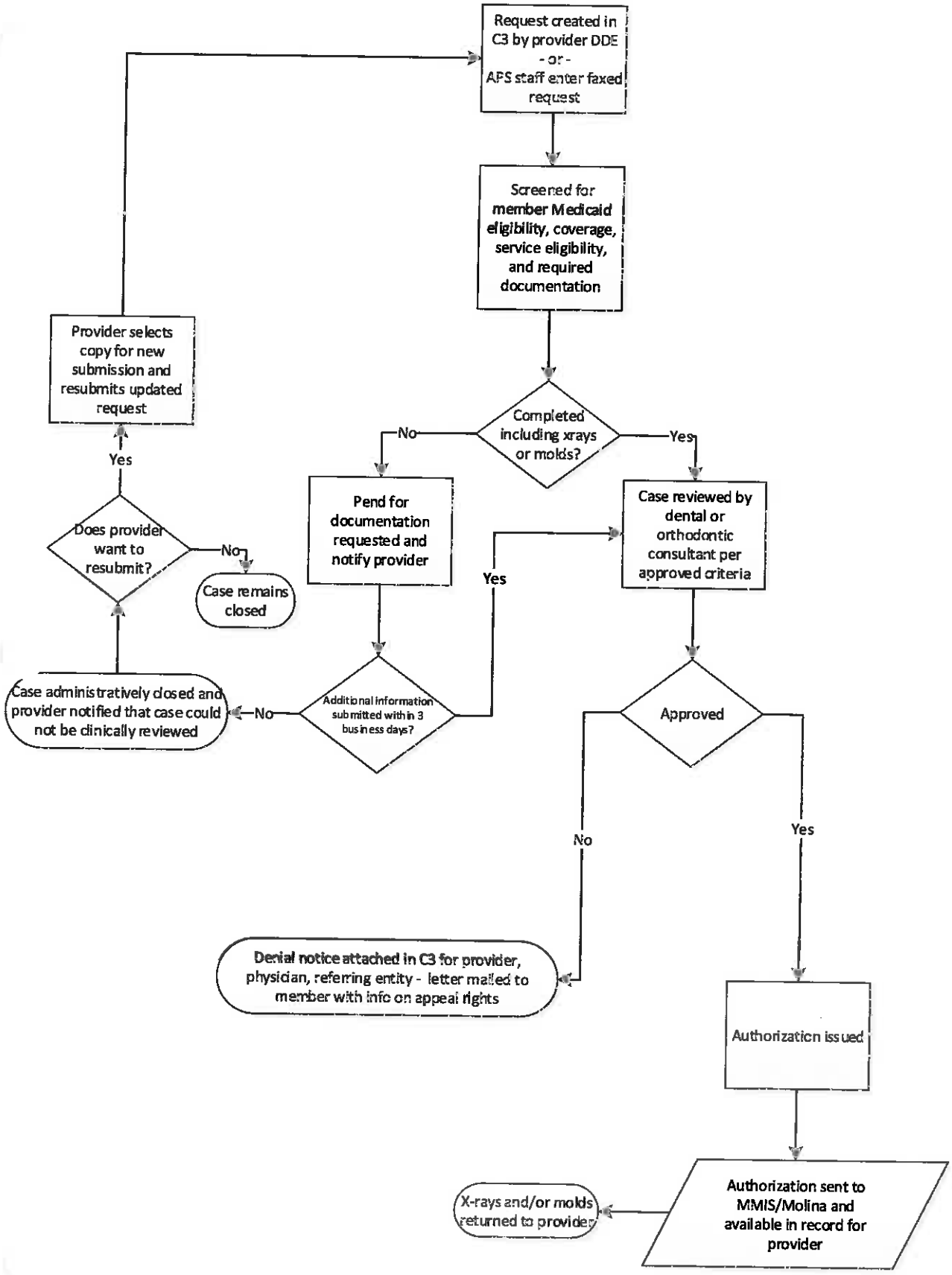
Medical Necessity Criteria Recommendations & Updates



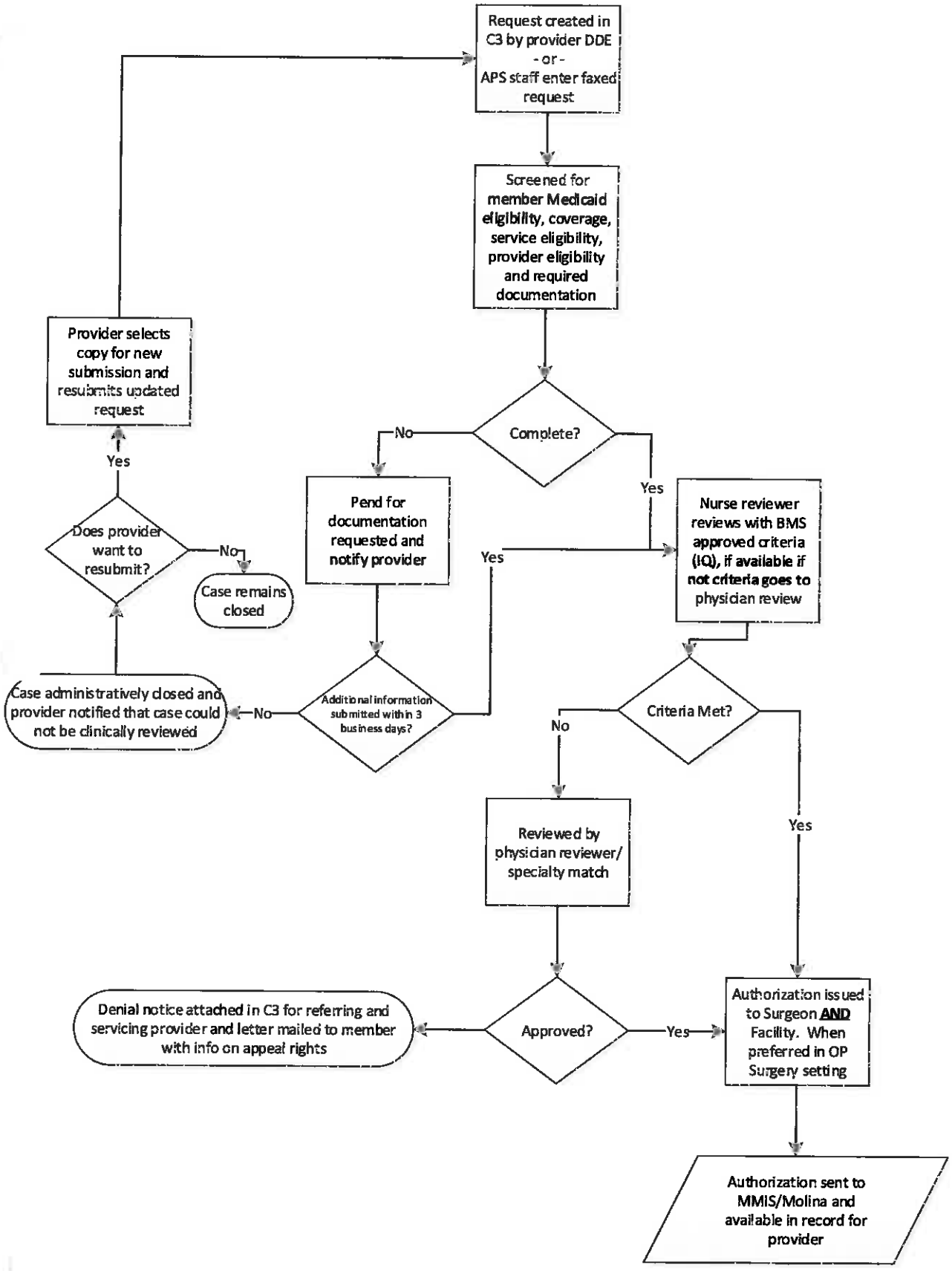
Inpatient Medical Rehabilitation Services ≤ 20



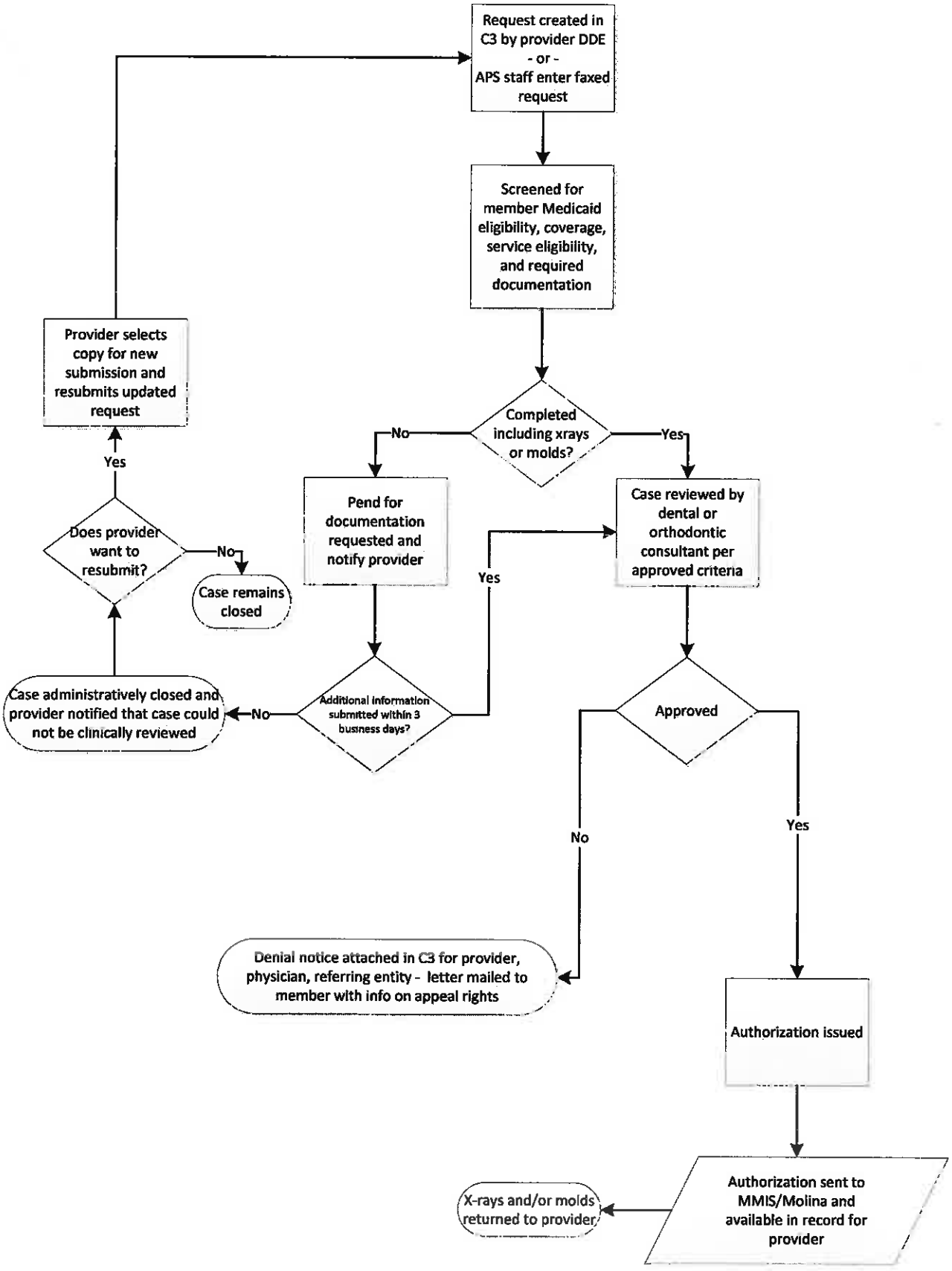
Dental, Orthodontic, Oral/Maxillofacial Surgery Services
Dental Services



Oral Maxillofacial Dental Surgery Services



Orthodontics Services



Policy Letters v. Clinical Letters

Case Situation	Type of Request		
	Original	Reconsideration	Letter/Timeline/Recipients
Clinical Denial	Action: this is a case clinically reviewed and denied. Choose Status: Denied and Status reason: does not meet medical necessity.	N/A	Appropriate Napersoft Denial letters are created and attached within 2 business days. Requesting provider is messaged in C3- criteria note is placed at Summary& Submit as note. See letter grid for specific procedures.
Reconsideration Upheld	N/A	The reconsideration request is physician reviewed. If upheld select denied-appeal upheld; if overturned **choose** approved- appeal overturned.	Appropriate Napersoft Reconsideration letters are created and attached within 2 business days. Requesting provider is messaged in C3-criteria note is placed at Summary& Submit as note. See letter grid for specific procedures.
Documentation Requested but not Received	Select: Status: Closed and Status Reason: Closed- Clinical and create an external policy note that indicates clinical review cannot be completed since requested documentation was not received within 3 business days (per LMP).	N/A	No letter is required in this instance.
Pricing Required but No Cost Invoice Received within 30 days	Select: Status: Denied and Status Reason: Does not meet medical necessity and letter indicates clinical review was completed and approved pending pricing but authorization could not be granted because requested code requires pricing and unaltered cost invoice was not sent (per policy)	The reconsideration request is NOT physician reviewed if cost invoice is sent. If not sent denial is upheld select denied-appeal upheld.	Appropriate Napersoft Denial and Reconsideration letters (if applicable) are sent within 2 business days.

	by provider within 30 days.		
Non-Covered Service	For EPSDT-this is the true use of status- Denied- Reason non-covered service, if you are NOT approving the EPSDT request. The criteria note in this case should indicate the service is non-covered but was reviewed under EPSDT and denied. <u>For ALL other cases</u> select: Status: Closed and Status Reason: Closed- Administrative and create a policy note that indicates request cannot be clinically reviewed- service requested is not covered by WV Medicaid. NOTE: we should not SEE non-covered requests because these CPT/HCPCS codes are not available in C3. However, if a provider uses the EPSDT grid they could make such a request.	Only for EPSDT could reconsideration be requested. All other cases would not have this action available.	For EPSDT original request appropriate Napersoft Denial letters are created and attached within 2 business days. Requesting provider is messaged in C3- criteria note is placed at Summary& Submit as note. See letter grid for specific procedures. For a reconsideration of an EPSDT request Napersoft Reconsideration letters are created and attached within 2 business days. Requesting provider is messaged in C3- criteria note is placed at Summary& Submit as note. See letter grid for specific procedures. For ALL other cases create a policy letter indicating the service is could not be clinically reviewed because it is NOT covered by WV Medicaid. The policy letter is created within 2 business days. Requesting provider is messaged in C3- policy note is placed at Summary& Submit as note.
Requested Service Does not Require PA	Select: Status: Closed and Status Reason: Closed- Clinical and create a general note that indicates service requested does not require prior authorization.	N/A	No letter is required in this instance.
PA Request not meeting Policy (timelines) OR Retrospective Request not meeting policy	Select: Status: Closed and Status Reason: Closed- Administrative and create a general note that	N/A	Select policy letter in Napersoft with reason clinical review cannot be completed since request was not received within timelines for

(e.g. not TPL or retroactive Medicaid)	indicates service was not requested within policy timelines.		requesting prior authorization. The policy letter is created within 2 business days. Requesting provider is messaged in C3- policy note is placed at Summary& Submit as note. If the service has ALREADY been performed and there are 2 providers involved BOTH the referring provider AND servicing provider recieve the appropriate letter for their role. If the requesting provider is both referring/servicing only the referring letter is required. If the service has NOT been performed the REQUESTING provider gets the letter appropriate to their role in the request (they must be either referring or servicing and get the letter appropriate to what they selected).

Psychiatric Inpatient and High Intensity Service Authorizations by Funding Source with Unduplicated Count and Average Length of Authorized Stay

4 Months: Between March 1 and June 30 2014

	# Unduplicated with Inpatient* Authorization	Inpatient Average Authorized Length of Stay	# Unduplicated with High-Intensity** Authorization	High Intensity Service Average Authorized Length of Stay
BBHHF Charity Care	Source of this Data: BBHHF	N/A	300	26
Medicaid Coverage	1,980	7	2,348	162
ABP-Expanded	822	2	594	11

4 Months:Between August 1 and November 30 2013

	# Unduplicated with Inpatient* Authorization	Inpatient Average Authorized Length of Stay	# Unduplicated with High-Intensity** Authorization	High Intensity Service Average Authorized Length of Stay
BBHHF Charity Care	Source of this Data: BBHHF	N/A	765	18
Medicaid Coverage	2,104	6	2,436	148

4 Months: Between March 1 and June 30 2013

	# Unduplicated with Inpatient* Authorization	Inpatient Average Authorized Length of Stay	# Unduplicated with High-Intensity** Authorization	High Intensity Service Average Authorized Length of Stay
BBHHF Charity Care	Source of this Data: BBHHF	N/A	763	11
Medicaid Coverage	2,019	13	2,413	138

* Psychiatric Inpatient < 21, Sub-Acute Hospitalization for < 21, Adult Inpatient Psychiatric Services (DRG and non-DRG)

** Children's Residential Services Levels I, II, and III, Children's Emergency Shelter, Psychiatric Residential TX Facility, Partial ACT and Community Psychiatric Community Support (Crisis Stabilization)

West Virginia I/DD Waiver Program
Fiscal Year 2013-2014 (July 01 2013 - June 30 2014)
Respite Services*: APS Healthcare Authorization Summary

	AGE GROUPS	
	Less than 18 years	18 years or Older
# Unduplicated Members	858	1,332
Total # of Authorized Units	3,978,368	5,576,763
Total Cost of Authorized Units	$17,089,551	$24,232,232
Average # of Authorized Units per Member	4,324	3,602
Average Authorized Cost per Member	$18,576	$15,654

*T1005U1: Respite - Agency (1:1), T1005U5: Respite - Agency (1:2), T1005U6: Respite - Agengy (1:3), T1005U7: Respite - Crisis Site (1:1), T1005U8: Respite - Crisis Site (1:2), T1005U9: Respite - Crisis Site (1:3) T1005UD: Respite - Personal Options

West Virginia I/DD Waiver Program

Fiscal Year 2013-2014 (July 01 2013 - June 30 2014)

