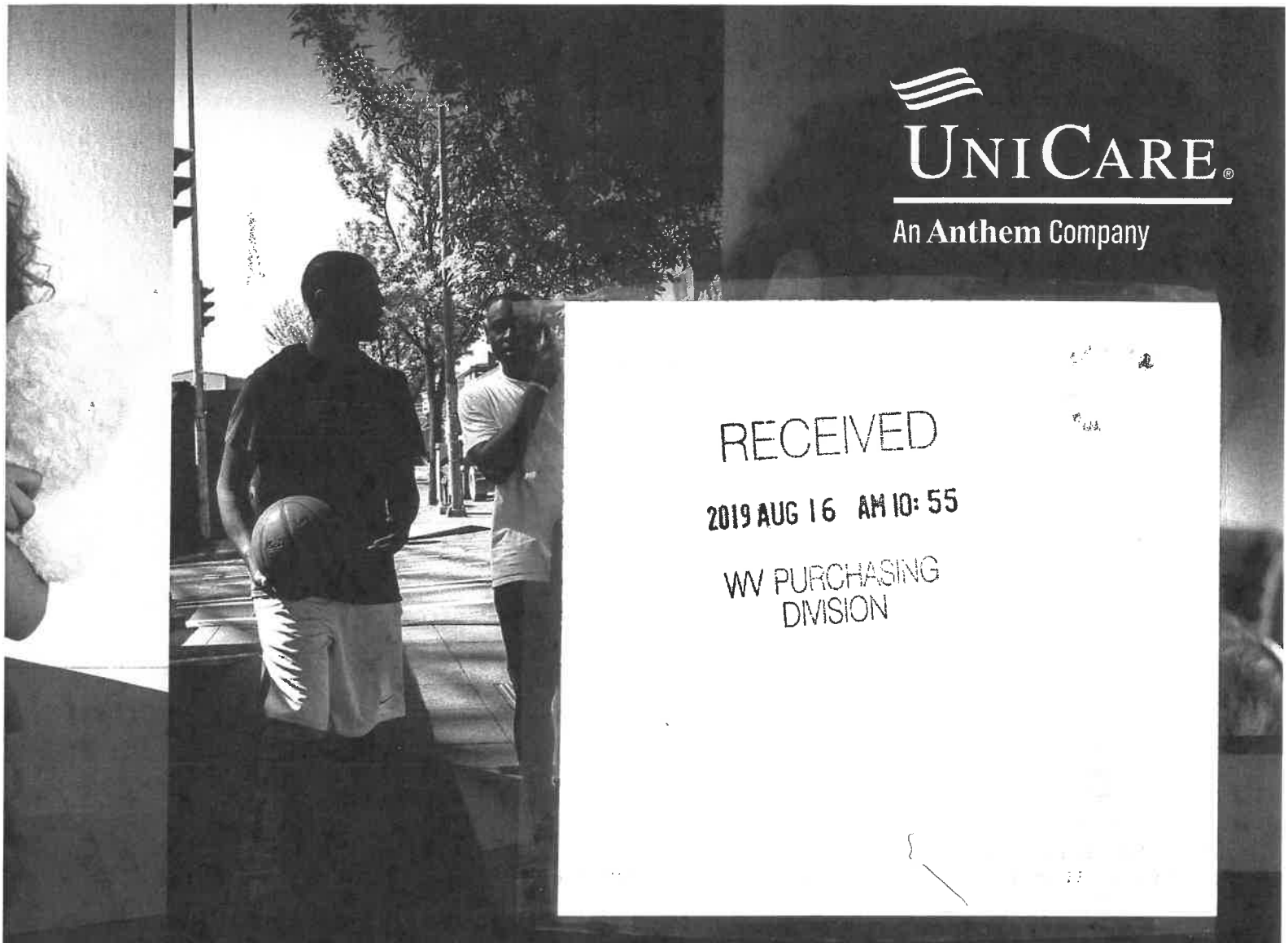


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WV PURCHASING
DIVISION

UniCare Health Plan of West Virginia, Inc.

Department of Health and Human Resources (DHHR), Specialized Managed Care for Children and Youth

REQUEST FOR PROPOSAL

CRFP 0511 BMS1900000001

TECHNICAL PROPOSAL

ORIGINAL

BID OPENING DATE: August 16, 2019 • BID OPENING TIME: 1:30 PM EST

UNICARE.

An Anthem Company

August 16, 2019

April Battle, File #22
Department of Administration, Purchasing Division
2019 Washington Street, East
Charleston, WV 25305-0130

RE: Response to DHHR's Request for Proposal (RFP) for Specialized Managed Care for Children and Youth Solicitation No. CRFP 0511 BMS1900000001

Dear Ms. Battle,

UniCare Health Plan of West Virginia, Inc. (UniCare), Respondent to this RFP, is pleased to submit our response to the Specialized Managed Care for Children and Youth Solicitation No. CRFP 0511 BMS1900000001. UniCare is experienced in serving Medicaid members in the West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) programs. We are excited about this opportunity to further serve West Virginia and look forward to bringing our unique Fostering Healthy Lives and Fostering Independence models to the Department of Health and Human Resources (DHHR). As DHHR has been developing an integrated approach to caring for children and youth in child welfare, UniCare has appreciated the opportunity to provide insight and thought leadership to help create a successful program. We look forward to providing experience and expertise that will bring the Specialized Managed Care for Children and Youth Program (the Program) to life.



West Virginia's children, youth, families, and caregivers who are served through the Program will need support tailored to their unique circumstances. As a Managed Care Organization (MCO) that has coordinated care for members in West Virginia for 16 years under West Virginia Medicaid programs, UniCare will provide that support and go above and beyond simply coordinating health care. We offer exceptional service, partnerships, and innovative solutions to meet the needs of our members and expectations of DHHR. We will expand our already successful model to support members with family-centered care that includes the coordination of health care services, behavioral health (BH) services, and socially necessary services (SNS) provided by local providers and community organizations who understand their needs.

We are West Virginians serving West Virginians. Our local leadership and locally based operations draw upon our existing relationships with all divisions of DHHR, our experience, and our passion. ***Our designated key personnel bring more than 200 years of combined, relevant health care experience.*** Our team is led by Tadd Haynes, a West Virginia native inspired to build programs and initiatives that help people manage their health conditions and get access to the care they need. For three years running, the West Virginia Chamber of Commerce has recognized UniCare as a "Five-Diamond Employer." The Five-Diamond designation ***recognizes outstanding companies for their employee policies, continuing educational opportunities for employees, community***



service participation, and empowerment of employees. Our reputation as a top employer allows us to recruit and retain experienced and driven staff to lead our programs.

Our experience has helped us develop our Fostering Healthy Lives and Fostering Independence models for West Virginia, both of which were designed specifically for children and youth in the child welfare system and their families, while addressing the specific goals and objectives of DHHR and the unique West Virginia Medicaid landscape. Our local focus and knowledge, paired with administrative advantages from our ultimate parent, Anthem, Inc. (Anthem), and the ability to leverage and share ideas and programs with our affiliates solidifies UniCare's optimal position to serve the children and youth of West Virginia. Anthem is one of only two organizations in the nation whose affiliates are operating single-entity specialty contracts exclusively serving members in foster care, juvenile justice, and adoption assistance programs.

In this Transmittal Letter and throughout our proposal, we highlight our strengths, unique capabilities, and ties to DHHR's goals and will showcase them as related to key concepts. Developed using our experience, understanding of members, our robust provider network, and strong community ties, we offer solutions that will stabilize and strengthen families, support child and youth caregivers, help DHHR achieve its goals, empower providers, and make our communities stronger together.



Keeping Families Together Through Coordination of Care

UniCare's Fostering Healthy Lives model is designed to stabilize and strengthen West Virginia families engaged with the child welfare system, helping to reduce the number of children removed from their home. Emphasizing integration, our Utilization Management (UM) and Care Coordination teams will work together to ensure children and youth get the right care, at the right time, in the right setting. In accordance with our family-driven and youth-guided care coordination model, we will engage members and their families to ensure SNS reflect their preferences and priorities, which are unique to each situation.

Over the past 16 years, we have continually proven our commitment to integrating and coordinating care for West Virginians. For example, after BH services were carved into our current MCO contract, UniCare focused on bringing members placed in out-of-state psychiatric residential treatment facilities (PRTFs) back to West Virginia. ***Between July 2015 and June 2017, we reduced the number of youths in out-of-state placements from 22 youths to three, an 86% reduction, by working directly with residential providers to improve quality of services and securing local, community-based alternative placements.*** We will bring the same commitment, innovative solutions, and demonstrated outcomes to serving the children and youth enrolled in the Program.

Enhanced Coordination of Care by Supporting Caregivers

Our coordination of care approach supports our members' biological, adoptive, and foster families and kinship caregivers with a family-centered care model that includes the coordination of health care services, BH services, and SNS, such as parenting education, social and emotional support, and life skills. We recognize we can best support children by assuring their caregivers receive the services and supports they need.

The UniCare Parent-child Interaction Therapy Model

Through collaboration with Dr. Cheryl McNeil of West Virginia University (WVU), one of only 15 PCIT International Master Trainers, and FMRS Health Systems, Inc., a Comprehensive Behavioral Health Center headquartered in Beckley, UniCare has adapted the typical PCIT program to improve access for caregivers while maintaining the program's effectiveness. Parent-Child Interaction therapy (PCIT) is an evidence-based parent-child treatment program focusing on promoting positive parent-child relationships and interaction, and teaching parents effective child management skills. PCIT has been adapted as an intervention for families including those receiving child welfare services or exposed to violence, those with children on the autism spectrum, adoptive families, foster families, and those in kinship care.

Supporting Kinship Care with Healthy Grandfamilies

UniCare provides funding support for West Virginia State University's Healthy Grandfamilies program, providing $25,000 in 2019 to offset program costs for statewide expansion and providing expert presenters for specific educational topics. The Healthy Grandfamilies program is a series of free educational discussion groups geared toward grandparents raising their grandchildren. The program has been funded by the USDA's National Institute of Food and Agriculture and has been limited to a small number of West Virginia counties. The overwhelming need for this type of program prompted the West Virginia legislature to authorize funds to expand this program statewide.

Real Stories

UniCare helped put a grandmother's mind at ease

Kayla, a grandmother in Charles Town, was identified via the automated new member screener call and was immediately connected to a UniCare representative. Kayla had concerns regarding her grandson, Michael, a UniCare member with a personal and family history of mental problems and physical abuse. Kayla was concerned that her grandson might be suicidal because his girlfriend was moving away and was also concerned about his living conditions with his father. The UniCare representative listened carefully to Kayla's concerns and explained the care management process that UniCare offers to its members. Kayla thought that her grandson would agree to care management, but was concerned that the Care Coordinator would have difficulty contacting him. A BH Care Coordinator from UniCare worked with Kayla to get Michael his own phone so that the Care Coordinator could contact him directly to get him enrolled in care management. Kayla was so thankful that UniCare took the time to listen to her. She started crying and said, "You don't know how hard it is to see someone you love try to end their own life and the struggles he faces with his mental health issues." She stated that UniCare gave her hope. Michael is enrolled in care management today.

WV_FC2019_Kayla_RS_01

Helping DHHR Reduce the Opioid Crisis' Impact on Foster Care

As of 2018, DHHR estimated there are more than 6,000 children in out-of-home care. These numbers are rising at an alarming rate primarily due to the opioid epidemic affecting the state. Year over year, West Virginia's rate of overdose deaths has been significantly higher than any other state, resulting in many children losing a parent to this crisis.

As a current MCO, we have developed new solutions and support existing community programs that benefit our members, their families and caregivers, and our communities. We view our medication assisted treatment (MAT) and neonatal abstinence syndrome (NAS) initiatives as preventive strategies that help reduce the number of children coming into care or being raised by grandparents or other kinship caregivers. We see a clear correlation from our promotion of MAT and the decrease in overdoses. In 2018, we saw a 100% increase in MAT and a 30% reduction in opioid overdoses claims over 2017. In the first quarter of 2019, we have seen a 50% reduction in opioid overdose claims over the first quarter of 2018. We know our thoughtful consideration of our programs can and will make an impact on the epidemic and will be an important component of our Fostering Healthy Lives and Fostering Independence models.

Preventing Neonatal Abstinence Syndrome (NAS)

West Virginia is experiencing an increasing number of newborns diagnosed with NAS or neonatal opioid withdrawal syndrome (NOWS) year over year, attributed to high substance use during pregnancy. To combat this increase, we developed a comprehensive NAS/NOWS program that seeks to both proactively educate women on substance use during pregnancy and improve health outcomes for women and newborns already affected by substance use disorder, including opioid use and misuse before and during pregnancy. ***Since initiating our NAS/NOWS programs, we have seen a 29% reduction in our claims for perinatal substance abuse from 2017 to 2018.***

Our Provider Pledge – Simplifying Health Care for Providers

We are committed to ongoing efforts of support and collaboration through our Provider Pledge to deliver a best-in-class experience by simplifying health care so our providers can focus on member health. We will equip providers with tools to care for children and youth who may have been exposed to Adverse Childhood Experiences, resulting in early stress and trauma, and who may require specialized care coordination to address their complex needs. Our Alternate Payment Model (APM) strategy focuses on rewarding physical health (PH) and BH providers for adhering to DHHR and UniCare quality and performance standards. In addition to APMs, UniCare also offers additional opportunities and recognitions to providers to promote their expertise in areas of importance to the Program and members. We will use our value-based payment incentives and other performance-based incentive programs to drive improvement in evidence-based, clinical performance.