Respite Services*: APS Healthcare Authorization Summary

Service Code	Age Group	# Unduplicated Members with this Service Authorized	Total # of Authorized Units	Total Cost of Authorized Units	Average # of Authorized Units per Member	Average Authorized Cost per Member
T1005U1 Respite - Agency (1:1)	Less than 18 years old	656	2,729,290	$13,673,742.90	4,067	$ 20,378.16
T1005U1 Respite - Agency (1:1)	18 years or older	1,044	3,935,559	$19,717,150.59	3,647	$ 18,273.54
T1005U1 Respite - Agency (1:1)		**1,700**	**6,664,849**	**$ 33,390,893.49**	**3,920**	**$ 19,641.70**
T1005U5 Respite - Agency (1:2)	Less than 18 years old	16	36,318	$ 90,795.00	2,269	$ 5,674.69
T1005U5 Respite - Agency (1:2)	18 years or older	87	128,795	$ 321,987.50	1,463	$ 3,658.95
T1005U5 Respite - Agency (1:2)		**103**	**165,113**	**$ 412,782.50**	**1,603**	**$ 4,007.60**
T1005U6 Respite - Agency (1:3)	Less than 18 years old	6	8,312	$ 13,881.04	1,385	$ 2,313.51
T1005U6 Respite - Agency (1:3)	18 years or older	61	64,970	$ 108,499.90	1,047	$ 1,750.00
T1005U6 Respite - Agency (1:3)		**67**	**73,282**	**$ 122,380.94**	**1,094**	**$ 1,826.58**
T1005U7 Respite - Crisis Site (1:1)	Less than 18 years old	3	5,896	$ 29,538.96	1,965	$ 9,846.32
T1005U7 Respite - Crisis Site (1:1)	18 years or older	22	56,179	$ 281,456.79	2,442	$ 12,237.25
T1005U7 Respite - Crisis Site (1:1)		**25**	**62,075**	**$ 310,995.75**	**2,483**	**$ 12,439.83**
T1005U8 Respite - Crisis Site (1:2)	Less than 18 years old	2	1,960	$ 4,900.00	980	$ 2,450.00
T1005U8 Respite - Crisis Site (1:2)	18 years or older	20	18,373	$ 45,932.50	874	$ 2,187.26
T1005U8 Respite - Crisis Site (1:2)		**22**	**20,333**	**$ 50,832.50**	**924**	**$ 2,310.57**
T1005U9 Respite - Crisis Site (1:3)	Less than 18 years old	2	1,840	$ 3,072.80	920	$ 1,536.40
T1005U9 Respite - Crisis Site (1:3)	18 years or older	12	4,211	$ 7,032.37	350	$ 586.03
T1005U9 Respite - Crisis Site (1:3)		**14**	**6,051**	**$ 10,105.17**	**432**	**$ 721.80**
T1005UD Respite - Personal Options	Less than 18 years old	216	1,194,752	$ 3,273,620.48	5,430	$ 14,880.09
T1005UD Respite - Personal Options	18 years or older	263	1,368,676	$ 3,750,172.24	5,204	$ 14,259.21
T1005UD Respite - Personal Options		**479**	**2,563,428**	**$ 7,023,792.72**	**5,352**	**$ 14,663.45**

West Virginia I/DD Waiver Program

Fiscal Year 2013-2014 (July 01 2013 - June 30 2014)

Transportation & Skilled Nursing - LPN Services: APS Healthcare Authorization Summary

TRANSPORTATION SERVICES

Service	# Unduplicated Members with this Service Authorized	Total # of Authorized Units	Total Cost of Authorized Units	Average # of Authorized Units per Member	Average Authorized Cost per Member	Cost per Unit
A0120HI Transportation - Trips	1,467	537,632	$4,467,722	334	$2,784	$5.95
A0160U1 Transportation - Miles	3,643	24,142,079	$11,346,777	6,110	$2,872	$0.47
A0160U3 Transportation - Personal Options	731	5,558,002	$2,612,261	7,561	$3,554	$0.47

SKILLED NURSING - LPN SERVICES

Service	# Unduplicated Members with this Service Authorized	Total # of Authorized Units	Total Cost of Authorized Units	Average # of Authorized Units per Member	Average Authorized Cost per Member	Cost per Unit
T1003U2 Skilled Nursing - LPN (1:3)	31	43,340	$159,058	1,398	$5,131	$3.67
T1003U3 Skilled Nursing - LPN (1:2)	45	96,117	$528,644	2,135	$11,748	$5.50
T1003U4 Skilled Nursing - LPN (1:1)	1,949	2,404,883	$26,501,811	1,135	$12,513	$11.02

WVDHHR Bureau for Beha al Health and Health Facilities

SFY 2013 -2014 Charity Care Utilization Management Summary

Number of Charity Care Funded Service Authorizations by Service by Provider

SERVICE	APPALACHIAN CHC	EASTRIDGE HEALTH SYSTEMS	FMRS HEALTH SYSTEMS	HEALTH-WAYS	LOGAN-MINGO AREA MENTAL HEALTH	NORTHWOOD HEALTH SYSTEMS	POTOMAC HIGHLANDS GUILD	PRESTERA CENTER	SENECA HEALTH SERVICES	SOUTHERN HIGHLANDS CMHC	UNITED SUMMIT CENTER	VALLEY HEALTH CARE	WESTBROOK HEALTH SERVICES	Total per Service
Assertive Community Treatment (ACT)	0	0	7	0	0	0	0	32	0	0	23	13	6	81
BH Counseling, Professional, Group, Intensive Services	3	24	242	0	0	37	0	327	0	0	228	0	82	943
BH Counseling, Professional, Group	134	20	593	26	13	35	30	1088	199	84	50	8	186	2466
BH Counseling, Professional, Individual Intensive Services	242	352	757	259	590	496	411	3184	1494	689	1224	614	759	11071
BH Counseling, Professional, Individual Intensive Services	3	25	75	0	0	37	0	321	0	0	41	0	61	563
BH Counseling, Supportive Group, Intensive Services	3	25	28	0	0	34	0	252	0	0	22	0	7	371
BH Counseling, Supportive Individual, Intensive Services	0	24	0	0	0	12	0	241	0	0	0	0	54	331
BH Counseling, Supportive, Group	26	1	0	0	1	4	4	177	0	1	11	3	4	232
BH Counseling, Supportive, Individ.	1	16	10	0	0	3	114	549	0	29	110	50	72	954
Community Psychiatric Supportive Treatment	0	0	236	0	0	185	0	388	0	159	288	114	139	1509
Comprehensive Community Support Services	7	9	10	3	0	12	6	11	0	14	0	0	6	78
Comprehensive Evaluation by a Psychologist	5	0	1	50	19	20	145	92	10	7	167	1	35	552
Crisis Intervention	0	0	1	0	0	0	25	1	8	0	15	0	0	50
Developmental Testing: Limited	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Mental Health Assessment by non-Physician	362	778	2923	85	424	554	500	4715	2200	2227	1670	546	776	17760
Mental Health Comprehensive Medication Services	0	0	0	0	0	4	0	0	0	0	0	2	0	6
Mental Health Service Plan Development by non-physician	100	42	283	200	0	878	84	715	0	61	753	224	433	3773
Neuropsychological Testing by Psychologist or Physician	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacologic Management	1	0	3	0	0	0	0	5	2	2	0	1	0	14
Physician Coordinated Care Oversight Services	10	38	0	25	0	12	0	103	0	45	1	0	0	234
Psychiatric Diagnostic Evaluation	0	6	188	0	18	16	120	5	0	0	41	2	61	457
Psychiatric Diagnostic Evaluation with Medical Services	64	389	949	156	159	0	0	2886	13	607	876	413	283	6795
Psychiatric diagnostic Interview by a Psychologist	27	118	291	11	30	65	72	1362	712	164	78	75	148	3153
Screening by Licensed Psychologist	0	0	113	0	28	1	2	9	126	32	0	0	0	311
Targeted Case Management	61	9	4	9	0	0	0	346	0	0	358	228	97	1112
Total Number of Authorizations per Proivder	**1049**	**1876**	**6714**	**824**	**1282**	**2405**	**1513**	**16809**	**4764**	**4121**	**5957**	**2294**	**3209**	
Unduplicated Individuals per Provider	**359**	**822**	**3137**	**326**	**616**	**686**	**621**	**6136**	**2225**	**2355**	**2000**	**944**	**1110**	
verage Authorizations per Individual per Provider	**3**	**2**	**2**	**3**	**2**	**4**	**2**	**3**	**2**	**2**	**3**	**2**	**3**	

Data Extracted 07/26/2(

WVDHHR Bureau for Behavior[illegible]alth and Health Facilities

SFY 2013 -2014 Charity Care Utilization Management Summary

21,070 Unduplicated Individuals were Authorized for 52,817 Charity Care Funded Service of which 20,806 were Authorized by One Provider, 260 had two Providers and 4 had three Providers

Number of Unduplicated Individuals with an Authorization by Service by Provider

SERVICE	APPALACHIAN CHC	EASTRIDGE HEALTH SYSTEMS	FMRS HEALTH SYSTEMS	HEALTH-WAYS	LOGAN-MINGO AREA MENTAL HEALTH	NORTHWOOD HEALTH SYSTEMS	POTOMAC HIGHLANDS GUILD	PRESTERA CENTER	SENECA HEALTH SERVICES	SOUTHERN HIGHLANDS CMHC	UNITED SUMMIT CENTER	VALLEY HEALTH CARE	WESTBROOK HEALTH SERVICES	Total per Service
Assertive Community Treatment (ACT)	0	0	5	0	0	0	0	32	0	0	22	11	5	75
BH Counseling, Professional, Group, Intensive Services	3	24	181	0	0	35	0	313	0	0	207	0	67	830
BH Counseling, Professional, Group	134	19	589	26	13	29	30	1084	189	81	48	8	181	2431
BH Counseling, Professional, Individual Intensive Services	209	324	753	238	574	405	379	3079	1440	672	1169	586	691	10519
BH Counseling, Professional, Individual Intensive Services	3	24	72	0	0	36	0	310	0	0	39	0	57	541
BH Counseling, Supportive Group, Intensive Services	3	24	27	0	0	34	0	242	0	0	20	0	7	357
BH Counseling, Supportive Individual, Intensive Services	0	23	0	0	0	12	0	234	0	0	0	0	54	323
BH Counseling, Supportive, Group	26	1	0	0	1	4	4	177	0	1	11	3	4	232
BH Counseling, Supportive, Individ.	1	16	9	0	0	3	109	542	0	28	109	50	72	939
Community Psychiatric Supportive Treatment	0	0	234	0	0	144	0	387	0	159	288	114	136	1462
Comprehensive Community Support Services	7	9	9	3	0	9	5	11	0	14	0	0	6	73
Comprehensive Evaluation by a Psychologist	5	0	1	50	19	20	145	91	10	7	167	1	35	551
Crisis Intervention	0	0	1	0	0	0	25	1	8	0	15	0	0	50
Developmental Testing: Limited	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Mental Health Assessment by non-Physician	347	778	2918	84	424	512	499	4713	2124	2204	1670	546	772	17591
Mental Health Comprehensive Medication Services	0	0	0	0	0	1	0	0	0	0	0	2	0	3
Mental Health Service Plan Development by non-physician	93	42	141	150	0	422	83	526	0	50	380	112	253	2252
Neuropsychological Testing by Psychologist or Physician	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pharmacologic Management	1	0	3	0	0	0	0	5	2	2	0	1	0	14
Physician Coordinated Care Oversight Services	10	38	0	25	0	12	0	94	0	45	1	0	0	225
Psychiatric Diagnostic Evaluation	0	6	188	0	18	16	120	5	0	0	41	2	61	458
Psychiatric Diagnostic Evaluation with Medical Services	64	388	945	156	158	0	0	2869	13	607	874	412	283	6769
Psychiatric diagnostic Interview by a Psychologist	27	118	291	11	30	65	72	1362	712	164	78	75	148	3153
Screening by Licensed Psychologist	0	0	113	0	28	1	2	9	126	32	0	0	0	311
Targeted Case Management	59	9	4	9	0	0	0	346	0	0	354	227	97	1105
Unduplicated Individuals per Provider	**359**	**822**	**3137**	**326**	**616**	**686**	**621**	**6136**	**2225**	**2355**	**2000**	**944**	**1110**	

Data Extracted 07/26/2014

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

BARRY ROBINSON CENTER PSYCHIATRIC RESIDENTIAL TREATMENT

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			BARRY ROBINSON CENTER PSYCHIATRIC RESIDENTIAL TREATMENT		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	139		139

Disposition of Submissions

Service	All Out of State Providers			BARRY ROBINSON CENTER PSYCHIATRIC RESIDENTIAL TREATMENT		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1			1	
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168	98	19	15
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2		6		
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	104	20	15
% of Total Processed	69.45%	20.37%	10.18%	74.82%	14.39%	10.79%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

BARRY ROBINSON CENTER PSYCHIATRIC RESIDENTIAL TREATMENT

Requested Service	All Out of State Providers									Y ROBINSON CENTER PSYCHIATRIC RESIDENTIAL TREATM								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			83			3	12				
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13					5				1				
Review of Care-Youth Services					3		1											

APS Healthcare, Inc. - West Virginia
Bureau for Children and Families
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FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

BELLEFAIRE JCB

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			BELLEFAIRE JCB		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	5	1	4

Disposition of Submissions

Service	All Out of State Providers			BELLEFAIRE JCB		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46		1	3	
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	**1289**	**378**	**189**	1	3	
% of Total Processed	69.45%	20.37%	10.18%	25%	75%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia
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BELLEFAIRE JCB

Requested Service	All Out of State Providers									BELLEFAIRE JCB								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1			1								
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

COASTAL HARBOR

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			COASTAL HARBOR		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	235	4	231

Disposition of Submissions

Service	All Out of State Providers			COASTAL HARBOR		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16		1	
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168	159	55	16
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	159	56	16
% of Total Processed	69.45%	20.37%	10.18%	68.83%	24.24%	6.93%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Out of State Providers Data Submission Activity Report

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COASTAL HARBOR

Requested Service	All Out of State Providers									COASTAL HARBOR								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			140			19					
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

CORNELL ABRAXAS

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			CORNELL ABRAXAS		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	10		10

Disposition of Submissions

	All Out of State Providers			CORNELL ABRAXAS		
Service	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16		8	
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46			2	
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189		10	
% of Total Processed	69.45%	20.37%	10.18%		100%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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Out of State Providers Data Submission Activity Report

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CORNELL ABRAXAS

Requested Service	All Out of State Providers									CORNELL ABRAXAS								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	**33**			**6**	**5**		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

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DEVEREUX

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			DEVEREUX		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	136	3	133

Disposition of Submissions

Service	All Out of State Providers			DEVEREUX		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168	60	26	29
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2		12	2	
Review of Care-Youth Services	4			4		
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	76	28	29
% of Total Processed	69.45%	20.37%	10.18%	57.14%	21.05%	21.8%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia
Bureau for Children and Families
Out of State Providers Data Submission Activity Report
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DEVEREUX

Requested Service	All Out of State Providers									DEVEREUX								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			39			8	11		2		
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13					3			1	8				
Review of Care-Youth Services					3		1							3		1		

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Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

FOX RUN RESIDENTIAL TREATMENT CENTER

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			FOX RUN RESIDENTIAL TREATMENT CENTER		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	267	2	265

Disposition of Submissions

Service	All Out of State Providers			FOX RUN RESIDENTIAL TREATMENT CENTER		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168	199	27	39
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	199	27	39
% of Total Processed	69.45%	20.37%	10.18%	75.09%	10.19%	14.72%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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FOX RUN RESIDENTIAL TREATMENT CENTER

Requested Service	All Out of State Providers									FOX RUN RESIDENTIAL TREATMENT CENTER								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			170			1	25		3		
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

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Out of State Providers Data Submission Activity Report

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GEORGE JUNIOR REPUBLIC

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			GEORGE JUNIOR REPUBLIC		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	78		78

Disposition of Submissions

	All Out of State Providers			GEORGE JUNIOR REPUBLIC		
Service	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33		7	24	
Residential Children's Service - Level III	45	46		8	39	
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	15	63	
% of Total Processed	69.45%	20.37%	10.18%	19.23%	80.77%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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GEORGE JUNIOR REPUBLIC

Requested Service	All Out of State Providers									GEORGE JUNIOR REPUBLIC								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10						2			5					
Residential Children's Service - Level III	33			6	5		1			5			3					
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

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KIDSPEACE NATIONAL CENTER

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			KIDSPEACE NATIONAL CENTER		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	32	1	31

Disposition of Submissions

Service	All Out of State Providers			KIDSPEACE NATIONAL CENTER		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5	25	6	
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	25	6	
% of Total Processed	69.45%	20.37%	10.18%	80.65%	19.35%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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KIDSPEACE NATIONAL CENTER

Requested Service	All Out of State Providers									KIDSPEACE NATIONAL CENTER								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21					20			5					
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

Disposition as of 07/15/2015

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LAKELAND BEHAVIORAL HEALTH SYSTEM

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			LAKELAND BEHAVIORAL HEALTH SYSTEM		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	4		4

Disposition of Submissions

	All Out of State Providers			LAKELAND BEHAVIORAL HEALTH SYSTEM		
Service	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5		1	
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2		3		
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	3	1	
% of Total Processed	69.45%	20.37%	10.18%	75%	25%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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LAKELAND BEHAVIORAL HEALTH SYSTEM

Requested Service	All Out of State Providers									LAKELAND BEHAVIORAL HEALTH SYSTEM								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13					3								
Review of Care-Youth Services					3		1											

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NEW HOPE CAROLINAS, INC.

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			NEW HOPE CAROLINAS, INC.		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	146	1	145

Disposition of Submissions

Service	All Out of State Providers			NEW HOPE CAROLINAS, INC.		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16	7	3	9
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5		1	
Psychiatric Residential Treatment (PRTF)	961	236	168	66	36	12
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2		11		
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	84	40	21
% of Total Processed	69.45%	20.37%	10.18%	57.93%	27.59%	14.48%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

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NEW HOPE CAROLINAS, INC.