Psychiatric Residential Treatment Facilities

UniCare's UM and Care Coordination teams collaborated to focus on decreasing the average length of stay for children and youth in PRTFs. We will closely work with facility discharge planning staff and apply evidence-based transition of care practices to ensure shorter stays in PRTFs. Shorter stays mutually benefit the member living in the PRTF by achieving a quicker return to a stable home environment as well as the other members who have an unmet need to receive that level of care locally. ***Through our focus and efforts to reduce the length of stay for children and youth in PRTFs, length of stay averaged three to five months fewer than originally expected through deployment of in-home services, intensive service, and/or outpatient treatment.***

Serving Members in Our Local Communities — Stronger Together

Our relationships with community organizations and the public agencies that support children in foster care provide insight into the issues facing these children and families, and allow us to come together to offer unique and effective solutions. In preparation for serving these members, we have engaged extensively with advocacy groups, foster caregivers, community leaders, and providers to fully understand the experiences, needs, and challenges most important to them. Our community partnerships, built on collaboration and communication, are focused on ensuring children, youth, and their families have the tools they need to fulfill their goals. ***We serve our communities by forming partnerships with 1,165 local organizations that include community or faith-based organizations, government agencies, and schools. Since January 2017, we have sponsored 4,269 community events and, since January 2018, donated more than $400,000 through UniCare and nearly $300,000 through the Anthem Foundation to benefit our community, directly affecting our membership in positive and meaningful ways.***

TITLE PAGE

RFP subject: West Virginia Department of Health and Human Resources, Specialized Managed Care for Children and Youth, Technical Proposal

Number: CRFP 0511 BMS1900000001

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

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

Telephone number: (888) 611-9558

Fax number: (877) 833-5729

Name of contact person: Tadd Haynes

Email address: Tadd.Haynes@anthem.com

Vendor signature: 

Date: August 13, 2019

TITLE PAGE

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6.8 Availability of Information

Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

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

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

President
(Representative Name, Title)

Contact Phone: (888) 611-9558/Fax Number: (877) 833-5729
(Contact Phone/Fax Number)

7/25/19
(Date)

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

[signature], President
(Representative Name, Title)

Contact Phone: (888) 611-9558/Fax Number: (877) 833-5729
(Contact Phone/Fax Number)

7/25/19
(Date)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS1900000001

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

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

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[✓]	Addendum No. 6
[✓]	Addendum No. 2	[ ]	Addendum No. 7
[✓]	Addendum No. 3	[ ]	Addendum No. 8
[✓]	Addendum No. 4	[ ]	Addendum No. 9
[✓]	Addendum No. 5	[ ]	Addendum No. 10

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

UniCare Health Plan of West Virginia, Inc.
Company

Authorized Signature

08/06/2019
Date

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

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS1900000001

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.

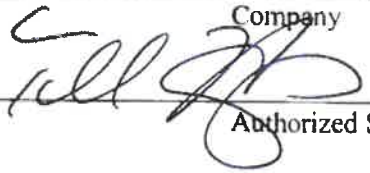
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UniCare Health Plan of West Virginia, Inc.
Company



Authorized Signature

08/06/2019
Date

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

ATTACHMENT B: VENDOR QUALIFICATIONS & EXPERIENCE

1. ORGANIZATION OVERVIEW

This section of the Vendor's Technical Proposal should include an overview of the Vendor and any subcontractor(s). The Vendor should complete the template below. Unless otherwise stated, requested documentation must be provided to the Department as part of the bid submission.

1.1 Vendor Overview

Provide all relevant information regarding the general profile of the Vendor.

The Vendor is NOT to change any of the pre-filled cells in the following tables. The Vendor should only delete <Response> and add text in its place.

Table 6: Vendor Overview

Vendor Overview	
Corporate (Legal) Name	UniCare Health Plan of West Virginia, Inc. (UniCare)
Name of Parent Company (If Applicable)	Anthem, Inc. (Anthem)
Tax Identification Number	84-1620480
Industry (North American Industry Classification System [NAICS])	524114
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	UniCare is a wholly owned subsidiary of Anthem, Inc. Anthem is a publicly traded corporation.
Number of Full-Time Employees	UniCare, with support from our parent company, has 98 current full-time employees, and we anticipate the addition of 152 full-time employees to support the Specialized Managed Care for Children and Youth (the Program), resulting in a total of 250 employees dedicated to our West Virginia operations.
Last Fiscal Year Company Revenue	$449,020,262
Last Fiscal Year Company Net Income	$26,050,870
% of Revenue From State Government Clients in the United States	100%
Number of Years in Business	More than 16

Vendor Overview	
Number of Years Vendor has been Providing the Type of Services Specified in the RFP	UniCare has provided Medicaid managed care services for more than 16 years. While this Program will be our first exclusively youth-oriented program, we have served TANF members, including youth in similar situations to those that will be served by the Program, since we began operations.
Number of Employees Providing the Type of Services Specified in the RFP	UniCare, with support from our parent company, has 98 current full-time employees, and we anticipate the addition of 152 full-time employees to support this Program, resulting in a total of 250 employees dedicated to our West Virginia operations.
Headquarters in the United States	UniCare's headquarters is in Charleston, West Virginia. All operations will be administered or overseen from this location. Our ultimate parent company, Anthem, Inc., is headquartered in Indianapolis, Indiana.
Headquarters Mailing Address	200 Association Drive, Suite 200, Charleston, WV 25311
Street Address	200 Association Drive, Suite 200, Charleston, WV 25311
Telephone Number	888-611-9958
Fax Number	877-833-5729
Locations in the United States	Our Charleston, West Virginia headquarters is our only office location.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Name:** UniCare is administering this bid from its headquarters as provided above. **Mailing Address:** **Street Address:** **Telephone Number:** **Fax Number:**
Name of Contact Person for Bid	Tadd Haynes, Chief Executive Officer

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

Under the West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) programs, UniCare currently serves and intends to continue serving members in all 55 West Virginia counties. As an MCO health plan serving members statewide, we have received approval from the Department of Insurance to serve Medicaid members in each county.

The Vendor should describe the legal status of the Vendor and its parent company, as applicable.

UniCare is a domestic West Virginia corporation. Our ultimate parent company, Anthem, Inc., is a publicly traded corporation on the New York Stock Exchange under the symbol ANTM.

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

UniCare has served Medicaid members in West Virginia since its operations began over 16 years ago. UniCare is exclusively dedicated to West Virginia Medicaid and our members, and as such, we do not have membership in other states, and we do not operate under other lines of business in West Virginia. Anthem and our affiliates have served Medicaid beneficiaries since 1991, and today serve more than seven million members enrolled in Medicaid and other state-sponsored programs in 21 additional markets nationwide (see Table B.1-1).

Table B.1-1. Anthem's Medicaid Membership in Other Markets
(Bold font indicates markets where child welfare populations are served)

Market	Medicaid Membership
Arkansas	15,124
California	1,190,257
Colorado	**310,910**
District of Columbia	**46,171**
Florida	**521,795**
Georgia	**398,564**
Indiana	**443,487**
Iowa	**241,002**
Kentucky	**132,848**
Louisiana	**260,891**
Maryland	**278,777**
Minnesota	**334,011**
Nevada	191,171
New Jersey	**176,656**
New York	463,611
South Carolina	121,363
Tennessee	395,826
Texas	**770,789**
Virginia	**384,983**
West Virginia	154,000
Washington	187,958
Wisconsin	94,605

The Vendor should describe any experience managing services for the foster care population.