Requested Service	All Out of State Providers									NEW HOPE CAROLINAS, INC.								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8					7								
Psychiatric Acute inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			64				2				
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13					7				4				
Review of Care-Youth Services					3		1											

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

SOUTHWOOD PSYCHIATRIC FACILITY

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			SOUTHWOOD PSYCHIATRIC FACILITY		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	113	1	112

Disposition of Submissions

Service	All Out of State Providers			SOUTHWOOD PSYCHIATRIC FACILITY		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5	95	12	5
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	95	12	5
% of Total Processed	69.45%	20.37%	10.18%	84.82%	10.71%	4.46%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

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SOUTHWOOD PSYCHIATRIC FACILITY

	All Out of State Providers									SOUTHWOOD PSYCHIATRIC FACILITY								
Requested Service	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21					74				21				
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

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THE BRADLEY CENTER

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			THE BRADLEY CENTER		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	196	1	195

Disposition of Submissions

	All Out of State Providers			THE BRADLEY CENTER		
Service	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168	107	40	47
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2		1		
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	108	40	47
% of Total Processed	69.45%	20.37%	10.18%	55.38%	20.51%	24.1%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

THE BRADLEY CENTER

Requested Service	All Out of State Providers									THE BRADLEY CENTER								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			86				21				
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13					1								
Review of Care-Youth Services					3		1											

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FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

THE SUMMIT SCHOOL

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			THE SUMMIT SCHOOL		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	28		28

Disposition of Submissions

Service	All Out of State Providers			THE SUMMIT SCHOOL		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6		22	6	
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	22	6	
% of Total Processed	69.45%	20.37%	10.18%	78.57%	21.43%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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THE SUMMIT SCHOOL

Requested Service	All Out of State Providers									THE SUMMIT SCHOOL								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4						2	16		4					
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

APS Healthcare, Inc. - West Virginia

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Out of State Providers Data Submission Activity Report

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TIMBER RIDGE SCHOOL

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			TIMBER RIDGE SCHOOL		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	27	3	24

Disposition of Submissions

Service	All Out of State Providers			TIMBER RIDGE SCHOOL		
	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2			1	
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2		8	2	
Residential Children's Service - Level II	50	33		9	4	
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	17	7	
% of Total Processed	69.45%	20.37%	10.18%	70.83%	29.17%	

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

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Out of State Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

TIMBER RIDGE SCHOOL

Requested Service	All Out of State Providers									TIMBER RIDGE SCHOOL								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2						6			2					
Residential Children's Service - Level II	40			10						6			3					
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

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Out of State Providers Data Submission Activity Report

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UNIVERSAL HEALTH SERVICES, INC

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			UNIVERSAL HEALTH SERVICES, INC		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	418		418

Disposition of Submissions

	All Out of State Providers			UNIVERSAL HEALTH SERVICES, INC		
Service	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16	39	17	7
PRTF Substance Abuse Program		2			1	
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168	272	33	10
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33				
Residential Children's Service - Level III	45	46		36	2	
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1			1	
Totals by Status	1289	378	189	347	54	17
% of Total Processed	69.45%	20.37%	10.18%	83.01%	12.92%	4.07%

Disability Group by Authorized / Reviewed Service

Disposition as of 07/15/2015

APS Healthcare, Inc. - West Virginia

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Out of State Providers Data Submission Activity Report

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UNIVERSAL HEALTH SERVICES, INC

Requested Service	All Out of State Providers									UNIVERSAL HEALTH SERVICES, INC								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8					31				8				
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5			233			26	13				
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10														
Residential Children's Service - Level III	33			6	5		1			27			3	5		1		
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

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Out of State Providers Data Submission Activity Report

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WV CHILDREN'S HOME (ELKINS)

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers			WV CHILDREN'S HOME (ELKINS)		
All Service Requests	Errors/ Duplicates	Clinically Processed	All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856	39		39

Disposition of Submissions

	All Out of State Providers			WV CHILDREN'S HOME (ELKINS)		
Service	Authorized	Closed	Denied	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1				
Non-Clinical Alternative Placement-Youth Services	22	6				
PRTF Offender Program	46	29	16			
PRTF Substance Abuse Program		2				
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5			
Psychiatric Residential Treatment (PRTF)	961	236	168			
Residential Children's Service - Level I	8	2				
Residential Children's Service - Level II	50	33		34	5	
Residential Children's Service - Level III	45	46				
Review of Care-Child Protective Services	33	2				
Review of Care-Youth Services	4					
Sub-Acute Hospitalization for < 21		1				
Totals by Status	1289	378	189	34	5	
% of Total Processed	69.45%	20.37%	10.18%	87.18%	12.82%	

Disability Group by Authorized / Reviewed Service

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Out of State Providers Data Submission Activity Report

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WV CHILDREN'S HOME (ELKINS)

Requested Service	All Out of State Providers									WV CHILDREN'S HOME (ELKINS)								
	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4														
PRTF Offender Program	38				8													
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21													
Psychiatric Residential Treatment (PRTF)	815			57	84		5											
Residential Children's Service - Level I	6			2														
Residential Children's Service - Level II	40			10						32			2					
Residential Children's Service - Level III	33			6	5		1											
Review of Care-Child Protective Services	19			1	13													
Review of Care-Youth Services					3		1											

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Out of State Providers Data Submission Activity Report
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Out of State Residential Providers Aggregate Summary

APS CareConnection® for Behavioral Health Outpatient Services Record Submission

All Out of State Providers		
All Service Requests	Errors/ Duplicates	Clinically Processed
1873	17	1856

Unduplicated Consumer Information

Provider Group/Description	Total Consumers with Service Requests	Consumers with Authed Service Requests	Authorization Rate By Consumer
Out of State Providers	97	84	86.6%

Disposition of Submissions

Service	All Out of State Providers		
	Authorized	Closed	Denied
Non-Clinical Alternative Placement-Child Protective Services		1	
Non-Clinical Alternative Placement-Youth Services	22	6	
PRTF Offender Program	46	29	16
PRTF Substance Abuse Program		2	
Psychiatric Acute Inpatient Hospitalization < 21	120	20	5
Psychiatric Residential Treatment (PRTF)	961	236	168
Residential Children's Service - Level I	8	2	
Residential Children's Service - Level II	50	33	
Residential Children's Service - Level III	45	46	
Review of Care-Child Protective Services	33	2	
Review of Care-Youth Services	4		

Disposition as of 07/15/2015

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Out of State Residential Providers Aggregate Summary

Sub-Acute Hospitalization for < 21		1	
Totals by Status	**1289**	**378**	**189**
% of Total Processed	69.45%	20.37%	10.18%

Disability Group by Authorized / Reviewed Service

	All Out of State Providers								
Requested Service	MH	SA	MR/DD	MH & SA	MH & MR/DD	SA & MR/DD	MH & SA & MR/DD	EC	PI
Non-Clinical Alternative Placement-Youth Services	2	16		4					
PRTF Offender Program	38				8				
Psychiatric Acute Inpatient Hospitalization < 21	94			5	21				
Psychiatric Residential Treatment (PRTF)	815			57	84		5		
Residential Children's Service - Level I	6			2					
Residential Children's Service - Level II	40			10					
Residential Children's Service - Level III	33			6	5		1		
Review of Care-Child Protective Services	19			1	13				
Review of Care-Youth Services					3		1		

APS Healthcare, Inc. - West Virginia

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Socially Necessary Authorized Service Breakdown

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

Region I

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Adult Life Skills		199	578		52			88	28		15
Agency Transportatation							1				
Agency Transportation		739		9	146			888		22	76
Agency Transportation One			1266						114		
Agency Transportation Two			771						17		
CAPS Case Management		8	28					286	23		
CAPS Family Assessment		8	28					286	22		
Case Management Services	27										
Connection Visit			1								
Emergency Respite			1								
Family Assessment							1				
Family Crisis Response		10						14			3
General Parenting		3	2								
In State Home Study			46								
Individual Review			14					5	10		
Individualized Parenting		305	739		79			378	91		49
Intervention Transport Time		453	848		96			299	32		27
Lodging			10						6		1

APS Healthcare, Inc. - West Virginia

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Socially Necessary Authorized Service Breakdown

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

Region I

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Lodging Pre-adoptive			1								
MDT		105	747		57			103	44		20
Meals			11						11		
Meals Pre-adoptive			1								
Needs Assessment	36										
Pre-Reunification Support			23								
Private Transportation		3			3						
Private Transportation One			151						26		
Private Transportation Two			69						2		
Public Transportation		46			2			9			
Public Transportation One			98								
Respite Daily			13								
Safety Services		283			38			115			20
Supervised Visitation 2			343		10				5		
Supervised Visitation One		57	547						5		
Supervised Visitation Two		30									
Supervised Vistitation One					31			5			
Supervision		103			22			296			38

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Socially Necessary Authorized Service Breakdown
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Region I

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Transitional Living Placement Phase 2 Part 1				9						21	
Transitional Living Placement: Phase 2 Part 2										1	
Transport Time		10	16		6			2			

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Bureau for Children and Families

Socially Necessary Authorized Service Breakdown

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Region II

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Adult Life Skills		536	1229		156			132	23		24
Agency Transportation		1319			275			1243		12	97
Agency Transportation One			2395						150		
Agency Transportation Two			867						20		
CAPS Case Management		29	56					695	46		
CAPS Family Assessment		28	56					694	46		
Case Management Services	55										
Connection Visit			1						2		
Emergency Respite			2								
Family Crisis Response		7	1		5			11	3		1
General Parenting		1	7								
In State Home Study			404								
Individual Review			14						28		
Individualized Parenting		652	1450		180			432	88		79
In-state Home Study									3		
Intervention Transport Time		819	1917		178			238	40		45
Lodging			12						23		
MDT		45	679		73			64	11		16

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Bureau for Children and Families

Socially Necessary Authorized Service Breakdown

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Region II

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Meals			12						24		
Needs Assessment	57										
Pre-Reunification Support			14								
Private Transportation		1						2			
Private Transportation One			242						78		
Private Transportation Two			147						9		
Public Transportation		209			12			45			3
Public Transportation One			170						10		
Public Transportation Two			3								
Respite Daily			8								
Safety Services		490			50			36			16
Supervised Visitation 2			325		14				3		
Supervised Visitation One		95	1140						19		
Supervised Visitation Two		17									
Supervised Vistitation One					53			7			
Supervision		129			55			121			6
Transitional Living Placement Phase 2 Part 1				2						12	
Transitional Living Placement: Pre-Placement Activities										1	

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Socially Necessary Authorized Service Breakdown

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Region II

Service	Child Protective Services						Youth Services				
	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Transport Time		68	162		24			26	10		12
Tutoring			3								

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Socially Necessary Authorized Service Breakdown

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Region III

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Adult Life Skills		223	393		33			34	6		2
Agency Transportation		419			46			310		21	53
Agency Transportation One			787						29		
Agency Transportation Three			1								
Agency Transportation Two			398						1		
CAPS Case Management		31	48					87	9		
CAPS Family Assessment		31	48					89	9		
Case Management Services	41										
Connection Visit			2								
Family Crisis Response								5			
General Parenting			1								
In State Home Study			44								
Individual Review			1						7		
Individualized Parenting		246	450		40			160	18		32
In-state Home Study									2		
Intervention Transport Time		271	500		40			129	10		34
Lodging			19						51		
MDT		109	458		25			125	11		34

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Socially Necessary Authorized Service Breakdown
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Region III

Service	Child Protective Services						Youth Services				
	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Meals			23						56		
Needs Assessment	52										
Pre-Reunification Support			11								
Private Transportation One			139						72		
Private Transportation Two			89								
Public Transportation One			32						48		
Respite Daily			4								
Safety Services		89			2			35			10
Supervised Visitation 2			164		1						
Supervised Visitation One		45	340						1		
Supervised Visitation Two		22									
Supervised Vistitation One					6			1			
Supervision		51			19			135			35
Transitional Living Placement Phase 2 Part 1										22	
Transport Time		4	12					2			
Tutoring			4								

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Socially Necessary Authorized Service Breakdown

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Region IV

Service	Child Protective Services						Youth Services				
	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Adult Life Skills		595	1168		128			117	17		20
Agency Transportation		1580			322			838		10	134
Agency Transportation One			2786						149		
Agency Transportation Three			1								
Agency Transportation Two			831						19		
CAPS Case Management		6	16					103	7		
CAPS Family Assessment		6	16					101	7		
Case Management Services	1										
Connection Visit			1								
Emergency Respite			1								
Family Crisis Response		12	4		3			7			
General Parenting		5	6								
Home Maker Services		8									
In State Home Study			363								
Individual Review		1	8						5		
Individualized Parenting		780	1366		164			425	69		74
In-state Home Study									5		
Intervention Transport Time		817	2042		204			238	99		38

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Socially Necessary Authorized Service Breakdown

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

Region IV

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Lodging			6						12		
MDT		195	1045		97			193	37		37
Meals			6						16		
Needs Assessment	6										
Pre-Reunification Support			27						1		
Private Transportation		4									
Private Transportation One			77						17		
Private Transportation Two			41								
Public Transportation		92			20			27			3
Public Transportation One			82						4		
Respite Daily			38						1		
Safety Services		239			15			24			1
Supervised Visitation 2			189		4				2		
Supervised Visitation One		139	1390						53		
Supervised Visitation Two		9									
Supervised Vistitation One					47			2			1
Supervision		379			120			306			54
Transitional Living Placement Phase 2 Part 1										12	

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Socially Necessary Authorized Service Breakdown

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

Region IV

	Child Protective Services						Youth Services				
Service	Family Support	Family Preservation	Foster Care	Chafee	Reunification	Adoption Preservation	Family Support	Family Preservation	Foster Care	Chafee	Reunification
Transport Time		619	1134		116			114	56		16
Tutoring			1								

APS Healthcare, Inc. - West Virginia

Bureau for Children and Families

Social Necessity Providers Data Submission Activity Report

FYTD 2014 - 2015 (Jul 2014 - Jun 2015)

Socially Necessary Service Providers Aggregate Report

SERVICE REQUESTS

Provider Group / Description	Requests Received	Errors	Duplicates	Auto Closed	Clinically Processed	% Processed
21 Licensed Behavioral Health Centers	18640	29	33	545	18033	96.74%
316 Private Providers	56442		104	1347	54991	97.43%
Totals for All Providers	75082	29	137	1892	73024	97.26%

CLINICALLY PROCESSED SERVICE REQUESTS

Provider Group / Description	Clinically Processed	Denials	Pend to Close	Pend to Auth	Auto Auth	Auth Rate
21 Licensed Behavioral Health Centers	18033	88	1701	13894	2350	90.08%
316 Private Providers	54991	409	5347	36537	12698	89.53%
Total for All Providers	73024	497	7048	50431	15048	89.67%

STATUS OF CONSUMERS WITH SERVICE REQUESTS

Provider Group/Description	Total Consumers with Service Requests	Consumers with Authorized Service Requests	Authorization Rate By Consumer
Licensed Behavioral Health Centers	3225	3163	98.08%
Private Providers	8575	8361	97.5%
All Providers	11387	11111	97.58%

AUTHORIZATION ADJUSTMENTS: MODIFICATION OF AN EXISTING AUTHORIZATION

Provider Group / Description	Modification Increased Authorized Units and/or Expanded the Authorized Date Range	Modification Decreased the Authorized Units and/or Decreased the Authorized Date Range
18 LBHC	1077	3778
1 OoS	7	8
180 PP	3102	15270
Totals for All Providers	4186	19056

Disposition as of 07/15/2015

APS
Overview and Analysis of Provider Retrospective Reviews
Behavioral Health Outpatient Providers
Round: August 1, 2010 – January 31, 2012

Descriptive Summary

During this 18-month training/consultation round **5568 unduplicated charts** were reviewed. The intent of the Consultation Review process is to improve the quality of services our members receive. One improvement measure would be an increase in provider scores.

The review tools were the same tools used in the previous round. Providers were familiar with the tools but additional trainings were conducted which included training smaller groups of providers within an agency for a more individualized approach.

Sixty five (65) was the expected benchmark score for Basic Living Skills, Behavior Management, Crisis Support, Residential Level I, Level II and Level III. All other reviewed services were targeted at a score of at least 50. No Authorization Adjustments or Administrative Rollbacks were issued during this round.

There was only one provider for the service of Basic Living Skills and the score was 0%. 6 of 9 providers scored below 65% for Behavior Management Development and 2 of 3 providers scored below 65% for Behavior Management Implementation. There were 2 out of 4 providers who scored below 65% for Crisis Support/ Child Emergency Shelter. For Residential I, only 1 of 4 providers scored above 65%. 9 out of 17 providers scored below the 65% benchmark for Residential II, and 3 of 6 scored below the benchmark for Residential III.

Targeted Case Management continued to be one of the lowest scoring services, with only 4 of the 51 providers reviewed receiving an overall score above 50%. All 8 ACT providers scored above 50%. 14 of the 19 remaining services averaged a score above 50% (BH Counseling Professional Group, BH Counseling Professional Individual, BH Counseling Supportive Group, BH Counseling Supportive Individual, Crisis Stabilization, Crisis Intervention, CFT, Day Treatment, Family Therapy, Group Therapy, Individual Psychotherapy, Individual Psychotherapy with Med. Management, Med, Management, IOP, Mental Health Assessment by Non-Physician, Diagnostic Psychiatric Evaluation, Diagnostic Psychological Evaluation, Psychological Testing, and Psychological Screening). The results for each of the services will be listed below including results of the Organizational tools of Clinical Consistency, Consumer Rights, and Credentialing.

The organizational tools are currently used with only Licensed Behavioral Health Centers (LBHC). Due to credentialing and clinical consistency issues observed in Private Practices (PP), it is recommended that the PP also be evaluated for these issues. An organizational tool can be developed to address these concerns in PP.

Introduction

APS conducts Provider Consultations to examine the utilization management process of outpatient behavioral health providers and to evaluate the degree to which the providers' documentation supports the medical necessity and appropriate utilization of services authorized in the current statewide Utilization Management initiative conducted by APS on behalf of the West Virginia Department of Health and Human Resources. During the **August 1, 2010-January 31, 2012** Consultation Cycle, Provider Consultations were conducted with Behavioral Health (BH) providers which included Licensed Behavioral Health Centers, Bureau for Children and Families Out-of-State Providers and Private Practices. A total of **5568** unduplicated Behavioral Health consumer charts were reviewed during this consultation round.

Clinical Services Reviewed

The following are the Medically Necessary services currently evaluated at Licensed Behavioral Health Centers or Private Practices:

- ACT
- Behavioral Health Counseling-Professional
- Behavioral Health Counseling-Professional Group
- Behavioral Health Counseling-Supportive
- Behavioral Health Counseling-Supportive Group
- Community Psychiatric Supportive Services (CSU)
- Community Comprehensive Support Services (CFT)
- Crisis Intervention
- Crisis Support (Children's Shelter)
- Day Treatment
- Family Therapy
- Group Therapy
- Individual Therapy with Medical Management
- Intensive Program
- Medication Management
- Mental Health Assessment by Non-Physician
- Psychiatric Diagnostic Interview by Psychiatrist
- Psychiatric Diagnostic Interview by Psychologist
- Psychological Testing
- Psychotherapy (Low End)
- Residential I
- Residential II
- Residential III
- Screening by a Licensed Psychologist
- Skills Training and Development (Basic Living Skills)
- Therapeutic Behavioral Services-Development
- Therapeutic Behavioral Services-Implementation
- Targeted Case Management

On-Site vs. Desk Reviews

All LBHC providers receive on-site consultations. All PP providers receive unless their total number of unduplicated consumers for the relevant authorization period is 50 or less. For those with 50 or less, desk audits are conducted. The number of cases reviewed per provider is determined by a statistical model that incorporates factors related to both quantity of services and unduplicated consumers and quality of documentation as based upon previous review scores.

All providers received feedback from their Trainer/Consultant(s) verbally at the Exit Interview at the end of each consultation and in the Consultation Report, which is conveyed to the provider within 30 business days of the consultation. Trainer/Consultants provide regional, statewide and on-site training as necessary on all aspects of documentation and Utilization Management for the myriad of Medicaid BH services authorized.

Frequency of Reviews

The majority of Licensed Behavioral Health Centers are reviewed twice in an 18-month cycle and may be reviewed as many as three times. The determination as to whether a LBHC is reviewed twice or thrice is determined at the beginning of each review cycle and is based upon data from the previous cycle which includes the number of unduplicated consumers served, the number of services provided, total authorizations for the provider and the provider's previous scoring in APS reviews.

Private Practices are reviewed at least once in an 18-month cycle. Out of State providers are reviewed once each 18-month cycle.