Anthem is one of only two organizations in the nation whose subsidiaries are operating sole source specialty contracts exclusively serving Members in Foster Care, Juvenile Justice, and Adoption Assistance.
WV_FC2019_SpecialtyContracts_CCB_04

UniCare is the largest Medicaid managed care organization (MCO) in West Virginia serving 154,000 members who receive their health care through the West Virginia Medicaid programs. Since 2003, UniCare has developed strong relationships with families, communities, providers, State agencies, and other stakeholders that enhance our knowledge and understanding of the strengths and needs of the populations we serve, as well as the challenges members may experience in achieving their personal goals and wellness. Our affiliate health plans currently serve approximately 84,000

children and youth in child welfare systems in 13 markets, as detailed in Table B.1-2. Our health plan affiliate in Georgia is a single, statewide MCO dedicated to overseeing the holistic care of over 33,000 youth involved in child welfare that includes foster care, adoption assistance, and juvenile justice. In addition, our affiliate health plan in Louisiana is the preferred health plan for children and youth in the child welfare system. As we serve the West Virginia foster care population, we will draw on best practices and lessons learned from these and other affiliates administering programs serving the foster care population.

Table B.1-2 Affiliates' Experience Serving Child Welfare Populations

States	Prime, MCO or ASO	Years Serving Similar Populations*	Current Similar Populations Members*
CO	Prime, MCO	1 year	5,627
DC	Prime, MCO	2 years	13
FL	Prime, MCO	16 years	6,636
GA**	Prime, MCO	5 years	33,647
IA	Prime, MCO	3 years	4,592
IN	Prime, MCO	4 years	4,705
KY	Prime, MCO	5 years	1,656
LA***	Prime, MCO	7 years	4,050
MD	Prime, MCO	20 years	3,556
MN	ASO	<1 years	1,800
NJ	Prime, MCO	23 years	2,225
TX	Prime, MCO	7 years	12,007
VA	Prime, MCO	3 years	3,890
Grand Total			84,404

*Foster Care, Former Foster Care, Adoption Assistance and/or Juvenile Justice
**Our Georgia affiliate is the sole source MCO for these populations
***Our Louisiana affiliate is the "preferred plan" for these populations
WV_FC2019_AffiliatesExp_DIA_01

The Vendor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Vendor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

UniCare is a wholly owned subsidiary of our ultimate parent company, Anthem, Inc. We have provided Anthem's primary business address below, followed by a list of every other Medicaid business location in Table B.1-3.

Primary Location:

Anthem, Inc.
220 Virginia Avenue
Indianapolis, IN 46204
800-331-1476

Other Business Locations

Table B.1-3. Anthem's Nationwide Medicaid Business Locations

Address	City	State	Zip
650 S Shackleford Road, Suite 440	Little Rock	AR	72211
5250 North Palm Avenue, Suite 421	Fresno	CA	93704
425 East Colorado Street, Suite 600	Glendale	CA	91205
406 E Colorado Street	Glendale	CA	91205
2000 Corporate Center Drive, Building 7	Newbury Park	CA	91320
2868 Prospect Park Drive, Suite 100	Rancho Cordova	CA	95670

Address	City	State	Zip
11030 White Rock Road	Rancho Cordova	CA	95670
9655 Granite Ridge Drive, Suite 600	San Diego	CA	92123
120 South Via Merida	Thousand Oaks	CA	91362
3330 West Mineral King, Suite A	Visalia	CA	93292
21555 Oxnard Street	Woodland Hills	CA	91367
7150 Campus Drive, Suite 120	Colorado Springs	CO	80920
700 Broadway	Denver	CO	80273
1125 17th Street, Suite 1000	Denver	CO	80202
108 Leigus Road	Wallingford	CT	06492
609 H Street, NE, Suite 200	Washington	DC	20002
2290 Lucien Way	Maitland	FL	32751
9250 West Flagler Street, Suite 600	Miami	FL	33174
1000 South Pine Island, Suite 900	Plantation	FL	33324
4200 West Cypress Street, Suite 900	Tampa	FL	33607
4170 Ashford Dunwoody Road, Suite 100	Atlanta	GA	30319
3350 Peachtree Road	Atlanta	GA	30326
621 Northwest Frontage Road, Suite 310	Augusta	GA	30907
6087 Technology Parkway	Midland	GA	31820
8001 Chatham Center Drive, Suite 100	Savannah	GA	31405
4800 Westown Parkway	West Des Moines	IA	50266
7509 Eagle Crest Boulevard	Evansville	IN	47715
13550 Triton Park Boulevard	Louisville	KY	40223
10000 Perkins Rowe, Suite 510	Baton Rouge	LA	70810
3850 North Causeway Boulevard, Suite 600	Metairie	LA	70002
7550 Teague Road, Suite 500	Hanover	MD	21076
3000 Ames Crossing Road, Suite 100	Eagan	MN	55121
14120 Ballantyne Corporate Place, Suite 225	Charlotte	NC	28277
101 Wood Avenue South, Suite 800	Iselin	NJ	08830
9133 West Russell Road	Las Vegas	NV	89148
11 Corporate. Woods Boulevard	Albany	NY	12211
32-31 Steinway	Astoria	NY	11103
2411 Grand Concourse	Bronx	NY	10468
968 Southern Boulevard	Bronx	NY	10459
241 37th Street, 4th Floor	Brooklyn	NY	11232
2875 West 8th Street	Brooklyn	NY	11224
364 Knickerbocker Avenue	Brooklyn	NY	11237
471 5th Avenue	Brooklyn	NY	11215
815 59th Street	Brooklyn	NY	11220
2009 Church Avenue	Brooklyn	NY	11226
257 West Genesee Street, 6th Floor	Buffalo	NY	14202
3913 104th Street	Corona	NY	11368
13656 39th Avenue	Flushing	NY	11354
91 North Franklin Street	Hempstead	NY	11550
95-40 Roosevelt Avenue	Jackson Heights	NY	11372
9 Pine Street (aka 14 Wall Street), 14th Floor	New York	NY	10005
221 Sherman Avenue	New York	NY	10034
28 Bowery, Unit B	New York	NY	10013
139 Centre Street	New York	NY	10013
153-17 Jamaica Avenue	Queens	NY	11432
11603 Liberty Avenue	South Richmond Hill	NY	11419

Address	City	State	Zip
32 Richmond Terrace	Staten Island	NY	10301
37 Thurber Boulevard, Suite 108	Smithfield	RI	02917
4101 Percival Road	Columbia	SC	29229
7130 Goodlett Farms Parkway	Cordova	TN	38016
9041 Executive Park Drive, OFC 18, Suite 250	Knoxville	TN	37923
22 Century Boulevard, Suite 220	Nashville	TN	37214
823 Congress Avenue, Suite 400	Austin	TX	78701
7430 Remcon Circle, Building C, Suite 120	El Paso	TX	79912
2505 North Highway 360, Suite 300	Grand Prairie	TX	75050
3800 Buffalo Speedway, Suite 400	Houston	TX	77098
5959 Corporate Drive, Suite 3500	Houston	TX	77036
3223 South Loop 289, Suite 110	Lubbock	TX	79423
12500 San Pedro, Suite 400	San Antonio	TX	78216
11820 Fountain Way, Suite 200	Newport News	VA	23606
5800 Northampton Boulevard	Norfolk	VA	23502
10701 Parkridge Boulevard, Suite 100	Reston	VA	20191
2015 Staples Mill Road	Richmond	VA	23230
1330 Amerigroup Way	Virginia Beach	VA	23464
4425 Corporation Lane	Virginia Beach	VA	23462
4433 Corporation Lane	Virginia Beach	VA	23462
705 5th Avenue South, Suite 300	Seattle	WA	98104
216 Pinnacle Way, Suite 260	Eau Claire	WI	54701
N17W24222 Riverwood Drive, Suite 300	Pewaukee	WI	53188
200 Association Drive, Suite 200	Charleston	WV	25311

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

Anthem's tax identification number is **35-2145715.** UniCare does not have ownership interest in a subcontractor.

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

No such relationship exists. Anthem is the sole owner of UniCare. No other owners or entities with control interest in UniCare exist.

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

Our ultimate parent company, Anthem, conducts managed care business through the following subsidiaries and their affiliates: America's 1st Choice, Amerigroup, Aspire Health, CareMore, Freedom Health, HealthLink, HealthSun, Optimum HealthCare, Simply Healthcare, and UniCare. Anthem is also an independent licensee of the Blue Cross and Blue Shield Association (BCBSA), an association of independent health benefit plans.

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Vendor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

The UniCare Chief Executive Officer will serve as our managing employee.

Name: Tadd Haynes
Address: [redacted]
Date of Birth: [redacted]
Social Security Number: [redacted]

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

UniCare has held NCQA accreditation since 2006. Our most recent renewal was in 2018, and it is valid until September 2021. In addition, our organization's behavioral health program is accredited nationally as a Managed Behavioral Healthcare Organization (MBHO) by NCQA. In 2017, UniCare received NCQA's Multicultural Health Care Distinction. UniCare has never experienced a suspension, denial, or revocation of an NCQA accreditation, nor has our ultimate parent company, Anthem, its subsidiaries, nor our affiliates.

1.2 Subcontractor Overview (if applicable)

If the proposal includes the use of Subcontractor(s), provide all relevant information regarding the profile of each Subcontractor. This section may be duplicated in its entirety and a page created per Subcontractor included.

The Vendor is NOT to change any of the pre-filled cells in the following tables. The Vendor should only delete <Response> and add text in its place.

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Anthem, Inc. (Anthem)
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	35-2145715
Industry (NAICS)	524114
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	65,300
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	$92.1 billion
Last Fiscal Year Company Net Income	$3.75 billion

Subcontractor Overview	
% of Revenue From State Government Clients in the United States	60.3%
Number of Years in Business	More than 80 through subsidiary health plans
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	28 providing Medicaid managed care 17 providing services to members in foster care and adoption assistance
Number of Employees Providing the Type of Services Specified in the RFP	7,545
Headquarters in the United States	Yes
Headquarters Mailing Address	220 Virginia Avenue Indianapolis, IN 46204
Street Address	220 Virginia Avenue Indianapolis, IN 46204
Telephone Number	800-331-1476
Fax Number	317-488-6477
Locations in the United States	Little Rock, AR Fresno, CA Glendale, CA Newbury Park, CA Rancho Cordova, CA San Diego, CA Thousand Oaks, CA Visalia, CA Woodland Hills, CA Colorado Springs, CO Denver, CO Wallingford, CT Washington, DC Maitland, FL Miami, FL Plantation, FL Tampa, FL Atlanta, GA Augusta, GA Midland, GA Savannah, GA West Des Moines, IA Evansville, IN Indianapolis, IN Louisville, KY Albany, NY Astoria, NY Bronx, NY Brooklyn, NY Buffalo, NY Corona, NY Flushing, NY Hempstead, NY Jackson Heights, NY New York, NY Queens, NY South Richmond Hill, NY Staten Island, NY Smithfield, RI Columbia, SC Cordova, TN Knoxville, TN Nashville, TN Austin, TX El Paso, TX Grand Prairie, TX Houston, TX Lubbock, TX San Antonio, TX Newport News, VA

Subcontractor Overview		
	Baton Rouge, LA Metairie, LA Hanover, MD Eagan, MN Charlotte, NC Iselin, NJ Las Vegas, NV	Norfolk, VA Reston, VA Richmond, VA Virginia Beach, VA Seattle, WA Eau Claire, WI Pewaukee, WI Charleston, WV
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Name:** same as above **Mailing Address:** **Street Address:** **Telephone Number:** **Fax Number:**	
Name of Contact Person for Bid	Felicia Norwood, Executive Vice President and President, Government Business Division	

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

Shares of Anthem's common stock are publicly traded on the New York Stock Exchange under the symbol ANTM. As such, Anthem common stock may be acquired in the ordinary course of business through open market purchases. Per Securities and Exchange Commission (SEC) filings, as of March 31, 2019, Anthem is aware of the following entities, listed in Table B.1-4, that own beneficially 5% or more of the outstanding shares of Anthem's common stock. It should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

Table B.1-4. Entities That Own Beneficially 5% or More of the Outstanding Share of Anthem Stock as of March 31, 2019

Entity Name	Business Address	Percent Owned
BlackRock, Inc.	Primary: 40 East 52nd Street, New York, New York 10022 Additional locations: BlackRock has 70 offices in 30 countries. U.S. locations are in: Newport Beach, CA; Palo Alto, CA; San Francisco, CA; Santa Monica, CA; Denver, CO; Greenwich, CT; Boca Raton, FL; Miami, FL; Ponte Vedra Beach, FL; Atlanta, GA; Chicago, IL; Boston, MA; Bloomfield Hills, MI; Princeton, NJ; New York, NY;	8.56%

Entity Name	Business Address	Percent Owned
	Charlotte, NC; Philadelphia, PA; Pittsburgh, PA; Dallas, TX; Houston, TX; Seattle, WA Non-US locations can be found at: https://www.blackrock.com/corporate/about-us/contacts-locations	
T. Rowe Price Associates, Inc.	Primary: 100 East Pratt Street, Baltimore, Maryland 21202 Additional locations: T. Rowe Price Associates, Inc. has locations in the United States and 15 other countries. U.S. locations are in: San Francisco, CA; Colorado Springs, CO; Baltimore, MD; Owings Mills, MD; New York, NY; and Philadelphia, PA Exact location addresses can be found at: https://www.troweprice.com/corporate/en/locations.html	7.50%
The Vanguard Group, Inc.	Primary: P.O. Box 2600, Valley Forge, Pennsylvania 19482 Additional locations: The Vanguard Group, Inc. has four locations in the United States and 14 international offices in 11 countries. U.S. locations are in: Scottsdale, AZ; Washington, D.C.; Charlotte, NC; and Valley Forge, PA	7.56%

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

BlackRock, Inc. – 32-0174431

T. Rowe Price Associates, Inc. – 52-2264646

The Vanguard Group, Inc. – 23-1945930

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

No such relationship exists.