Explanation of Tables and Abbreviations:
LBHC – Licensed Behavioral Health Center
Comp LBHC – Comprehensive Licensed Behavioral Health Center
Comp LBHC Specialty – Comprehensive Licensed Behavioral Health Center, Specialty (for private practice codes)
LBHC and Child Res – Licensed Behavioral Health Center and Children's Residential Center
Child Res Only – Children's Residential Center

The first three tables to follow will list the scores per provider review for each of the Licensed Behavioral Health Centers for the last 18-month cycle for the organizational scores (Clinical Consistency, Consumer Rights, and Credentialing). The table will list the provider name and date of review, the provider type (LBHC, Comp LBHC, Comp LBHC Specialty, LBHC and Child Res, Child Res Only, and Private Practice), the score for that review date, and the aggregate score for all reviews in the round with an indicator of the only ((1)), initial ([score] (1)), second ([score] (2)), or third ([score](3)) review. Two of the tables will indicate in gray shading all those providers who scored below the threshold of 50% and the aggregate scores per provider that scored below 50%. The other table, Consumer Rights, does not have shading due to every provider scoring above the threshold.

The next table lists each service and the aggregate score across all providers. Each service that scored below 50% will be indicated by gray shading.

The tables that follow will list each provider's review scoring for each service. The services that score below the threshold (50% or 65% depending on the service) will be indicated by gray shading along with the aggregate scores per provider that fall below the threshold.

SUMMARY

As stated previously in this report, 9 out of 28 services reviewed scored below 50% aggregately. The lowest scoring service was Basic Living Skills which was only provided by one provider. It is believed that there are no providers providing this service since the review period. Targeted Case Management was the next lowest score at 21% with 29 providers. Day Treatment scored 42% with 4 providers. Behavioral Health Counseling Supportive scored 44% with 29 providers. Behavior Management – Implementation scored 44% with 3 providers. Behavior Health Counseling – Professional Group scored 45% with 7 providers. Crisis Intervention scored 45% with 14 providers. Residential I scored 48% with 4 providers. Behavioral Health Counseling – Supportive Group scored 49% with 7 providers. The three highest aggregate scores across providers were for the services of Medication Management, Psychological Evaluation, and Psychological Screening.

These aggregate scores across providers should be interpreted with caution, as there is great variance between scores for different and same providers for each service reviewed. A more detailed assessment of provider scoring can be seen in the summaries for each individual service.

APS remains committed to improving the quality of service provision and documentation for Medicaid behavioral health services in West Virginia. To meet provider needs we offer on-site, webinar, email and statewide training as requested and at the suggestion of each individual Trainer/Consultant.

Recommendations:

Policy Recommendation: (Continued:
Review the Behavioral Health Medicaid manuals' sections regarding credentialing and clinical supervision. Specifically:

Chapter 502 Behavioral Health Clinic Services sections

- 502.4.1 Enrollment Requirements: Agency Administration and
- 502.4.2 Enrollment Requirements: Staff Qualifications

Chapter 503 Behavioral Health Rehabilitation sections

- 503.4.1 Enrollment Requirements: Agency Administration and
- 503.4.2 Enrollment Requirements: Staff Qualifications

The manual leaves the agency to set policies for staff training, supervision and compliance monitoring. However, based upon findings in both the organizational and clinical sections of the APS Retrospective Review Tools, there is a lack of clinical supervision and established competence levels throughout the Licensed Behavioral Health Centers. Supervisory staff is signing off on clinical documentation that does not meet the mechanical documentation standards and/or the service definition of the code being provided. The staff members' personnel charts indicate they are fully competent and credentialed by the agency. However, how the determination was made is not clear. Clinical supervision notes, if present, appear cursory in nature. The link between what is discussed in clinical supervision and the impact to direct practice is not demonstrated.

Systemic Recommendation:

The three bureaus should present to all the different types of behavioral health providers a united expectation of competency and accountability. When it is determined a provider is providing services or a single service below expectations an agency should require to complete a functional assessment and plans to follow up on deficits to be reviewed with the three Bureaus. Most of the agencies that are still struggling have systemic deficits and/or a mission that is not consistent with their payer sources.

Work force development continues to be an issue across the state for services provided by bachelors and masters level clinicians. Discussions with in state colleges and universities regarding program/curriculum changes would benefit all three bureaus.

Retrospective Review Tool Recommendations:

Consider not penalizing providers for getting authorizations and not implementing them. Current scoring is based on the premise the providers completed an assessment and by requesting specific codes, the provider is verifying these are the services necessary for the consumer's recovery. While not using requested services is important, it could be documented in the findings and recommendations without reducing the agency's overall scores.

Service Specific Recommendations/Observations:

Basic Living Skills:

- Basic Living Skills was provided by one agency who mainly provides IDD Waiver services. The members were awaiting IDD Waiver Slots
- A time limit should be set for this service. If the basic living skills cannot be rehabilitated in the specified period Assertive Community Treatment would most likely be a more appropriate service.

Targeted Case Management:

- A new manual has been implemented addressing the majority of concerns for this service. The outpatient population providers have historically targeted should be enrolled in a Health Home when/where available.

Day Treatment:

- Documentation did not support medical necessity in the lower scoring agencies.
- Goals and objectives on the individuals treatment plans were not commiserate with the assessed need.
- One provider was combining all the members receiving clinic day treatment, rehabilitative day treatment and CFT into one group and completing the same activities including going into the community for outings.

Behavioral Health Counseling-Supportive Individual and Group:

- This service is concentrated in foster care, IS and children's residential settings. Intensive Service programs generally demonstrate a better utilization of the code in part because their target audiences are narrowly defined and provided in a very structured manner.
- When utilized in child care situation the service notes reflect a mentoring type service. There appears to be more difficulty implementing the concept of medically necessity in these settings. It is the most frequently used service in the residential bundle and requires the least educated staff which conflicts with the purpose of providing treatment in this setting. When provided in a foster family home the documentation is more reflective of a monthly face-to face visit than an actual behavioral health intervention. Therapy is often the more appropriate service upon review of the chart.
- These codes should be an adjunct service to professional therapy.

Residential Level One:

- The behavioral health needs of youth receiving this service are minimal. The main service provided is supportive counseling. Providers struggle in documentation to differentiate what is medically necessary and what is purely environmental. Fee for Service may be a better option rather than a residential bundle to meet the target population's needs.

Crisis Intervention:

- The main reasons for agencies scoring below the mean are no documentation; service was rendered to someone other than the identified client and case management functions being performed such as referral to a hospital.

Behavioral Health Counseling- Professional group:

- Scores for this service were reduced because staff members did not have the proper credentials.
- The service was also being utilized to complete DUI classes.

Behavior Management Implementation:

- There were only three providers of this service.
- One provider had no plans in any of the charts to be reviewed.
- The second provider was using the service to address age appropriate behaviors rather than behaviors related to the diagnosis and used this service for recreational activities.
- More providers need to be recruited for behavior management particularly to service children with behavioral disorders.

Logan Mingo Area Mental Health: Fiscal Year 2013-2014 Authorizations by Service & Payer

	Authorized Payer		
Service	BBHHF	MEDICAID	Total Auths
Behavioral Health Counseling, Professional, Group	13	168	181
Behavioral Health Counseling, Professional, Individual	440	979	1,419
Behavioral Health Counseling, Supportive, Group	1	0	1
Comprehensive Community Support Services	0	34	34
Comprehensive Evaluation by a Psychologist	10	51	61
Mental Health Assessment by non-Physician	310	642	952
Psychiatric Diagnostic Evaluation	12	58	70
Psychiatric Diagnostic Evaluation with Medical Services	102	226	328
Screening by Licensed Psychologist	18	23	41
Total # of Authorizations by Payer and Grand Total	**906**	**2,181**	**3,087**
Unduplicated Authorized Persons	**465**	**1,029**	**1,382**

Note: 56 Persons had authorization for both payers, thus 465 + 1,029 does not equal 1,382

Logan Mingo Area Mental Health: Fiscal Year 2014-2015 Authorizations by Service & Payer

	Authorized Payer		Service
Service	BBHHF	MEDICAID	Totals
Behavioral Health Counseling, Professional, Group	155	682	837
Behavioral Health Counseling, Professional, Individual	255	972	1,227
Behavioral Health Counseling, Supportive, Group	7	31	38
Behavioral Health Counseling, Supportive, Individual	6	22	28
Comprehensive Community Support Services	0	30	30
Comprehensive Evaluation by a Psychologist	1	9	10
Mental Health Assessment by non-Physician	153	747	900
Mental Health Service Plan Development by non-physician	8	66	74
Physician Coordinated Care Oversight Services	4	21	25
Psychiatric Diagnostic Evaluation	1	11	12
Psychiatric Diagnostic Evaluation with Medical Services	110	600	710
Screening by Licensed Psychologist	18	31	49
Total # of Authorizations by Payer and Grand Total	**718**	**3,222**	**3,940**
Unduplicated Authorized Persons	**284**	**1,113**	**1,359**

Note: 39 Persons had authorization for both payers, thus 284 + 1,114 does not equal 1359

Unduplicated Authorized Persons During Fiscal Years 2013-2014 and 2014-2015: 2,798

Data as of 10/07/2015

Calendar Year 2014: Persons with a Sexual Abuse Diagnosis Authorized for Service

Age Group	# of Unduplicated Individuals
Adult (21 Years and Greater)	210
Child (Less than 21 Years)	2863
Total Unduplicated	3073

Calendar Year 2014: 133 Providers Gained Service Authorization for Persons with Sexual Abuse Diagnosis

Provider Received Service Authorization for Individual(s) with a Sexual Abuse or Offender Diagnosis	
PROVIDER	# Persons Authorized for this Provider
A. P. T., INC.	1
ALICE C. TYLER VILLAGE OF CHILDHELP	13
APPALACHIAN COMMUNITY HEALTH CENTER	6
APPALACHIAN PSYCHIATRIC SERVICES	1
APPALACHIAN PSYCHOLOGICAL ASSOCIATES, INC.	8
ASPIRE - LESTER SARGENT	10
ASSOCIATED BEHAVIORAL CONSULTANTS - CATHY L. CARUTHERS, M.A.	5
BARBOUR COUNTY HEALTH DEPARTMENT	9
BARRY ROBINSON CENTER PSYCHIATRIC RESIDENTIAL TREATMENT	11
BOARD OF CHILD CARE	40
BRALEY AND THOMPSON, INC.	33
BRIDGEPORT BEHAVIORAL CLINIC	2
BURLINGTON UNITED METHODIST FAMILY SERVICES	71
CAMMACK CHILDREN'S CENTER	19
CARDINAL PEDIATRICS	6
CHAMELEON HEALTH CARE	4
CHILDREN'S HOME SOCIETY OF WEST VIRGINIA	336
CLEAR CREEK COUNSELING	5
CLIFTON R. HUDSON, PH. D.	4
COASTAL HARBOR	1
COMMUNITY HEALTH SYSTEMS	2
CORNELL ABRAXAS	2
CRITTENTON SERVICES, INC.	257
CRYSTAL KNIGHT-DUNKLEY	14
DALE M. RICE - PAIS	1
DAMOUS PSYCHOLOGICAL SERVICES - LBHC	27
DAVIS-STUART, INC.	29
DAYMARK	15
DEVEREUX	5
E. A. HAWSE HEALTH CENTER, INC.	2
EASTERN PSYCHOLOGICAL SERVICES, INC.	42
EASTRIDGE HEALTH SYSTEMS	24
ELKINS MOUNTAIN SCHOOL	21
EMILY E. WILSON, PLLC DBA RIVER VALLEY ASSOCIATES	1
FAMILY & MARITAL COUNSELING CENTER, INC.	11
FAMILY CARE HEALTH CENTER	1
FAMILY CONNECTIONS	6
FAMILY COUNSELING CONNECTION	42
FAMILY OPTIONS PROVIDERS, INC.	58
FAMILY PRESERVATION SERVICES OF WV, INC.	98
FAMILY SERVICE OF MARION & HARRISON COUNTIES	5
FMRS MENTAL HEALTH COUNCIL	105
FOX RUN RESIDENTIAL TREATMENT CENTER	5
GENESIS YOUTH CENTER, INC.	58

Calendar Year 2014: 133 Providers Gained Service Authorization for Persons with Sexual Abuse Diagnosis

PROVIDER	# Persons Authorized for this Provider
GEORGE JUNIOR REPUBLIC	5
Golden Girl, Inc.	9
GREGORY E. TRAINOR, M.A. & ASSOCIATES	1
HAMNER PSYCHOLOGICAL SERVICES	93
HEALING MINDS CLINIC, PLLC	1
HEALTHWAYS, INC.	5
HIGHLAND - CLARKSBURG HOSPITAL	33
HIGHLAND HOSPITAL	38
HOME BASE	3
HORIZON PSYCHOLOGICAL SERVICES	2
JEFFERSON SCHOOL BASED HEALTH CENTER	1
JUDITH F. LUCAS, M.A.	1
KANAWHA VALLEY CENTER, INC.	165
KAY COLLINS-BALLINA	4
LANTERN MENTAL HEALTH INC.	2
LAUREL MOUNTAIN PSYCHOLOGICAL INC.	1
LAUREL RIDGE PSYCHOLOGICAL ASSOCIATES	2
LOGAN-MINGO AREA MENTAL HEALTH	14
MAREDA L REYNOLDS	1
MCCULLOUGH PSYCHOLOGICAL SERVICE	2
MERCER MEDICAL GROUP	3
MIDLAND BEHAVIORAL HEALTH	24
MID-VALLEY HEALTHCARE	2
MILESTONES PHYSICAL THERAPY	5
MISTI JONES WHEELER, MS INC.	1
MONONGALIA COUNTY YOUTH SERVICES CENTER	3
MOUNTAIN STATE PSYCHOLOGICAL SERVICES, PLLC	6
NATIONAL DEAF ACADEMY	3
NATIONAL YOUTH ADVOCATE PROGRAM	155
NECCO, INC.	105
NEW HOPE CAROLINAS, INC.	7
NEW HORIZONS THERAPY SERVICES, LLC	112
NEW RIVER HEALTH ASSOCIATION	3
Northwood Health Systems	6
OLYMPIC CENTER - PRESTON, INC.	2
PARK VALLEY BEHAVIORAL	4
PARKERSBURG PSYCHOLOGICAL SERVICES	3
PATHWAYS PSYCHOLOGICAL CENTER	8
POTOMAC CENTER	11
Potomac Highlands Guild	22
PRESSLEY RIDGE SCHOOLS	161
PRESTERA CENTER FOR MENTAL HEALTH SERVICES	199
PROCESS STRATEGIES	24
PROFESSIONAL COUNSELING ASSOCIATES, INC	8
PSYCH SERVICES OF ROANE COUNTY, INC.	14

Calendar Year 2014: 133 Providers Gained Service Authorization for Persons with Sexual Abuse Diagnosis

PROVIDER	# Persons Authorized for this Provider
PSYCHOLOGICAL ASSOCIATES OF LOGAN	1
RAINELLE MEDICAL CENTER	6
RITCHIE COUNTY SCHOOL BASED HEALTH & WELLNESS CTR	1
RITCHIE REGIONAL HEALTH CTR PARKERSBURG SO. CAMPUS	2
RIVER PARK HOSPITAL	97
ROANE COUNTY FAMILY HEALTHCARE, INC.	1
S. ELIZABETH HICKS	10
SAAR PSYCHOLOGICAL GROUP	5
SCHWABE & ASSOCIATES	1
SENECA HEALTH SERVICES INC.	44
SEQUEL SCHOOLS, LLC	1
SHARON G. MCMILLEN, M.A.	48
SHENANDOAH VALLEY MEDICAL SYSTEM	8
SOLUTIONS OUTPATIENT SERVICES, INC.	48
SOLUTIONS PSYCHOLOGICAL SERVICES, PLLC	36
SOUTHERN HIGHLANDS COMMUNITY MH CTR	5
SPAULDING PSYCHOLOGICAL SERVICES	62
St. John's Home for Children	10
ST. MARY'S MEDICAL CENTER	1
STARLIGHT BEHAVIORAL HEALTH SERVICES	9
Stepping Stone, Incorporated	2
STEPPING STONES, INC.	2
TAMMY CORBETT-ALDERMAN	7
TERESA C. SAMSOCK	2
TERRY LAURITA SIGLEY	14
THE BRADLEY CENTER	7
THE CHILDREN'S HOME OF WHEELING, INC.	5
TRY-AGAIN HOMES	65
UNITED SUMMIT CENTER	57
UNIVERSAL HEALTH SERVICES, INC	29
VALLEY HEALTH CARE	1
VALLEY HEALTH HURRICANE	2
VIRGINIA COMMONWEALTH UNIVERSITY HEALTH SYSTEM	1
WESTBROOK HEALTH SERVICES	66
WHEELING HOSPITAL	21
WILLOW RIDGE	1
WV CHILDREN'S HOME (ELKINS)	3
WV FAMILY SUPPORT & REHABILITATION SERVICES	20
WVU HEALTHCARE	14
YORE ACADEMY, INC.	6
YOUTH ACADEMY, LLC	8
YOUTH ADVOCATE PROGRAMS (YAP), INC.	8
YOUTH HEALTH SERVICES	114
YOUTH SERVICES SYSTEM	71

Youth Services: Unduplicated Youth with C/R Authorization by Provider

Between July 01 2013 and June 30 2015

68 LBHCs Obtained a Clinic/Rehabilitation Service Authorization

For Youth under the age of 18 on the Requested Start Date of Service

The statewide unduplicated number of youth with an authorization = 25,920

Whereas, the unduplicated number of youth per provider = 31,766

LBHC - Clinic/Rehabilitation Provider	# of Unduplicated Youth
APPALACHIAN COMMUNITY HEALTH CENTER	516
BARBOUR COUNTY HEALTH DEPARTMENT	266
BECKLEY TREATMENT CENTER	7
BOARD OF CHILD CARE	167
BRALEY AND THOMPSON, INC.	170
BURLINGTON UNITED METHODIST FAMILY SERVICES	438
CAMMACK CHILDREN'S CENTER	205
CHARLESTON TREATMENT CENTER	8
CHILDREN'S HOME SOCIETY OF WEST VIRGINIA	1893
CLARKSBURG TREATMENT CENTER	1
CRITTENTON SERVICES, INC.	1466
DAMOUS PSYCHOLOGICAL SERVICES - LBHC	1538
DAVIS-STUART, INC.	269
DAYMARK	114
EASTRIDGE HEALTH SYSTEMS	1150
ELKINS FAMILY COUNSELING CENTER	66
ELKINS MOUNTAIN SCHOOL	280
FAMILY CONNECTIONS	229
FAMILY COUNSELING CONNECTION	430
FAMILY OPTIONS PROVIDERS, INC.	785
FAMILY PRESERVATION SERVICES OF WV, INC.	850
FAMILY SERVICE OF MARION & HARRISON COUNTIES	60
FAMILY SERVICE, DIV. OF GOODWILL IND. KYOWVA, INC.	112
FMRS MENTAL HEALTH COUNCIL	831
GENESIS YOUTH CENTER, INC.	351
Golden Girl, Inc.	67
GRAFTON INTEGRATED HEALTH NETWORK	14
HEALTHWAYS, INC.	294
HIGHLAND HEALTH CENTER, INC.	2
HOME BASE	27
HUNTINGTON TREATMENT CENTER	1
KANAWHA VALLEY CENTER, INC.	623