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

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

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

Anthem officers are listed in Table B.1-5 and directors in Table B.1-6. If UniCare is selected, we will provide full information on Anthem's officers and directors upon Department of Health and Human Resources (DHHR) request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-5. Anthem Officers

Entity Name	Title	Address	DOB and SSN
Scott Anglin	Treasurer	[redacted]	[redacted]
Gail Boudreaux	President and CEO	[redacted]	[redacted]
John Gallina	Chief Financial Officer	[redacted]	[redacted]
Kathleen Kiefer	Corporate Secretary	[redacted]	[redacted]
Ronald Penczek	Chief Accounting Officer	[redacted]	[redacted]
Elizabeth Tallett	Chairperson	[redacted]	[redacted]

Table B.1-6. Anthem Directors

Entity Name	Title	Address	DOB and SSN
Gail Boudreaux	Director	[redacted]	[redacted]
Ronald Clark	Director	[redacted]	[redacted]
Robert Dixon, Jr.	Director	[redacted]	[redacted]
Lewis Hay III	Director	[redacted]	[redacted]
Julie Hill	Director	[redacted]	[redacted]
Bahija Jallal	Director	[redacted]	[redacted]
Antonio Neri	Director	[redacted]	[redacted]
Ramiro Peru	Director	[redacted]	[redacted]
Elizabeth Tallett	Director	[redacted]	[redacted]

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Advanced Medical Reviewers, LLC (AMR)
Name of Parent Company (If Applicable)	ExamWorks, LLC
Tax Identification Number	59-3791598
Industry (NAICS)	621999
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	74
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	[redacted]
Last Fiscal Year Company Net Income	[redacted]
% of Revenue From State Government Clients in the United States	[redacted]
Number of Years in Business	14
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	14
Number of Employees Providing the Type of Services Specified in the RFP	40
Headquarters in the United States	Yes
Headquarters Mailing Address	600 Corporate Pointe, Suite 300 Culver City, CA 90230
Street Address	600 Corporate Pointe, Suite 300 Culver City, CA 90230
Telephone Number	800-726-1207
Fax Number	310-470-4717
Locations in the United States	Culver City, CA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Name:** same as above **Mailing Address:** **Street Address:** **Telephone Number:**

Subcontractor Overview	
	Fax Number:
Name of Contact Person for Bid	Amanda Marfise Markle, VP Strategic Partnerships

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

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

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

ExamWorks – 26-1114252

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

No such relationship exists.

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

N/A

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

The managing employee of the subcontractor is listed in Table B.1-7. If UniCare is selected, we will provide this individual's full information upon DHHR's request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-7. Managing Employee of AMR

Name	Title	Address	DOB and SSN
Megan Kaufman	General Manager	[redacted]	[redacted]

Table 7: Subcontractor Overview

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

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

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

Exela Technologies, Inc. has no person (individual or corporation) with an ownership or control interest.

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

N/A

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

No such relationship exists.

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

N/A

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

The managing employee of the Subcontractor is listed in Table B.1-8. If UniCare is selected, we will provide this individual's full information upon DHHR's request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-8. Managing Employee of Exela

Name	Title	Address	DOB and SSN
Christy Hudson	Director, Customer Relationship Management	[redacted]	[redacted]

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	SKYGEN USA, LLC (SKYGEN)
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	81-0762694
Industry (NAICS)	524292
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Approximately 600
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	[redacted]
Last Fiscal Year Company Net Income	[redacted]
% of Revenue From State Government Clients in the United States	[redacted]
Number of Years in Business	25
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	25
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 600
Headquarters in the United States	Yes
Headquarters Mailing Address	W140 N8981 Lilly Road Menomonee Falls, WI 53051
Street Address	W140 N8981 Lilly Road Menomonee Falls, WI 53051
Telephone Number	262-946-4400
Fax Number	262-347-3219
Locations in the United States	Menomonee Falls, WI Mequon, WI
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of	**Name:** same as above **Mailing Address:**

Subcontractor Overview	
Business Unit Administering This Bid (if different from above)	**Street Address:** **Telephone Number:** **Fax Number:**
Name of Contact Person for Bid	Mark Dasek, Executive, Client Experience

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

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

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

Grambino Technologies, LLC, 20-8448188
MOA Investments, LLC, 39-01865244
Scion Holdings, Inc., 82-3326543

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

No such relationship exists.

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

N/A

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted*

version with its proposal, and if the Vendor is selected, the Department will request full information.

The managing employees of the Subcontractor are listed in Table B.1-9. If UniCare is selected, we will provide their full information upon DHHR's request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-9. Managing Employees of SKYGEN

Name	Title	Address	DOB and SSN
Craig Kasten	Chief Executive Officer/President	[redacted]	[redacted]
Steven Berryman	Chief Learning Officer/Secretary	[redacted]	[redacted]
James Purko	Chief Financial Officer/Treasurer	[redacted]	[redacted]

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)
Name of Parent Company (If Applicable)	Symphony Performance Health Holdings, Inc.
Tax Identification Number	46-4593394
Industry (NAICS)	541511
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	731
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	[redacted]
Last Fiscal Year Company Net Income	[redacted]
% of Revenue From State Government Clients in the United States	[redacted]
Number of Years in Business	More than 35
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	More than 35
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 625
Headquarters in the United States	Yes
Headquarters Mailing Address	11605 Haynes Bridge Road, Suite 400 Alpharetta, GA 30009
Street Address	11605 Haynes Bridge Road, Suite 400 Alpharetta, GA 30009
Telephone Number	770-978-3173
Fax Number	770-623-4075
Locations in the United States	Branford, CT Alpharetta, GA Duluth, GA Farmington Hills, MI Fort Worth, TX Arlington, VA

Subcontractor Overview	
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Name:** same as above **Mailing Address:** **Street Address:** **Telephone Number:** **Fax Number:**
Name of Contact Person for Bid	Matt Smith, Senior Project Director

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

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

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

Symphony Performance Health Holdings, Inc. – 46-4600805

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

No such relationship exists.

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

N/A

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

The managing employee of the Subcontractor is listed in Table B.1-10. If UniCare is selected, we will provide this individual's full information upon DHHR's request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-10. Managing Employee of SPH

Name	Title	Address	DOB and SSN
Colin Rogoff	Chief Financial Officer	[redacted]	[redacted]

Table 7: Subcontractor Overview

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

Subcontractor Overview		
	Atlanta, GA Honolulu, HI Chicago, IL Indianapolis, IN Boston, MA	Portland, OR Greenville, SC Nashville, TN Dallas, TX Seattle WA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Name:** same as above **Mailing Address:** **Street Address:** **Telephone Number:** **Fax Number:**	
Name of Contact Person for Bid	Annie Mayo, Area VP, Health & Government Markets	

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

Vision Service Plan Insurance Company has no owners, stockholders, or shareholders.

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

N/A

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

No such relationship exists.

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

N/A

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

The managing employee of the Subcontractor is listed in Table B.1-11. If UniCare is selected, we will provide this individual's full information upon DHHR's request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-11. Managing Employee of VSP

Name	Title	Address	DOB and SSN
Annie Mayo	Chief Executive Officer/President	[redacted]	[redacted]

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Wipro LLC (Wipro)
Name of Parent Company (If Applicable)	Wipro Limited
Tax Identification Number	98-0154401
Industry (NAICS)	541511
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	170,000
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	[redacted]
Last Fiscal Year Company Net Income	[redacted]
% of Revenue From State Government Clients in the United States	[redacted]
Number of Years in Business	73
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	More than 25
Number of Employees Providing the Type of Services Specified in the RFP	11,500
Headquarters in the United States	2 Tower Center Boulevard, Suite 2200, East Brunswick, NJ 08816
Headquarters Mailing Address	Doddakannelli, Sarjapur Road, Bengaluru, KARNATAKA, 560035, India
Street Address	Doddakannelli, Sarjapur Road, Bengaluru, KARNATAKA, 560035, India
Telephone Number	91-80-28440011
Fax Number	91-80-28440256
Locations in the United States	Anchorage, AK Bentonville, AR Mountain View, CA Quincy, MA Franklin, TN Houston, TX

Subcontractor Overview		
	Palmetto Bay, FL Tampa, FL Boston, MA	Plano, TX Redmond, WA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	**Name:** same as above **Mailing Address:** **Street Address:** **Telephone Number:** **Fax Number:**	
Name of Contact Person for Bid	Himanshu Shah, General Manager	

The Subcontractor should provide the following information in accordance with 42 CFR § 455.104:

- The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address. In the case of an individual, the date of birth and Social Security Number should be provided. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information.*

Entity Name	Business Address	Percent Owned
Wipro Limited	Primary: Doddakannelli, Sarjapur Road, Bengaluru - 560035 U.S. locations are in: Anchorage, AK; Bentonville, AR; Mountain View, CA; Washington, DC; Miami, FL; Tampa, FL; Atlanta, GA; Chicago, IL; Boston, MA; Troy, MI; Minneapolis, MN; East Brunswick, NJ; New York, NY; Syracuse, NY; Findlay, OH; Nashville, TN; Plano, TX; Houston, TX; Redmond, WA; Seattle, WA Non U.S. locations are in: Buenos Aires, Argentina; Caracas, Argentina; New South Wales, Australia; Vienna, Austria; Manama, Bahrain; Dhaka, Bangladesh; Curitiba, Brazil; Sao Paulo, Brazil; Calgary, Canada; Santiago, Chile; Shanghai, China; Chengdu, China; Dalian, China; Medellin, Columbia; San Jose, Costa Rica; Hellerup, Denmark; Copenhagen, Denmark; Giza, Egypt; Meerbusch, Germany; Fellbach, Germany; Munich, Germany; Berlin, Germany; Accra, Ghana; Bupadest, Hungary; Bengaluru, India; New Delhi, India; Jakarta, Indonesia; Baghdad, Iraq; Shannon, Ireland; Tel Aviv, Israel; Kanagawa, Japan; Tokyo, Japan; Atyrau, Kazakhstan; Nuevo Leon, Mexico; Amsterdam, Netherlands; Lagos, Nigeria; Oslo, Norway; Muscat, Oman; Lima,	100%

Entity Name	Business Address	Percent Owned
	Peru; Cebu, Philippines; Gdansk, Poland; Warsaw, Poland; Moreira- Maia, Portugal; Doha, Qatar; Bucharest, Romania; Moscow, Russia; Riyadh, Saudi Arabia; Cantonment, Singapore; Kualalumpur, Singapore; Johannesburg, South Africa; Madrid, Spain; Stockholm, Sweden; Bangkok, Thailand; Kiev, Ukraine; Berkshire, United Kingdom; London, United Kingdom	

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

Wipro Limited – 98-0154401

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

No such relationship exists.

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

Appirio GmbH; Appirio Limited; Appirio Limited; Appirio Inc.; Appirio, K.K; Cellent GmbH; Cellent GmbH; Cooper Software,LLC; Denim Group Limited; Denim Group Management, LLC; Designit A/S; Designit Colombia S A S; Designit Denmark A/S; Designit Germany GmbH (formerly known as Designit Munich GmbH); Designit Oslo A/S; Designit Peru SAC; Designit Spain Digital S.L.; Designit Sweden AB; Designit T.L.V. Limited; Designit Tokyo Co., Limited; Drivestream, Inc.; Frontworx Informationstechnologie GmbH; Healthplan Services Insurance Agency, LLC; Healthplan Services, LLC; Infocrossing, LLC; Opus Capital Market Consultants LLC; PT WT Indonesia; Rainbow Software LLC; Topcoder, LLC; Wipro (Dalian) Limited; Wipro (Thailand) Co. Limited; Wipro Arabia Co. Limited; Wipro Bahrain Limited Co. S.P.C (formerly known as Wipro Bahrain Limited WLL); Wipro Chengdu Limited; Wipro Corporate Technologies Ghana Ltd; Wipro Cyprus SE (Formerly known as Wipro Cyprus Public Limited); Wipro Digital APS; Wipro do Brasil Servicos de Tecnologia S.A (Formerly known as Infoserver SA); Wipro Do Brasil Sistemetas De Informatica Ltd; Wipro Do Brasil Technologia LTDA; Wipro Doha LLC; Wipro Europe Limited; Wipro Financial Services UK Limited; Wipro Gallagher Solutions, LLC; Wipro Gulf LLC; Wipro Holdings (UK) Limited; Wipro Holdings Hungary Korlátolt Felelősségű Társaság; Wipro Holdings Investment Korlátolt Felelősségű Társaság; Wipro HR Services India Private Limited (formerly known as Alight HR Services India Private Limited); Wipro Information Technology Egypt SAE; Wipro Information Technology Kazakhstan LLP; Wipro Information Technology Netherlands BV; Wipro Insurance Solutions, LLC; Wipro IT Services Poland SP Z.O.O.; Wipro IT Services S.R.L.; Wipro IT Services Bangladesh Limited; Wipro IT Services Ukraine, LLC; Wipro IT Services, LLC; Wipro Japan KK; Wipro Networks Pte Limited; Wipro Outsourcing Services (Ireland) Limited; Wipro Overseas IT Services Private Limited; Wipro Philippines, Inc. (formerly known as Wipro BPO Philippines Limited Inc.); Wipro Poland SP Z.O.O.; Wipro Portugal SA; Wipro Promax Analytics Solutions, LLC; Wipro SA Broad Based Ownership Scheme SPV (RF) (PTY) LTD; Wipro Shanghai Limited; Wipro Solutions Canada

Limited; Wipro Technologies Chile SPA; Wipro Technologies Peru SAC; Wipro Technologies SA; Wipro Technologies SA DE CV; Wipro Technologies SDN BHD; Wipro Technologies SRL; Wipro Technologies Vz, C.A; Wipro Technologies W.T. Sociedad Anonima; Wipro Technologies Australia Pty Ltd; Wipro Technologies GmbH; Wipro Technologies Limited; Wipro Technologies Nigeria Limited; Wipro Technologies South Africa (Proprietary) Limited; Wipro Trademarks Holding Limited; Wipro Travel Services Limited; Wipro UK Limited; Wipro US Foundation; Women's Business Park Technologies Limited

- The name, address, date of birth, and Social Security Number of an agent or a managing employee of the Subcontractor. *The Vendor should provide a redacted version with its proposal, and if the Vendor is selected, the Department will request full information*

The managing employee of the Subcontractor is listed in Table B.1-12. If UniCare is selected, we will provide this individual's full information upon DHHR's request, including address, date of birth (DOB), and Social Security Number (SSN).