LBHC - Clinic/Rehabilitation Provider	# of Unduplicated Youth
LOGAN-MINGO AREA MENTAL HEALTH	358
MID-VALLEY HEALTHCARE	44
MONONGALIA COUNTY YOUTH SERVICES CENTER	124
NATIONAL YOUTH ADVOCATE PROGRAM	453
NECCO, INC.	754
NEW HORIZONS THERAPY SERVICES, LLC	1058
Northwood Health Systems	147
OLYMPIC CENTER - PRESTON, INC.	69
PARKERSBURG TREATMENT CENTER	1
PETER J. CALLAHAN PLLC, DBA CALLAHAN COUNSELING SERVI	4
POTOMAC CENTER	47
Potomac Highlands Guild	418
PRESSLEY RIDGE SCHOOLS	1011
PRESTERA CENTER FOR MENTAL HEALTH SERVICES	4274
REM COMMUNITY OPTIONS, INC.	1
SENECA HEALTH SERVICES INC.	1358
SOUTHERN HIGHLANDS COMMUNITY MH CTR	362
St. John's Home for Children	29
STARLIGHT BEHAVIORAL HEALTH SERVICES	194
Stepping Stone, Incorporated	45
STEPPING STONES, INC.	36
THE CHILDREN'S HOME OF WHEELING, INC.	52
TRY-AGAIN HOMES	238
UNITED SUMMIT CENTER	3193
VALLEY HEALTH CARE	298
WESTBROOK HEALTH SERVICES	1842
WHEELING TREATMENT CENTER	3
WILLIAMSON TREATMENT CENTER	3
WV CHILDREN'S HOME (ELKINS)	92
WV FAMILY SUPPORT & REHABILITATION SERVICES	195
YALE ACADEMY, LLC	26
YORE ACADEMY, INC.	96
YOUTH ACADEMY, LLC	81
YOUTH ADVOCATE PROGRAMS (YAP), INC.	207
YOUTH HEALTH SERVICES	1068
YOUTH SERVICES SYSTEM	355

FQHC/RHC: 17 Organizations - 24 Sites Participating in UM Program between 01/28/2014 and 01/27/2015

BLUESTONE HEALTH CENTER
CABIN CREEK HEALTH SYSTEMS
CHANGE INC. FAMILY MEDICAL CARE
COMMUNITY HEALTH SYSTEMS
E. A. HAWSE HEALTH CENTER, INC.
FAMILY CARE HEALTH CENTER
GRAFTON CITY HOSPITAL DBA TYGART VALLEY TOTAL CARE CLINIC
JEFFERSON SCHOOL BASED HEALTH CENTER
LINCOLN COUNTY PRIMARY CARE
MINNIE HAMILTON HEALTH SYSTEM
MONROE COUNTY HEALTH CENTER
NEW RIVER HEALTH ASSOCIATION
RAINELLE MEDICAL CENTER
RITCHIE COUNTY PRIMARY CARE ASSOC. INC
RITCHIE COUNTY SCHOOL BASED HEALTH & WELLNESS CTR
RITCHIE REGIONAL HEALTH CTR PARKERSBURG SO. CAMPUS
ROANE COUNTY FAMILY HEALTHCARE, INC.
SHENANDOAH VALLEY MEDICAL SYSTEM
VALLEY HEALTH EAST HUNTINGTON
VALLEY HEALTH HUNTINGTON
VALLEY HEALTH HURRICANE
VALLEY HEALTH INC ARBOR
VALLEY HEALTH INC MILL CREEK
VALLEY HEALTH MILTON

Compiled: January 29 2015

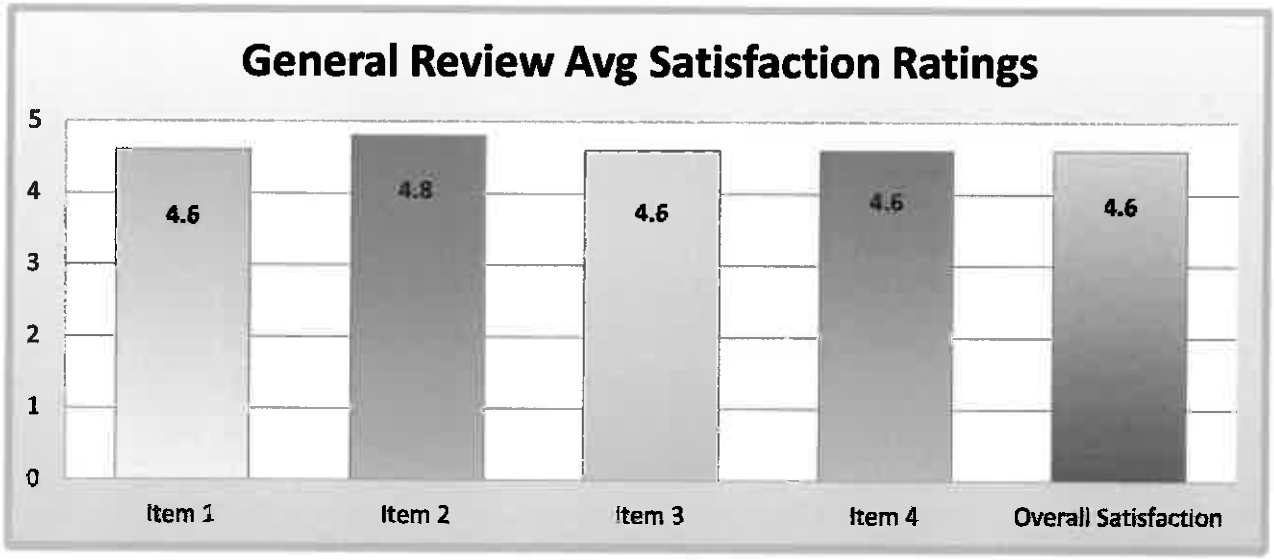
I/DD Waiver Quarterly Satisfaction Results
April 1-June 30, 2015

At the conclusion of each Provider review, APS Healthcare staff request that review participants complete a satisfaction survey. A 5-point Likert scale is used, with 5 being **strongly agree** and 1 being **strongly disagree**. The following data shows the overall satisfaction of providers during the quarter (April 1-June 30, 2015), with the general review as well as with individual Provider Educators (staff who conduct reviews).

In addition to collecting satisfaction ratings for Provider reviews, APS also requests that respondents at Annual Functional Assessments also complete a satisfaction survey. The same 5-point Likert scale described above is used.

Provider Review Results

Eight surveys were returned that rated satisfaction with the general review. The number of surveys returned for individual Provider Educators is specified below.



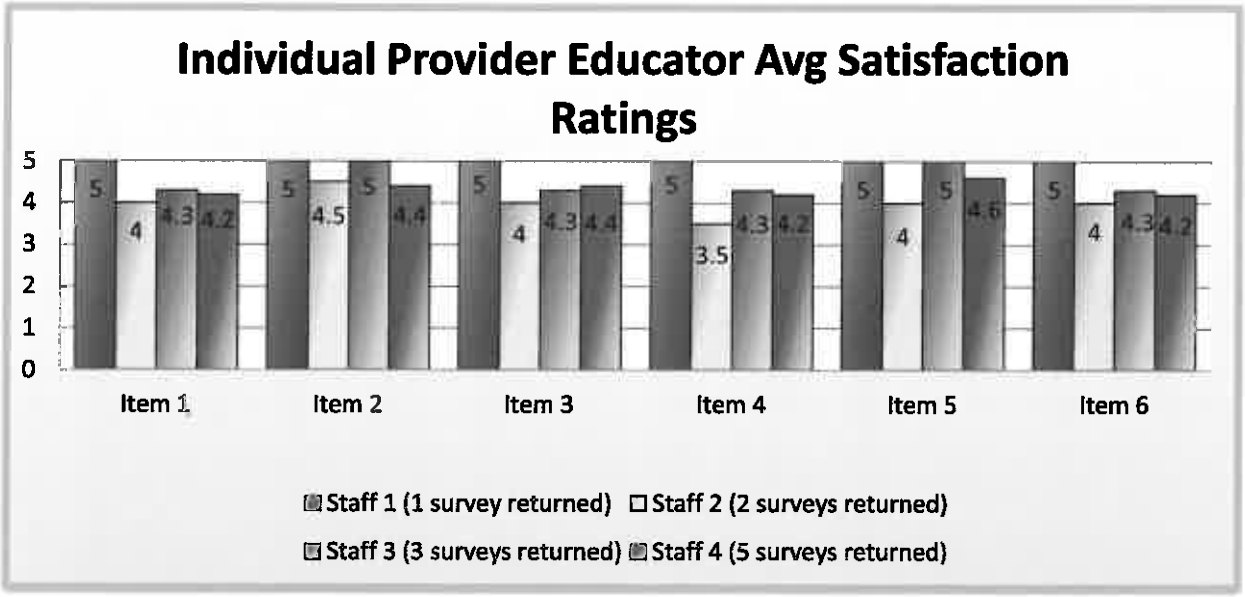
General Review Survey Items	
Item 1:	The APS Review was well organized.
Item 2:	The written materials and reports provided during the APS review were useful.
Item 3:	The information presented has better prepared my agency to comply with I/DD Waiver standards.
Item 4:	Overall, I am satisfied with the manner in which the APS review was conducted.

General Provider Comments:

~~ *"This was my first review and I thought it went very well! Thanks!"*

^^ "The TA was excellent. We always appreciate the education we receive from our reviews. They only help us in growing and providing quality services to all we serve... Thank you all very much for the help and support we receive. It is helpful to learn the best practices so that we may implement them and provide the best possible services to each and every member!"

++ "We truly appreciated the opportunity to learn."



Individual Provider Educator Survey Items	
Item 1:	The PE provided useful technical assistance throughout the review.
Item 2:	The PE was courteous throughout the review.
Item 3:	The PE was knowledgeable about I/DD Waiver Policies and Procedures.
Item 4:	The PE was responsive to my needs during the review.
Item 5:	The PE was available for questions during the review process.
Item 6:	The PE clearly conveyed the review findings during the Exit Interview.

<u>Provider Comments About Individual Provider Educators:</u>

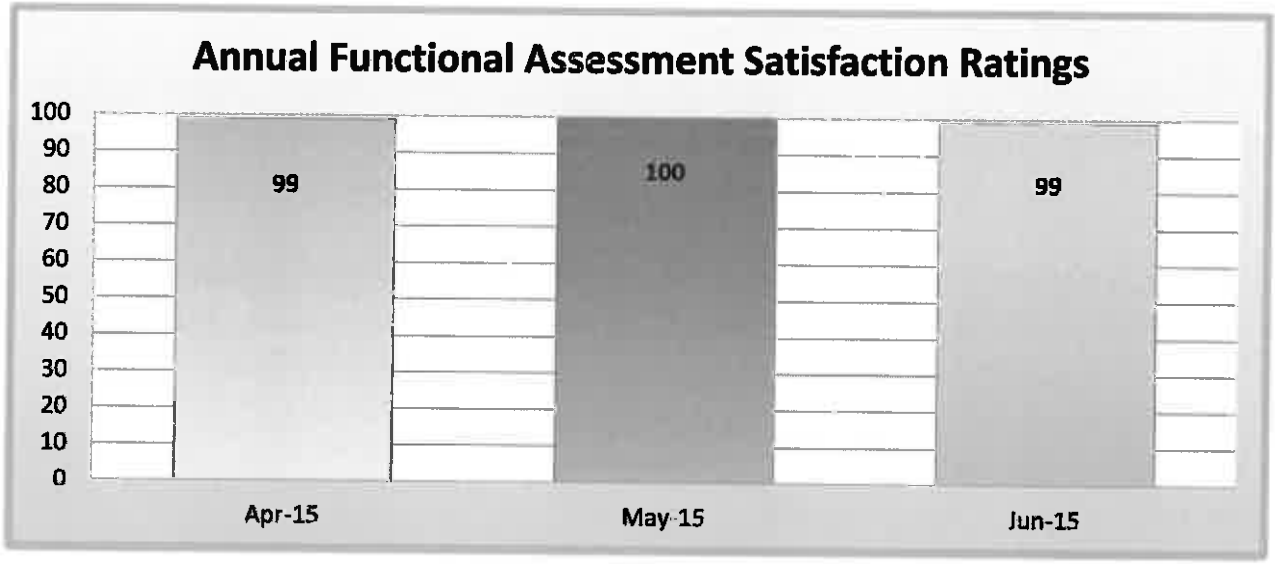
~~ **"(Staff 1) was great! He answered all of our questions....."**

^^ *"(Staff 3) took the time to talk with us about the improvements we can make as an agency. She gave us direct feedback throughout the process. She was positive and professional. I appreciated (staff 3) providing our agency with email links almost immediately to useful information to help us."*

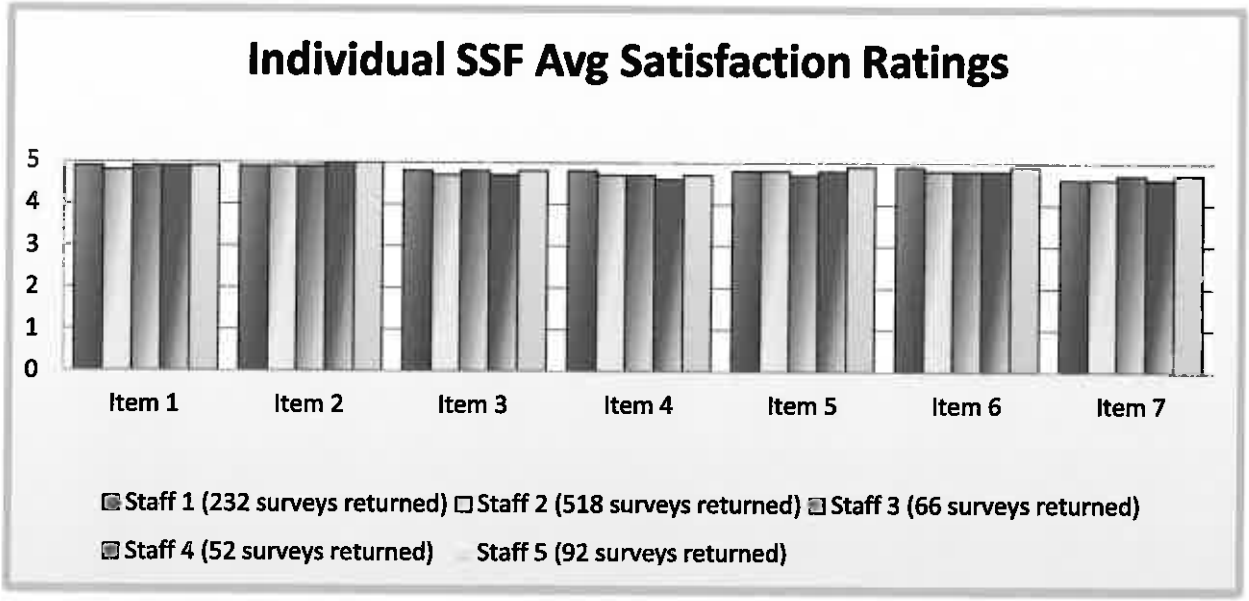
Annual Functional Assessment Results

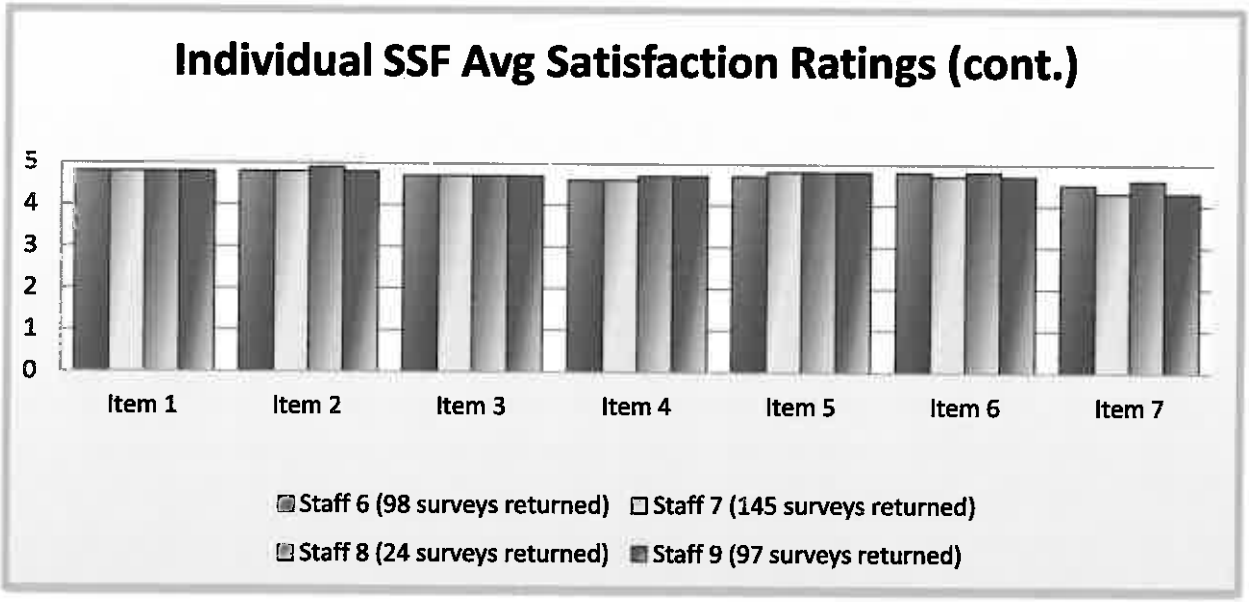
1,156 surveys were returned that rated respondent satisfaction with the Annual Functional Assessment. Due to the large volume of surveys completed, the percentage of satisfaction is measured instead of the average score. To calculate the percentage, each score has the following weight: 1=20%; 2=40%; 3=60%; 4=80%; and 5=100%.

The number of surveys returned for individual Service Support Facilitators is specified below.



Annual Functional Assessment Survey Items	
Item 1:	The APS staff was able to answer my questions or direct me to the proper person.
Item 2:	The APS staff was polite and friendly and I was given the option to ask questions.
Item 3:	The written materials provided were useful to me.
Item 4:	The assessment accurately captured the individual's abilities and support needs.
Item 5:	I feel I have an adequate understanding of choices available for services and providers from review and discussion of the I/DD2.
Item 6:	I feel the amount of time spent for the assessment was adequate.
Item 7:	I have a better understanding of the individualized budget and eligibility assessment.





Respondent Comments About Individual Service Support Facilitators:

~~ "(Staff 1) extremely pleasant. She made a difficult situation a lot easier."

^^ *"(Staff 2) came to my house and was very understanding and nice. Explain things in a way that I understand."*

++ "Although APS Assessments are a somewhat tedious process (due to their very nature and amount of questions) (Staff 3) makes them an enjoyable process. She connects with the clients, is incredibly personable, and makes clients, family, and staff smile."

++ "(Staff 4) always schedules assessments for convenient times and is very helpful with questions during the assessment."

^^ "Always able to answer questions, very polite/friendly. Good at what she does!"

^^ *"I love how nice (staff 6) is. Assessment flows well and answers all questions asked!"*

~~ **"I wouldn't want anyone else to do my son's assessment."**

++ **"These assessments have helped me to see my son's progress on a yearly basis. I have not expected that from the assessment and I appreciate it."**

MEDICAID BEHAVIORAL HEALTH INTENSIVE SERVICES: January 01 - May 27 2015

Number of Intensive Services Authorizations

Provider Name	Behavioral Health Counseling, Professional Group, Intensive Services	Behavioral Health Counseling, Professional, Individual Intensive Services	Behavioral Health Counseling, Supportive Group, Intensive Services	Behavioral Health Counseling, Supportive Individual, Intensive Services
DAMOUS PSYCHOLOGICAL SERVICES	79	83	83	83
FMRS HEALTH SYSTEMS	160	92	74	
HEALTHWAYS, INC.	77	70	74	70
MID-VALLEY HEALTHCARE	18	18		17
NORTHWOOD HEALTH SYSTEMS	152	152	144	38
PRESTERA CENTER	633	629	558	551
SOUTHERN HIGHLANDS	60	60	60	35
UNITED SUMMIT CENTER	138	50	39	8
VALLEY HEALTH CARE	72	72	71	51
WESTBROOK HEALTH SERVICES	223	194	93	181

Number of Intensive Service Units Authorized

Provider Name	Behavioral Health Counseling, Professional Group, Intensive Services	Behavioral Health Counseling, Professional, Individual Intensive Services	Behavioral Health Counseling, Supportive Group, Intensive Services	Behavioral Health Counseling, Supportive Individual, Intensive Services
DAMOUS PSYCHOLOGICAL SERVICES	12,960	7,524	37,784	3,780
FMRS HEALTH SYSTEMS	86,206	2,820	7,085	
HEALTHWAYS, INC.	15,610	4,176	7,526	3,812
MID-VALLEY HEALTHCARE	6,826	898		2,262
NORTHWOOD HEALTH SYSTEMS	64,262	7,614	43,746	2,434
PRESTERA CENTER	267,362	22,622	147,708	16,528
SOUTHERN HIGHLANDS	23,684	1,624	17,182	560
UNITED SUMMIT CENTER	33,840	1,464	3,998	384
VALLEY HEALTH CARE	20,436	1,516	13,080	1,260
WESTBROOK HEALTH SERVICES	44,828	4,100	17,618	4,491

Number of Unduplicated Persons with IS Authorizations

Provider Name	# of Unduplicated Members with IS Authorizations	# of Members with BBHHF Charity Care Authorizations
DAMOUS PSYCHOLOGICAL SERVICES	64	0
FMRS HEALTH SYSTEMS	123	16
HEALTHWAYS, INC.	56	3
MID-VALLEY HEALTHCARE	14	0
Northwood Health Systems	129	10
PRESTERA CENTER FOR MENTAL HEALTH	549	92
SOUTHERN HIGHLANDS COMMUNITY MH	45	8
UNITED SUMMIT CENTER	126	43
VALLEY HEALTH CARE	64	8
WESTBROOK HEALTH SERVICES	169	5

Compiled 05/28/2015

AD Waiver - Managed Enrollees
Level of Care as of 02/25/14

Level of Care	# of Managed	% per LOC of total MEs
A	54	2.06%
B	1508	57.62%
C	932	35.61%
D	123	4.70%

FEE-FOR-SERVICE AUTHORIZATIONS

Youth Less than 21 Years of Age

Fiscal Year July 2013 – June 2014

MEDICAL SERVICES

Total Distinct Youth Member and Treatment Episode Counts

FY 2013 – 2014

Service Category	AGE 0-10 Years		AGE 11-14 Years		AGE 15-17 Years		AGE 18-20 Years	
	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes
Durable Medical Equipment	1,236	1,785	342	578	230	403	201	362
Health Home	6	6	20	20	20	20	17	17
Home Health	69	76	29	40	20	27	37	38
Hospice	6	10	0	0	2	2	0	0
Inpatient Rehab	7	7	3	3	3	3	5	7
Inpatient Services	803	1,175	161	217	149	239	358	506
Orthotics/Prosthetics	72	77	31	31	7	8	11	12
Outpatient Audiology	35	42	20	23	13	16	5	6
Outpatient Chiropractic Service	1	1	2	2	2	4	8	13
Outpatient Dental	5,173	5,659	2,189	2,300	1,177	1,330	781	975
Outpatient Imaging/Radiology/Lab	440	543	239	291	241	284	445	518
Outpatient OT	34	47	11	13	5	5	7	7
Outpatient PT	58	76	53	55	38	38	156	176
Outpatient Speech	214	382	26	45	19	23	6	18
Outpatient Surgery	321	382	118	130	113	125	252	274
Private Duty Nursing	69	237	13	56	11	43	5	12

MEDICAL SERVICES

In-Custody Youth Distinct Member and Treatment Episode Counts
FY 2013 – 2014

Service Category	AGE 0-10 Years		AGE 11-14 Years		AGE 15-17 Years		AGE 18-20 Years	
	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes
Durable Medical Equipment	198	246	32	40	21	36	18	24
Health Home	0	0	1	1	3	3	0	0
Home Health	4	4	1	1	3	3	1	2
Hospice	0	0	0	0	0	0	0	0
Inpatient Rehab	1	1	1	1	0	0	0	0
Inpatient Services	95	127	25	28	40	45	16	23
Orthotics/Prosthetics	11	11	4	4	4	4	0	0
Outpatient Audiology	7	11	2	2	1	1	0	0
Outpatient Chiropractic Service	1	1	0	0	0	0	0	0
Outpatient Dental	336	368	233	244	224	260	48	53
Outpatient Imaging/Radiology/Lab	121	136	53	63	83	89	29	32
Outpatient OT	5	5	0	0	0	0	0	0
Outpatient PT	12	13	13	13	28	30	3	3
Outpatient Speech	47	79	8	12	0	0	1	1
Outpatient Surgery	106	111	27	31	41	43	14	14
Private Duty Nursing	4	12	0	0	0	0	1	1

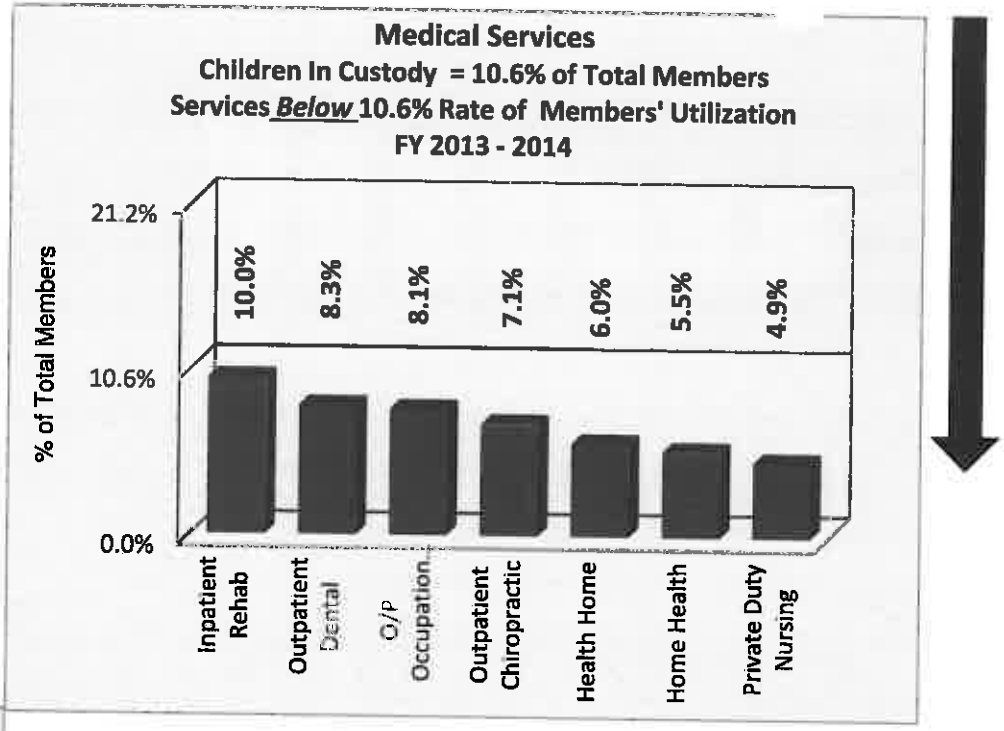
MEDI .L SERVICES

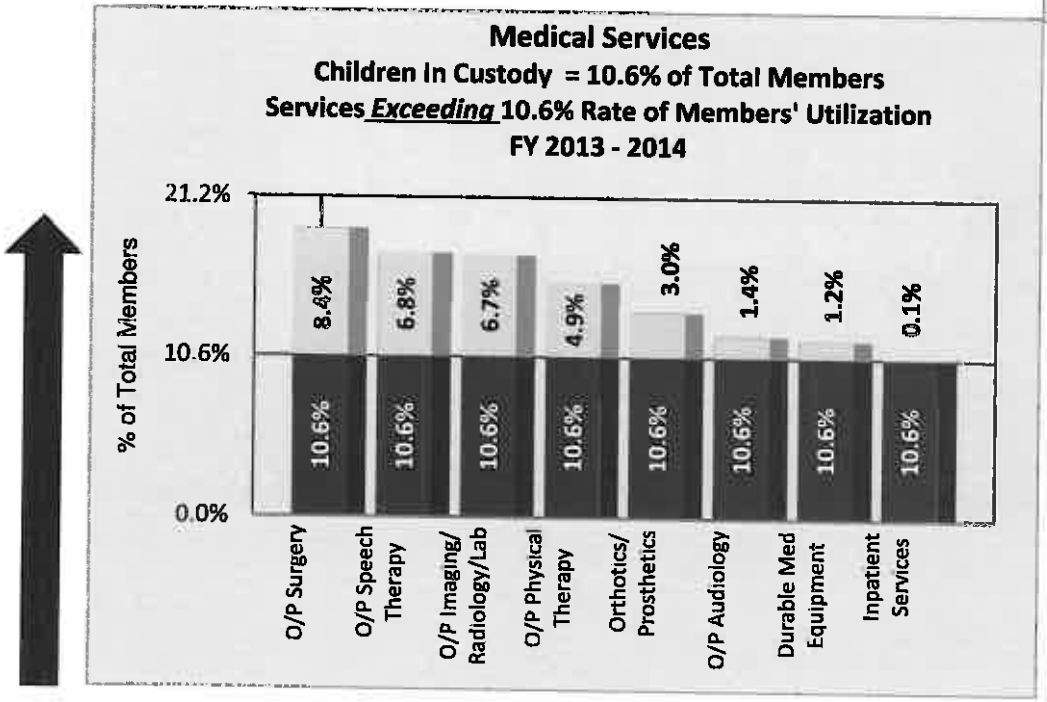
Medicaid Youth (Not in Custody) Distinct Member and Treatment Episode Counts
FY 2013 – 2014

Service Category	AGE 0-10 Years		AGE 11-14 Years		AGE 15-17 Years		AGE 18-20 Years	
	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes	# of Distinct Members	# TX Episodes
Durable Medical Equipment	1,236	1,785	342	578	230	403	201	362
Health Home	6	6	20	20	20	20	17	17
Home Health	69	76	29	40	20	27	37	38
Hospice	6	10	0	0	2	2	0	0
Inpatient Rehab	7	7	3	3	3	3	5	7
Inpatient Services	803	1,175	161	217	149	239	358	506
Orthotics/Prosthetics	72	77	31	31	7	8	11	12
Outpatient Audiology	35	42	20	23	13	16	5	6
Outpatient Chiropractic Service	1	1	2	2	2	4	8	13
Outpatient Dental	5,173	5,659	2,189	2,300	1,177	1,330	781	975
Outpatient Imaging/Radiology/Lab	440	543	239	291	241	284	445	518
Outpatient OT	34	47	11	13	5	5	7	7
Outpatient PT	58	76	53	55	38	38	156	176
Outpatient Speech	214	382	26	45	19	23	6	18
Outpatient Surgery	321	382	118	130	113	125	252	274
Private Duty Nursing	69	237	13	56	11	43	5	12

CHILDREN IN CUSTODY: Medical Services

The children in-custody constitutes 10.6% of all West Virgina children authorized for medical service in FY 2013-2014. As expected, children in-custody potentially accounts for a disproportionate, greater share in eight of the fifteen medical service categories, relative to their share of the total youth with fee-for-service authorizations.





Conversely and unpredicted, the children in-custody were authorized for a less than proportionate share of service in seven of the fifteen categories. Of particular interest are Dental Services where a higher rate of utilization is typical, of those authorized for dental services, only 8.3% were youth in custody even though they constitute 10.6% of the total number of children authorized.

APS Healthcare

APS Healthcare, Inc. – West Virginia for the Bureau for Behavioral Health & Health Facilities

Consumer Satisfaction Survey: Youth

YSS and YSS-F

2014 - 2015

This report contains the results of the 2014 - 2015 Youth Services Survey (YSS) and the Youth Services Survey for Families (YSS-F) administered by APS Healthcare, Inc. - West Virginia's Consumer and Community Affairs Department.

APS Healthcare, Inc. contracted with the Bureau for Behavioral Health and Health Facilities for administration of a consumer satisfaction survey for youth (13-17) and their families (families of youth 0-17) who received services in West Virginia during the period July 1, 2014 to June 30, 2015. The instruments utilized were the YSS and YSS-F surveys designed by SAMHSA through the Mental Health Statistical Improvement Project (MHSIP).

Survey Instruments

The survey instruments administered were:

- Youth Services Survey (YSS) developed by Molly Brunk, Ph.D. in 1999 as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS).

- Youth Services Survey for Families (YSS-F) developed by Molly Brunk, Ph.D. in 1999 as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS) - DRAFT URS/DIG Revised Version: February 17, 2006.

Survey Preparation

With the surveys copied on four different colors of paper each representing one of the four DHHR regions in the state to allow for distinction between the regions for the determination of the return rate by region of the YSS and YSS-F surveys.

Methodology: Face-to-Face Survey Administration

The APS Consumer and Family Affairs Director administered surveys face-to-face in the course of conducting focus groups and consumer/family education sessions at residential and service sites throughout the state. Youth 13 years or older were identified (appropriate for youth survey), as youth under the age of 13 are to ineligible to complete the YSS. The region in which the focus group or education session was took place was the region assigned to the submitted surveys. The administration of face-to-face surveys occurred from October 2014 to July 2015.

Survey Return Rates by Instrument by Survey Method

YSS	Face-to-Face
Beginning Sample	319
Final Sample	319
Respondents	319
Return Rate of Final Sample	100.0%

YSS- F	Face-to-Face
Beginning Sample	140
Final Sample	140
Respondents	140
Return Rate	100.0%

Surveys Return Rates by Instrument by Region

	YSS				YSS-F			
	Beginning Sample	Final Sample	Respondents	Return Rate	Beginning Sample	Final Sample	Respondents	Return Rate
Region I	52	52	52	100%	28	28	28	100%
Region II	69	69	69	100%	20	20	20	100%
Region III	119	119	119	100%	47	47	47	100%
Region IV	79	79	79	100%	45	45	45	100%

Analysis

Analysis' aim is to complete data requested in the Summary Profile of Client Evaluation of Care (Table 11), which includes:

- Client perception of Care:
  - Access (Q8, Q9)
  - Participation in Treatment (Q2, Q3, Q6)
  - Cultural Sensitivity (Q12, Q13, Q14, Q15)
  - Satisfaction (Q1, Q4, Q5, Q7, Q10, Q11)
  - Outcome (Q16, Q17, Q18, Q19, Q20, Q21)

- Confidence Intervals and Confidence Levels will be calculated (Using online MHSIP program)

- Additional information contained in the report includes:
  - Percentage of Consumers linked to physical health services (Q28, Q29)
  - Percentage of Children in family-like arrangements (Q26, Q27)
  - Percentage of Children in residential care (Q27)

The basis of the analysis was the **percentage/number of responses of the total**, the Final Sample in all data charts.

A positive response was considered a value of 4 Agree or 5 Strongly Agree in a Likert Scale when one item was used to determine the positive and negative response rates, whereas when more than one item using the Likert Scale was used to determine the type of response, an average value greater than 3.0 was considered a positive response. Additionally, a Yes response was a positive response when the response choices were Yes or No.

Table 11. presents the Results for the Summary Profile of Client Evaluation of Care and Confidence Intervals are summarized beginning on the following page.

Attached is an additional summary that includes **YSS-F Results of Social Connectedness, Arrests, School Attendance/Absences, and Suspensions/Expulsions** as requested by the Bureau.

Table 11. Summary Profile of Client Evaluation of Care

This table provides a summary of key indicators of client evaluation of outpatient mental health care used by State MHA's. The measures include those developed and implemented as part of the MHSIP Adult Community Consumer-oriented report card and the Youth Services Survey for Families but are not limited to the MHSIP survey.

Table 11.	
Report Year (Year Survey was Conducted):	July 1, 2014 – June 30, 2015
State Identifier:	West Virginia

Indicators	YSS (SED Youth=> 13 Years of Age)		
	Number of Positive Responses	Responses	Confidence Interval*
Reporting Positively About Access	301	319	2.35
Reporting Positively About General Satisfaction for Children	257	319	5.71
Reporting Positively About Outcomes for Children	317	319	1.44
Reporting on Participation in Treatment Planning.	289	319	4.22
Reporting High Cultural Sensitivity of Staff (Optional)	314	319	1.81

Indicators	YSS-F (Family of SED Youth <18 Years of Age)		
	Number of Positive Responses	Responses	Confidence Interval*
Reporting Positively About Access	117	140	8.07
Reporting Positively About General Satisfaction for Children	104	140	9.53
Reporting Positively About Outcomes for Children	129	140	5.88
Reporting on Participation in Treatment Planning	85	140	10.65
Reporting High Cultural Sensitivity of Staff (Optional)	124	140	6.93

* Confidence interval calculated using http://www.surveysystem.com/sscalc.htm

Additional analysis based on survey recommendations is as follows:

Indicators	YSS (SED Youth >12 Years of Age)		
	Number of Positive Responses	Responses	Percentage of Positive Responses
Consumers linked to physical health services	318	319	99.7%
Children in family-like arrangements in the last six months	302	319	94.7%
Children in residential care in the last six months	53	319	16.6%

Indicators	YSS-F (Family of SED Youth <18 Years of Age)		
	Number of Positive Responses	Responses	Percentage of Positive Responses
Consumers linked to physical health services	111	140	79.3%
Children in family-like arrangements in the last six months	119	140	85.0%
Children in residential care in the last six months	41	140	29.3%

Children/Adolescents Consumer Surveys:

1. Were the MHSIP Children's Surveys (YSS & YSS-F) used? __X__ Yes _____ No
   a. If no, please attach instrument(s) used.

   b. Did you use any translations of the MHSIP into another language?
      1. _____ Spanish
      2. _____ Other: _____

2. Populations covered in surveys? (Note all surveys should cover all regions of state)
   1. _____ All Consumers in State
   2. __X__ Sample of MH Consumers (see Question 3)
   3.

2a. If a sample was used, what sampling methodology was used?
   1. _____ Random Sample
   2. _____ Stratified Sample
   3. __X__ Convenience Sample
   4. _____ Other Sample: __

2b. Do you survey only people currently in services, or do you also survey persons no longer in service?
   __X__ 1. Persons Currently Receiving Service
   _____ 2. Persons No Longer Receiving Services
   2a. If yes to 2, please describe how you survey persons no longer receiving services.

3. Please describe the populations included in your sample (e.g., all children, only children with SED, etc)
   _____ 1. All Child Consumers in state
   __X__ 2. Children with Serious Emotional Disturbances
   _____ 3. Children who were Medicaid Eligible or Medicaid Managed Care
   _____ 4. Other: Describe (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data (Check all that apply)

YSS			YSS-F		
	Self-Administered	Interview		Self-Administered	Interview
Face-to-face	X Yes		Face-to-Face	X Yes	

4a. Who administered the surveys? (Check all that apply)

1. _____ Mental Health Consumers
2. _____ Family Members
3. _____ Professional Interviewers
4. _____ MH Clinicians
5. _____ Non-Direct Treatment Staff
6. __X__ Other, describe: **Administrative Services Organization's Consumer & Community Affairs Unit**

5. Are Responses Anonymous, Confidential, and/or Linked to other Patient Databases?

__X__ 1. Responses are Anonymous
__X__ 2. Responses are Confidential
_____ 3. Responses are matched to Client Databases

6. Sample Size and Response Rate	YSS	YSS-F
6a. How many Surveys were attempted?	**319**	**140**
6b. How many survey contacts were made?	**319**	**140**
6c. How many surveys were completed?	**319**	**140**
6d. What was your response rate?	**100%**	**100%**
6e. If you received "blank" surveys back from consumers (surveys with no responses on them), did you count these surveys as "completed" for the calculation of response rates?	**No**	**No**

7. Who Conducted the Survey?

7a. SMHA Conducted or contracted for the survey __X__ Yes _____ No

7b. Local Mental Health Providers/County mental health providers conducted or contracted the survey
_____ Yes __X__ No

7c. Other: Describe: _**Administrative Service Organization's Community and Consumer Affairs Director**_

Youth Arrests and School Suspension/Expulsions

Instrument: Youth Satisfaction Survey for Families (YSS-F)
Fiscal Year 2014-2015

2014-2015 YSSF Report	# of YSS-F Surveys	# of YES Responses	% of YES Responses
Was your child arrested since beginning to receive mental health services?	140	24	17.1%
Was your child arrested during the 12 months prior to that?	140	18	12.9%
Was your child expelled/suspended since beginning service?	140	22	15.7%
Was your child expelled/suspended the 12 months prior to that?	140	29	20.7%

Social Connectedness and Absence from School

Instrument: Youth Satisfaction Survey for Families (YSS-F)
Fiscal Year 2014-2015

Social Connectedness: 138 of 140 Responses or 98.6% were positive

Absence from School:

Over the last year, the number of days my child was in school is

a. Greater — **20 of 42 or 45.25%**
b. About the same — **10 of 42 or 23.81%**
c. Less — **9 of 42 or 21.43%**
d. Does not apply — **3 of 42 or 7.14%**

i. No Response: Child did not have a problem with attendance before starting services
ii. No Response: Child is too young to be in school
iii. No Response: Child expelled from school
iv. No Response: Child is home schooled
v. No Response: Child dropped out of school
vi. Other: _____

APS Healthcare, Inc. – West Virginia
SOCIALLY NECESSARY SERVICES
Stakeholder Focus Group Summary
Contract Year 2013-2014

During Contract Year 2013-2014, the Family Support Educator for APS Healthcare Inc. conducted seven (7) Focus Groups with twenty-three (23) consumers receiving Socially Necessary Services (SNS) through Child Protective Services (CPS) and/or Youth Services (YS) to provide personal input. The focus group participants represented the following populations:

- **Fourteen (14) youth**
- **Six (6) biological parents**
- **Three (3) foster/adoptive parents**

- **The purpose is to provide consumers who are receiving SNS in West Virginia the opportunity to candidly share their experiences and opinions in regard to access, service delivery, the referral process and any other areas pertaining to CPS, YS and foster-adoptive cases. These youth and families receiving SNS and supports are located in various regions across the state of West Virginia.**

The focus group questions were developed with input from the BCF ASO Support Group. The intent of these focus group questions was to generate responses identifying systemic issues regarding:

- Gaps in support systems
- Consumer knowledge of services and supports
- Parent and youth suggestions
- Engagement with system staff
- Consumer-perceived problems and solutions

FOCUS GROUP SUMMARIES BY PARTICIPANT POPULATION

Note: For the following focus group questions, the respondents were not limited to choosing a single response. Therefore a single participant may be represented in more than one response category. Percentages were rounded to the nearest whole number.

Q1: Do you have regular contact with your DHHR Workers? Is s/he available when you need him/ her or have a question?

Family Participant Response	% of Participants
Yes	**60%**
No	**40%**

Sixty percent (60%) of participants stated, "Yes." Of this response, fifty-six percent (56%) of participants agreed, "Yes, monthly," and four percent (4%) percent stated, "Yes, weekly."

Forty percent (40%) of participants stated, "No." Of this response, thirteen percent (13%) of participants who were foster adoptive parent participants agreed they had regular contact with the children's home finders but not their DHHR case workers. Nine percent (9%) of participants who were biological parents agreed, "No," the DHHR worker did not have regular contact with them nor return phone calls. However, participants agreed their provider was always available. In addition to this response, four percent (4%) stated all DHHR contact went through the provider and four percent (4%) stated all DHHR contact was relayed through the kinship relative caring for the children. Lastly, the youth participants stated, "No." Of this population response, four percent (4%) stated, "No. She only came here four months ago." Four percent (4%) stated, "Not really but she comes every other month." Four percent (4%) stated, "No, she will not answer my questions or make a plan." Four percent (4%) stated, "No, she doesn't have good contact." Four percent (4%) stated, "No," and her phone calls were not returned.

Family Response Category	% of Participants
Yes, monthly	52%
Yes, weekly	4%
No, Homefinder only	13%
No, worker goes through provider	13%
No, worker goes through kinship/relative	4%
No, visits every other month	4%
No, will not answer questions or make plan	4%
No, doesn't have good contact	4%
No, phone calls not returned	4%

Q2: Did the DHHR worker meet jointly with you, your family, and your provider as the service plan was being developed?

Family Participant Response	% of Participants
Yes	80%
No	20%

Family Participant Response	% of Participants
Yes (Did not elaborate)	**38%**
Yes, initially met with families. Unsure of service providers	**22%**
Yes, set clear goals	**12%**
Yes, MDT	**4%**
Yes, but had no family	**4%**
Not in the beginning	**9%**
No, still new so made own plans	**4%**
No, dad doesn't care	**4%**
Every case is different	**4%**

Eighty percent (80%) of participants stated, "Yes."

Of this response, twenty-two percent (22%) of participants who were youth agreed, "Yes," their DHHR workers met with their families regularly during the initial stages of the case but did not know when or if the DHHR worker met with the in-home service providers. Four percent (4%) who was a biological parent stated, "Yes," there was an MDT four months ago and everyone attended. Four percent (4%) who were youth stated, "Yes. We went over goals and are putting them into action. I didn't have a family to meet with." Four percent (4%) who were youth stated, "Yes, finish school and go to the Independent Living in Charleston." Four percent (4%) who were youth stated, "Yes, because my goals are to be less angry and everyone wants that." Thirty-eight percent (38%) did not elaborate on their response.

Twenty-one percent (21%) of participants stated, "No."

Of this response, nine percent (9%) of youth participants agreed, "Not in the beginning." Four percent (4%) stated, "Not really, I'm still new. I made my own plans to move back home with my dad and go to college." Four percent (4%) stated, "No, my dad doesn't care." Four percent (4%) who was a foster adoptive parent participant stated, "It's different for every case."

Q3: Is the DHHR meeting jointly with you, your family, and your provider as the service plan is being carried out?

Family Participant Response	% of Participants
Yes	80%
No	20%

Eighty percent (80%) of participants stated, "Yes," and reiterated responses from above.

Twenty percent (20%) of participants stated, "No," and reiterated responses from above.

Family Participant Response	% of Participants
Yes (Did not elaborate)	38%
Yes, visits monthly	22%
Yes, checks on goal progress	12%
Yes, meets with the children monthly	4%
Yes, no family, Provider and DHHR only	4%
Not in the beginning, but now	9%
No, still new so made own plans	4%
No, dad doesn't care	4%
Every case is different	4%

Q4: Do you feel actively involved in your service plan?

Seventy-nine percent (79%) of participants stated, "Yes," and twenty-one percent (21%) of participants stated, "No."

Family Participant Response	% of Participants
Yes	**79%**
No	**21%**

Q4a: Why?

Family Response Category	% of Participants
Provider/staff engagement	**78%**
Input expressed/ needs addressed	**22%**
MDT's	**13%**
Homefinders	**13%**

Of this response, twenty-two percent (22%) of participants stated, "Yes," and agreed they felt engaged and actively involved in services with the provider. Twenty-two percent (22%) of participants agreed, "Yes," because they were supported by staff in learning how to make decisions and weigh consequences regarding their futures, adulthood and education.

Nine percent (9%) of foster adoptive parent participants agreed, "Yes," because they participated in MDT's, communicated with service providers and had regular contact with Homefinders. Nine percent (9%) agreed with the response, "Yes," and felt their input was considered during their CAPS assessments and felt engaged by providers.

Four percent (4%) stated, "Yes." Participant stated she always met with the provider regarding the children's supervised visitations, made sure the children's needs were met and sought guidance from the Homefinder. Four percent (4%) stated, "Yes, I didn't have a choice not to." Four percent (4%) stated, "Yes, before when we had people coming to the house all of the time, I did because I started going to school again." Four percent (4%) stated, "Yes," he felt actively engaged by the provider in taking Parenting classes and actively seeking employment.

Q4b: Why not?

Family Response Category	% of Participants
Did not listen to us	**9%**
Not for truancy	**12%**
Geared toward parents	**8%**

Of this response, nine percent (9%) agreed, "No, they should have listened to us." Four percent (4%) stated, "No, I still did not go to school but it helped me and my mom get along better." Four percent (4%) stated, "No," because her father was on drugs which she could not help that. Lastly, four percent (4%) stated that even though she attended school more regularly, her parents fought more once providers were in the home, so she felt that the involvement was not an improvement.

Q5a: Do you see your service plan as being helpful and focused on the issues?

Family Participant Response	% of Participants
Yes	**88%**
Not sure	**4%**
I don't know	**4%**
No	**4%**

Eighty-eight percent (88%) of participants stated, "Yes."

Of this response, seventeen percent (17%) of participants agreed, "Yes," to current service plans, but not regarding past experiences. Thirteen percent (13%) agreed, "Yes, because the kids need visits, activities and therapy. That's what we as the foster parents focus on. Foster parents could always use more help and services." Nine percent (9%) agreed, "Yes," help was available if they wanted it. Four percent (4%) stated, "Yes," their provider listened to their input which was reflected in the service plan. Four percent (4%) stated, "Not at first, but now since the new provider has been in the home." Four percent (4%) stated, "I guess so. She was there all the time. I started listening and being less wild but I still didn't go to school which got me into placement."

Four percent (4%) stated, "I am not quite sure yet what all is in my plan but I will learn how to be independent."

Four percent (4%) stated, "I don't know."

Four percent (4%) stated, "No."

Q5b: What issues have the services addressed?

Forty-three percent (43%) of participants felt having providers who did not judge them, listened to their opinions and answered their questions provided needed support.

Thirty-nine percent (39%) of participants stated services helped regarding family communication and relationships so everyone got along better.

Twenty-six percent (26%) of participants agreed receiving linkage to other community programs, support and assistance from the staff in regards to the case and unmet needs. An additional nine percent (9%) agreed services at the time helped link them to other supports and services such as counseling, drug-court and family therapy.

Thirty percent (30%) of participants felt Parenting helped the most to improve family relationships via better communication, less fighting, more compassion for feelings and an increased understanding of children's needs leading to a closer bond. In addition, four percent (4%) made comments such as, "I learned how to have compassion and respect for my kids (...) I know how to safely keep the kids busy so I can clean (...) I learned time-outs are for me also to have a re-adjustment period."

Twenty-six percent (26%) of participants felt visits helped with separation issues from each other.

Twenty-two percent (22%) of participants felt that they were learning how to make better decisions, weighing the pros and cons of their behavior through choice and consequence. Participants felt that having the ability to make decisions and learning how to make good decisions helped them to become adults. Because of this, participants felt they made better choices surrounding school and as a result had a better outlook on their education and futures.

Seventeen percent (17%) of participants agreed services and providers helped them understand and navigate the system and the paper process and make logical decisions. They also obtained moral and social support from the provider

and received updates and encouragement to complete their goals and achieve reunification.

Thirteen percent (13%) of participants agreed respite was helpful for medical situations in addition to the strains of challenging behaviors from the children. In addition, four percent (4%) of participants stated transportation reimbursement really helped because they received children from all over and had to take them across county for the visits.

Thirteen percent (13%) of participants stated their employment outlook has improved because they have obtained work experience and learned how to get a job. Thirteen percent (13%) of participants stated they no longer run out of money because they learned how to budget and save for recreational items.

Nine percent (9%) of participants agreed services helped correct their behaviors and improve their outlooks for the future. Four percent (4%) stated services helped them become independent. Four percent (4%) stated, "I listened more at home but I was still truant at school."

Thirteen percent (13%) of participants felt services did not help. Of this response, Participants made comments such as, "Nothing, because my dad was on drugs and still is (...) They should have listened to us (...) It made things worse because mom became grumpier and my parents fought more."

Family Response Category	% of Participants
Support from provider	43%
Improved family relationships	39%
Improved communication	39%
Linkage to services/ community assistance	35%
Improved parenting knowledge/skills	30%
Visits helped separation	26%
Improved decision making	22%
Improved outlook for future	22%
Improved outlook for education	22%
Help with system navigation/understanding case	17%
Respite	13%
Gained employment skills	13%
Gained knowledge of budgeting	13%
Improved outlook for behavior	9%
Independence	4%
Increased active listening	4%
Transportation reimbursement	4%
Nothing	13%

Q5c: What would improve your services?

Family Response Category	% of Participants
Nothing, positive services/provider experience	**61%**
Reinstate community integration	**22%**
Adult life skills; meal/shopping planning	**22%**
Improved/more DHHR communication	**22%**
Service providers/DHHR listen to our needs	**13%**
Timely referrals	**13%**
Improved delivery of Casey life skills modules	**4%**
Earlier intervention	**4%**
Welfare assistance	**4%**
Transportation	**4%**
Family therapy	**4%**

Thirty-one percent (31%) of participants agreed, "Nothing regarding the services and the provider." Participants stated they were very happy with their understanding and helpful providers who they felt went above and beyond their duties. Twenty-two percent (22%) of participants agreed, "Nothing. The providers were understanding, made them a better person and became their support system. Four percent (4%) stated, "Nothing, they were good," but needed intervention earlier in their lives. Four percent (4%) stated, "Nothing, it helps," so would not change anything.

Twenty-two percent (22%) of participants agreed community integration should not have to come to a halt when a resident that was on probation came to the living situation. They feel that they should have been able to continue with their community activities and the person on probation should have had to stay behind. Twenty-two percent (22%) of participants agreed "Make our own meal plans." Twenty-two percent (22%) of participants agreed an increase in DHHR communication was needed.

Thirteen percent (13%) of participants agreed with the statement, "Listen to us." Thirteen percent (13%) of foster/adoptive parent participants agreed they needed SNS referrals in a timely matter in order to better receive their payments and/or reimbursements.

Four percent (4%) wanted their Casey Life Skills to address things they did not already know. Four percent (4%) needed transportation and welfare assistance. Four percent (4%) wanted family therapy.

Q6: Have you ever felt like you've had to cope with your situation alone?

Participant Response	% of Participants
Yes	**83%**
No	**17%**

Q6a: What has made you feel this way?

Family Response Category	% of Participants
Separation of children and siblings	26%
You are alone	26%
Emptiness	22%
Children are confused about home	22%
Placement	13%
No family	12%
Aging out of the system	4%
Single mother	4%
CPS grates on you	4%
Leaving significant others	4%
Workers always changing	4%
A lot in the beginning, adoption process	13%
A lot in the beginning, parents fighting	8%
No, confide in friends	9%
No, can't blame others	4%
No, ask for help	4%

Twenty-six percent (26%) of participants agreed the separation had been traumatizing, especially since the siblings have been split up.

Twenty-two percent (22%) of biological parent participants agreed with the response, "You just feel alone because you are alone," and, "It is very lonely." Another four percent (4%) stated, "Yes because you are alone. The workers just drop you off and my dad doesn't care. Every place you go they just try to fit you into their box."

In addition, twenty-two percent (22%) of participants agreed with the response, "There is emptiness."

Twenty-two percent (22%) of biological parent participants agreed it was difficult because the children were confused about where home is.

Thirteen percent (13%) of participants felt alone before because they did not feel a connection with their family. However, being in placement they feel more alone and now want to share with their families.

Eight percent (8%) of participants agreed they did not have a family anymore, the workers cannot find them a foster home and no one seemed concerned for their situation. Four percent (4%) stated he was in different foster homes his whole life, which affected his ability to make or maintain social ties due to moving, stigma and embarrassment.

Four percent (4%) stated, "Yes, just everything. Once you are in the system, you never really get back out no matter what you do until you age out. So you just play the game and wait."

Four percent (4%) stated, "I am a single mom, I have no one and do not even get child support."

Four percent (4%) stated, "This grates on you and CPS will kick you when you are down."

Four percent (4%) stated, "When they tell you to leave the boyfriend or husband, you just have to do it because your kids are the only thing that matters, not if you are alone."

Four percent (4%) stated, "Yes, my worker was constantly changing and I did not know what was going on or what was happening."

Twenty-one percent (21%) agreed, "Yes, a lot in the beginning." Of this response, thirteen percent (13%) of foster/adoptive parent participants agreed they were alone in learning the process and depended a lot on the Homefinder. Eight percent (8%) agreed, "Yes, back then," because the in-home services and truancy issue made their parents fight more.

Seventeen percent (17%) of participants stated, "No." Of this response, nine percent (9%) agreed they always had friends to confide in. Four percent (4%) stated, "Not really, I can't blame anyone for what I did." Four percent (4%) stated, "Well, I've never been one to ask for help or talk a lot. I am kind of a loner but this situation has taught me to ask for help if I needed it."

Q7: Do you know why you are receiving services and what is expected of you and your family to finish services and have the case closed?

Family Participant Response	% of Participants
Yes	**96%**
No	**4%**

Four percent (4%) stated, "No. This isn't even my fault. I'm not even allowed to see my family anymore. My worker said they were supposed to get off drugs and they never did. I don't even know where I am going to go, she just always says, 'We'll see.' It's not fair."

Ninety-six percent (96%) of the population stated, "Yes," they were receiving services for reasons such as CPS intervention and/ or YS involvement. Participants knew what was expected of them to reach their outcome goals due to court and provider assistance.

Of this response, thirty-nine percent (39%) had to improve their school attendance and grades.

Thirty percent (30%) of participants stated they had to learn life skills.

Twenty-six percent (26%) of participants had to learn and become responsible. Four percent (4%) added, "Be responsible for my daughter and go to college."

Twenty-six percent (26%) of participants stated they knew they had to complete parenting services, go to therapy, maintain appointments, keep the house clean, maintain clean drug-screens and maintain adequate housing to get the children reunified. In addition, thirteen percent (13%) of youth had to remain drug-free.

Twenty-two percent (22%) had to learn how to listen and improve decision making as well as budgeting.

Thirteen percent (13%) agreed with the comments, "It just depends on the case but we always work with providers, attend MDT's, keep in close contact with Homefinders, enroll kids in activities and make sure they are attending all appointments and bringing their grades up. Adoption adds a whole other side to it."

Nine percent (9%) had to complete a Domestic Violence Victim or Batterer Intervention program. Nine percent (9%) of participants agreed in addition to their truancy, their parents were supposed to fight less. Nine percent (9%) of participants had to build trust and improve family communication.

Four percent (4%) stated they need to obtain and maintain employment.

Q7a: If so, how do you know?

Family Response Category	% of Participants
SNS Provider	**96%**
Residential provider	**61%**
DHHR/Court	**61%**
School	**39%**
Probation Officer/Court	**9%**

Ninety-six percent (96%) of participants knew they were receiving specific services due to the SNS Providers' explanation. In addition, sixty-one percent (61%) of participants had an explanation from the DHHR case worker, while sixty-one percent (61%) of participants were assisted by their residential providers. Thirty-nine percent (39%) stated they knew they had truancy issues with the school. In addition, nine percent (9%) had the goals explained to them by their Probation Officer (PO) and court proceedings and four percent (4%) had reiteration through drug court.

Q8: Do you know of a service you would like to receive that you are not currently receiving?

Family Participant Response	% of Participants
Yes	**35%**
No	**65%**

Thirty five percent (35%) of participants needed additional assistance. Of this response, twenty-two percent (22%) of participants agreed they had enough formal services and just wanted to participate in community activities.

Thirteen percent (13%) wanted Respite payments and mileage reimbursements. After they attended the foster/adoptive parent provider training, they knew how to complete that process. In addition, four percent (4%) stated they should be able to get meal reimbursements for the children in the facilities they take on visits as well as parking and toll reimbursements. Lastly, four percent (4%) wanted to provide Connection Visits for the children in shelters.

Nine percent (9%) of participants needed Non-emergency Medical Transportation (NEMT) reimbursement services for their families because there were a lot of behavioral health and medical appointments involved.

Four percent (4%) needed economic assistance for home repair and utilities.

Four percent (4%) stated she was not getting the help she was supposed to be getting now regarding her emotions, adult life skills and permanency plan.

Four percent (4%) wanted to be taught to access services and benefits independently.

Fifty-seven percent (57%) stated they did not want additional services.

Family Response Category	% of Participants
Community activities	**22%**
SNS payments, reimbursements	**13%**
Transportation	**4%**
Provide Connection visits	**4%**
NEMT	**9%**
Economic assistance	**4%**
Supposed to be already receiving	**4%**
Access services and manage own benefits	**4%**

Q8a: Do you know how to obtain these services?

Family Participant Response	% of Participants
No	**39%**
Yes, after ASO training	**26%**
Did not want	**35%**

Thirty-nine percent (39%) of participants stated, "No." Of those that elaborated, twenty-two percent (22%) of participants did not know how they would be able to

participate in community activities because it was not up to them as youth. Four percent (4%) did not know how to receive what she was already supposed to be getting help with. Four percent (4%) did not think he could qualify for economic assistance because the children were not in the home. Four percent (4%) did not know how she would learn to manage her benefits or access services for herself.

Twenty-six percent (26%) of participants knew how to obtain SNS reimbursements and payments as well as utilize NEMT after their Administrative Service Organization (ASO) provider training.

Thirty-five percent (35%) of participants did not want any additional services.

Q9: What would prevent you from seeking services in the future?

Family Response Category	% of Participants
Nothing	**40%**
Nothing, would ask Homefinder	**13%**
Nothing, would ask mother	**8%**
Nothing if need help	**4%**
We've had enough services	**26%**
Not getting the help already asked for	**9%**

Sixty-five percent (65%) of participants stated, "Nothing." Twenty-six (26%) percent of participants would not seek services or help again because they felt they had had too many services over the years. Nine percent (9%) felt they weren't receiving help from their current services.

Q10a: Do you see any problems in the system that prevent you and your family from achieving your service plan goals?

Family Response Category	% of Participants
Yes	**96%**
Not really	**4%**

Ninety-six percent (96%) of participants stated, "Yes," giving examples of problems they experienced in the system.

Four percent (4%) agreed, "Not really. If you ask for help and really want it, you will get it."

Q10b: What are the problems?
Q10c: How do they cause problems?

Family Response Category	% of Participants
Bounced around/ No permanency, stability	48%
Lack of DHHR communication/ Prolongs, confuses case	43%
Lack of agreement/ Prolongs, confuses case	39%
Hard to get referrals, records, paperwork/ Makes you look bad	30%
Hard to get out of placement/ No permanency, stability	30%
Stigma/ Problems in family and community, employment	26%
Kids confused about where home is/ Upsetting	22%
Isolated/ Feel alone	22%
Guilty until proven innocent/ Harder in court	17%
Workers forget about you/ No permanency, stability	13%
Siblings separated	13%
Put you in a box/ Not individualized	9%
Fix everything/ They add more, overwhelming	4%
Welfare/ Financial needs	4%
Intervention time/ Too late	4%
Lost credits/ Fall behind	4%

Participants who previously stated, "Yes," gave examples of problems, causes and consequences.

Forty-eight percent (48%) of participants felt, "You just get bounced around from place to place until you age out." Four percent (4%) reiterated being in foster care your whole life prevented forming or maintaining family bonds, social and

community ties, which was lonely and embarrassing. Four percent (4%) stated, "I am a CPS case. I have to find a home and need therapy every day. I don't want to go to out-of-state placement. I am being punished for my parent's mistakes. I am tired of being in placement with no control over my life. No one is even trying to help me and they can't even find me a home." In addition, thirty percent (30%) of participants agreed with the statement, "Once you are in placement, you can never get out." Thirteen percent (13%) of participants stated they felt like their workers forgot about them. Participants agreed this interfered with their lives in regards to approvals, referrals, vouchers, records, support and guidance needed for their cases, futures and outcomes. These instances made participants feel there was no permanency, stability, hope or care taken in their cases.

Forty-three percent (43%) of participants stated there was a lack of DHHR communication which caused questions, unmet goals and prolonged cases. Specifically, four percent (4%) stated, "My worker doesn't keep me in the loop. My case is about me but I don't know anything about it because there is no communication." Another four percent (4%) stated, "My worker was constantly changing and I did not know what was going on or what was happening."

Thirty-nine percent (39%) of participants stated their case depended on all parties involved agreeing and being on the same page. In addition, participants agreed with comments such as, "The flow of your case depends on the DHHR worker you have. Everyone needs to be on the same page and agree." In addition, participants agreed with the statement, "People not being on the same page will prolong the case. If you stay on the Department, they get mad and take it out on you. If you don't, your case is prolonged even more and nothing happens that is supposed to."

Thirty percent (30%) agreed, "It is hard to get anything from the case workers, especially paperwork and referrals. It is just a lot of time and energy that could be avoided with one piece of paper." Participants stated in the beginning a lot of things were unclear and the information was overwhelming but they learned as they went through it. In addition, four percent (4%) added, "The judges want to know why you haven't had your parental evaluations but you can't get your special medical cards from the worker. So, the judges get mad at you. All of these things add more stress, make you look bad and prolong your case." In addition, seventeen percent (17%) agreed with the comments, "With CPS and the judges, you are guilty until proven innocent."

Twenty-two percent (22%) agreed with the comments, "The kids are conflicted about where home is." Thirteen percent (13%) of participants stated kids ended up separated from siblings in different strangers' homes. Participants agreed that because the children were separated and placed with non-family members, it created more trauma, confusion and anxiety.

Twenty-two percent (22%) of participants agreed with comments made that CPS and YS involvement caused problems within the extended family and community. Participants agreed with the statement, "We get constant judgment from CPS, neighbors, school and our own families." In addition, four percent (4%) stated, "It's hard at job interviews; no one wants to give you a chance. I have worked all of my programs. I have done my jail time and am still doing my time and more programs but they don't want to give you a chance." Twenty-two percent (22%) of participants agreed they sometimes felt, "Alone and isolated."

Nine percent (9%) felt services were not tailored to the individual. For example, statements were made such as, "Every child is different with different needs and you can't put them in a box." Four percent (4%) reiterated services did not treat the consumer as an individual, so his experiences have been repetitive.

Four percent (4%) stated, "This grates on you and CPS will kick you when you are down when there is just a little scratch of something you didn't do right. You fix everything, and then they add more." Four percent (4%) stated, "The people who really need welfare can't get it and the people who don't even try or don't need it get it so easily."

Four percent (4%) stated, "Before when we had people coming to the house all of the time, it helped but my mom had already gotten in trouble for me missing school. Now I am in trouble for getting pregnant and feel like they tricked me into lock up because I got pregnant. For my case if we had the people come sooner it would have helped more." Four percent (4%) stated that while in the system, moving from home to facilities, school credits are lost or non-transferable which worsens their truancy case, grades and holds grade levels back.

Q10d: How do you deal with this?

Family Response Category	% of Participants
Can't deal with it	26%
Wait to age out of system	22%
Confide in provider	22%
Provide/ prove your own records in court	17%
Push through	17%
Learn as you go	13%
Confide in peers	13%
Confide in parents	13%
Confide in sister	4%
Confide in God	4%
Confide in preacher	4%
Turn to myself	4%
You fix everything, then they add more	4%
Call DHHR Supervisor	4%
Try everyday	4%

Twenty-six percent (26%) did not have a solution. Of this response, participants agreed with comments such as, "The system can kill your hope (...) I can't deal with it (...) It is too much to deal with." In addition, four percent (4%) stated she could not deal with this and it made her hate her situation, her life and herself.

Twenty-two percent (22%) of participants felt they waited stating, "You just age out." Twenty-two percent (22%) of participants dealt with these issues by confiding in their provider.

Seventeen percent (17%) of participants agreed with the comment, "You have to provide and prove your own records and proof in court."

Seventeen percent (17%) agreed with the comment, "It is what it is and you can't change it. You just have to do what you have to do to push through whether it's your fault or your parents' faults."

Thirteen percent (13%) of participants agreed with comments such as, "You just have to learn as you go." Thirteen percent (13%) of participants confided in their peers and their parents.

Four percent (4%) of participants confided in their sister, God, or preacher. Four percent (4%) of participants stated, "I turned to myself." Four percent (4%) of participants reiterated, "You fix everything, then they add more." Four percent (4%) of participants stated, "I called a supervisor and got my worker switched." Lastly, four percent (4%) of participants stated, "I try every day."

10e: What could help change this?

Family Response Category	% of Participants
Keep families together	**70%**
Increase DHHR communication, contact, support, listen	**43%**
Everyone get on the same page	**39%**
More workers, helps with paperwork, referrals, support	**30%**
More foster homes, permanency plans	**30%**
Give people a second chance	**26%**
Adequate support for court	**17%**
Treat people as individuals	**9%**
Assist with financial needs	**4%**
Quicker intervention time	**4%**
Transfer credits	**4%**

Participants stated having a quicker case process, an increase in listening and communication between all parties involved and working towards the same goals would help. Participants felt with these changes rectified, it would improve the chances of desired outcomes in a timelier manner. Participants felt everyone involved with the case should fully understand what is happening, agree on goals and work together to reach those outcomes.

Seventy percent (70%) of participant thought there should be more focus to keep family members together regardless on the inconvenience of having to transfer the case to a different county or finding a foster home instead of a shelter for the youth. Thirty percent (30%) of participants stated instead of being forgotten about they should be advocated for to find a home and obtain a permanency plan.

Forty-three percent (43%) of participants agreed everyone should listen more, explain what is happening and answer questions. Thirty-nine percent (39%) of participants agreed, "Everyone needs to be on the same page."

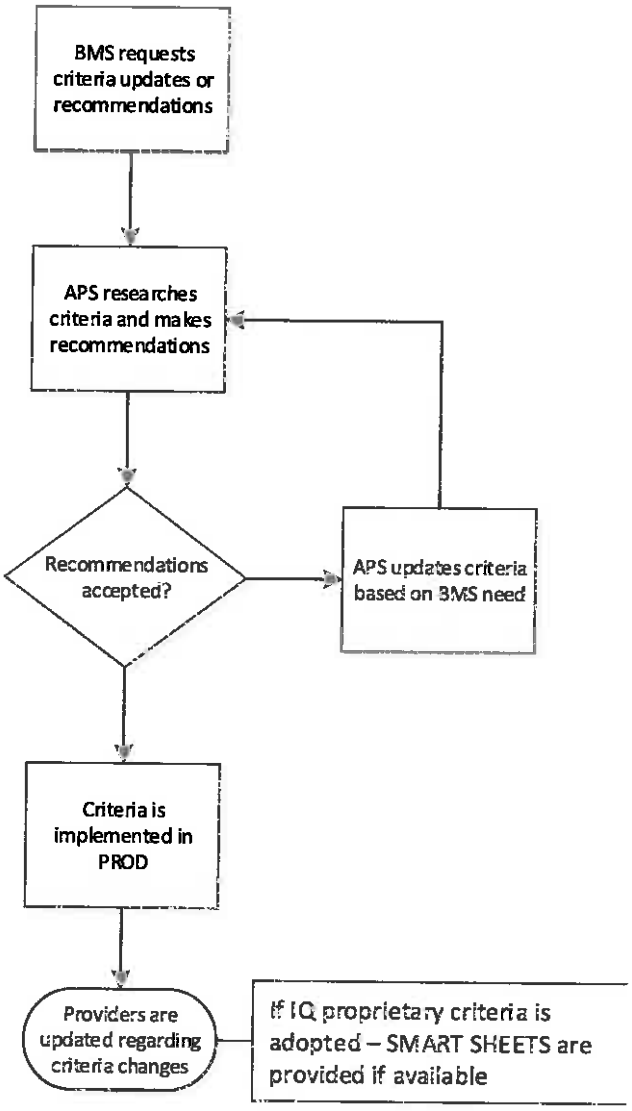
Thirty percent (30%) of participants wanted their DHHR worker to actively participate in their cases and support them. Thirty percent (30%) of participants thought the state should hire more workers to help with the paperwork.

Twenty-six percent (26%) of participants felt like they were not given another chance and this put them at a disadvantage within the court system and increased problems within the community being judged. Seventeen percent (17%) of participants felt they should be adequately represented in court instead of feeling as if court put them at a disadvantage.

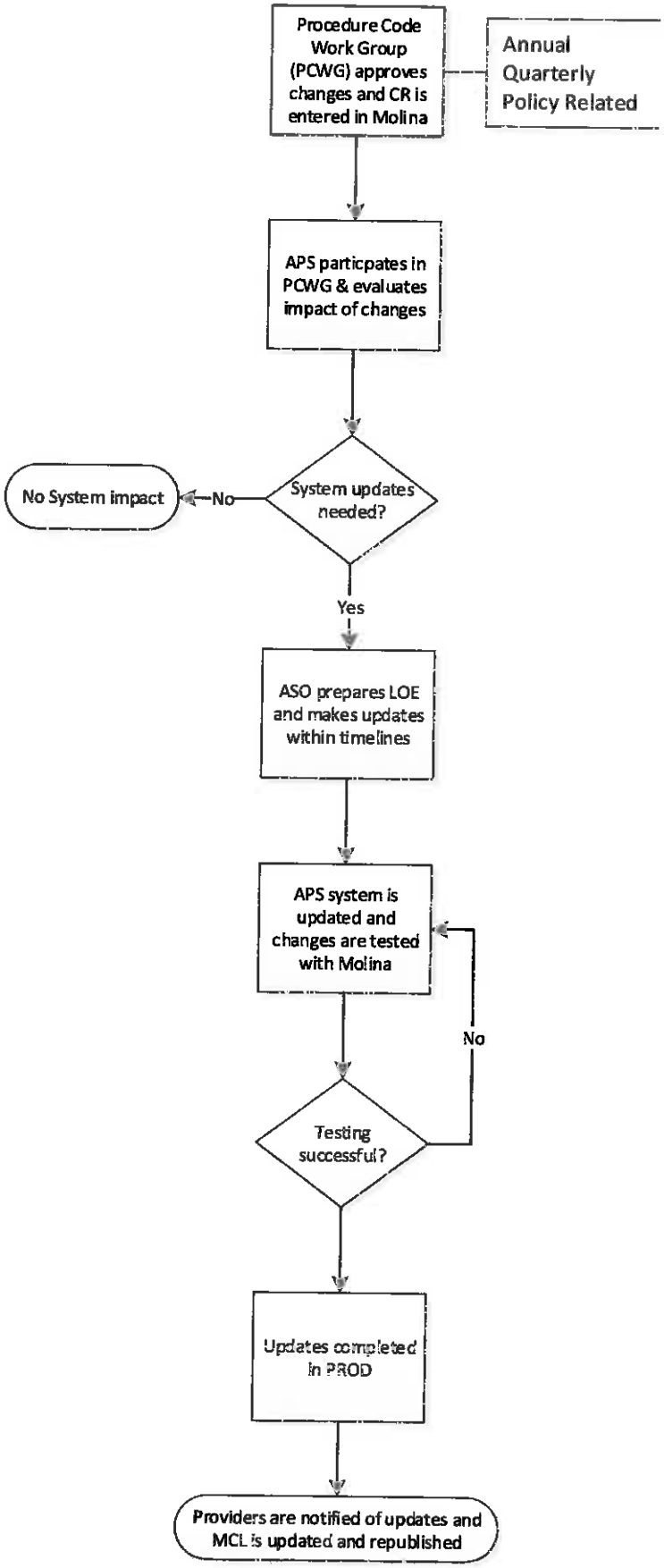
Nine percent (9%) of participants recommended more individualized plans. Four percent (4%) recommended better drug treatment for the parents.

Four percent (4%) needed financial assistance in order to get the children back but they didn't quality because the children were not in the home. Participant felt there should be contingencies where this was taken into account. Four percent (4%) recommended quicker intervention time and transferable school credits.

Medical Necessity Criteria Recommendations & Updates



Prior Authorization Code Updates (CPT/HCPCS updates)



Policy Update Implementation