Table B.1-12. Managing Employee of Wipro

Entity Name	Title	Address	DOB and SSN
Lakshmi Narayanan Venkatesan	General Manager	[redacted]	[redacted]

2. MANDATORY QUALIFICATIONS

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

The Vendor is NOT to change any of the pre-filled cells in the following table. The Vendor should only circle, highlight, or otherwise visibly and consistently indicate its "yes/no" response, then delete <Response> and add a brief narrative in its place.

Table 8: Mandatory Qualifications

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must demonstrate adherence to Certificate of Authority (COA) requirements as outlined by the West Virginia (WV) Office of the Insurance Commissioner and be in good standing in West Virginia. The Vendor shall provide a copy of its COA prior to contract start date.	**YES**	**NO**	UniCare has met the Certificate of Authority (COA) requirements outlined by the West Virginia Offices of the Insurance Commissioner. We have continuously been licensed and in good standing in West Virginia since beginning our operations in 2003.
The Vendor must be a NCQA-accredited entity and remain so for the duration of the contract, or be in the process of becoming an NCQA-accredited entity. NCQA certification must be provided prior to contract start date.	**YES**	**NO**	UniCare has held NCQA accreditation since 2006, with the most recent renewal in 2018 that is valid until September 2021. In 2017, UniCare received NCQA's Muticultural Health Care Distinction. In addition, our ultimate parent's, Anthem, Inc.'s, behavioral health program is accredited nationally as an MBHO by NCQA.
The Vendor must provide an organizational chart outlining the internal organizational structure for this project.	**YES**	**NO**	UniCare provides organizational charts in Attachment C: Project Organization and Staffing Approach.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must provide a description of the roles, responsibilities, and skill sets associated with each position outlined in the organizational chart.	YES	NO	We provide this information in a table as Supplemental Document B.2-1 (UniCare's Staffing Roles and Responsibilities).
The Vendor must provide a summary description of individual key staff members and the experience that qualifies them for their roles in this project. If any subcontractor is leveraged, the Vendor shall describe the assurance of quality and timeliness of the work to be done.	YES	NO	UniCare provides a summary of each key staff member and their experience and qualifications for their roles in this project in Attachment C: Project Organization and Staffing Approach, Table 12.
The Vendor must require at least one member of its care coordination team to participate in all multi-disciplinary team (MDT) meetings, as deemed necessary by the Department caseworker or court system.	YES	NO	UniCare will have a member of our Care Coordination team available to participate in all multi-disciplinary team (MDT) meetings deemed necessary by the Department caseworker or court system.
The Vendor must contract with specialists to assist in making medical or social service decisions, should the Vendor not be proficient in a given area.	YES	NO	***UniCare has qualified staff trained and in place in West Virginia and will not use contracted services to make medical or social service decisions***. Our Fostering Healthy Lives team will consist of Medical Directors, Utilization Management, and Care Coordination teams that have the clinical and community expertise to make determinations on the foster care and Medicaid delivery system. In rare instances, our experienced West Virginia-based team may leverage our national clinical and social services expertise through peer consultations, case conferences, and rounds.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must have experience working with children and youth populations requiring specialized care.	**YES**	**NO**	As a current West Virginia Health Bridge and Mountain Health Trust provider, collaborative State partner, and Medicaid thought leader serving West Virginia Medicaid members (for over 16 years), we will leverage our local experience and affiliate health plans' knowledge to serve children and youth populations throughout the child welfare system. Anthem, Inc., UniCare's ultimate parent company, and our affiliated health plans have a proven history of excellence in serving more than 84,000 children, youth, and young adults in child welfare systems across 13 markets.
The Vendor must demonstrate experience within the last three (3) years as the prime contractor for at least three (3) federal, state, or private healthcare entities, in an MCO and/or ASO capacity, where the proposed solution of similar size and scope is currently being or has been implemented.	**YES**	**NO**	UniCare has operated as a prime contractor MCO for DHHR under the Mountain Health Trust program since 2003 and the West Virginia Health Bridge program since 2015. We currently serve more than 154,000 members in TANF, aged, blind, and disabled (ABD), and Medicaid expansion. Additionally, we have affiliates currently operating Medicaid and other state-sponsored programs in 21 other markets across the country (19 as a prime contractor and two as a local MCO's principal subcontractor). Our affiliates have operated under MCO contracts with state health care entities since 1991.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			Thirteen of these affiliates currently serve child welfare populations similar to the Specialized Managed Care for Children and Youth Program (the Program), including members who are in foster care, are receiving adoption assistance, were formerly in foster care, or are children and families at-risk of entering foster care. Twelve of the 13 serve as the prime contractor, and one serves as the primary subcontractor for a local MCO, as shown in Section 1.1, Table B.1-2. Together, these affiliates serve more than 84,000 members in child welfare programs, including foster care, adoption assistance, and the juvenile justice system. These child welfare programs are of a similar size and scope to the Program, and are currently implemented and operational. Similar size and scope characteristics include: • Integrated physical and behavioral health services in 12 markets • 12 provide vision services and 11 provide dental services • 11 provide services statewide Comprehensively, UniCare and our affiliates serve nearly 41 million members across Medicaid, Medicare, Federal Employees Programs, and commercial programs. ***One in eight Americans receives coverage for their medical care through UniCare and our affiliates***.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
The Vendor must demonstrate at least five (5) years' experience in Medicaid and Health and Human Services.	**YES**	**NO**	UniCare has operated as an MCO under the Mountain Health Trust and West Virginia Health Bridge programs for more than 16 years; our affiliates have operated Medicaid and other state-sponsored programs for more than 28 years.
The Vendor must include at least three (3) references from clients served within the last three (3) years that demonstrate the Vendor's ability to perform the scope of work described in the RFP. Vendors may only use one reference per client served. The Department strongly prefers three (3) references from different state engagements where the proposed approach is currently in progress or has been implemented.	**YES**	**NO**	UniCare operates solely in West Virginia. We provide three references of our affiliates in Section 5.1 of Attachment B that demonstrate our ability to perform the scope of work described in the RFP. We provide references from different state engagements where our affiliates successfully implemented our proposed approach and are currently serving members. We provide references for: • **Georgia.** Our Georgia affiliate administers services as the single statewide entity for the Georgia Families 360°SM program and currently serves more than 33,000 youth and young adults in foster care, the juvenile justice system, or receiving adoption assistance. Our affiliate serves an additional 350,000 TANF members under a separate state contract that originated in 2006. • **Maryland.** Our Maryland affiliate began serving members, including those in foster care, in 1999. Of their more than 278,000 TANF, CHIP, Medicaid expansion, and ABD members, they

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			serve more than 3,500 members in foster care. • **Virginia.** Our Virginia affiliate has been serving members since 1996, including youth and young adults in foster care or receiving adoption assistance for more than five years. Currently, more than 3,900 of their almost 385,000 members are in foster care or receiving adoption assistance.
The approach proposed by the Vendor must have been previously implemented successfully in a State environment.	**YES**	**NO**	The approach UniCare proposes was developed based on our experience administering Mountain Health Trust and West Virginia Health Bridge (the West Virginia Medicaid) programs and our affiliate's successful implementation of the Georgia Families 360° program. Our Georgia affiliate's experience has been adapted to meet the needs and requirements of the West Virginia population. Our affiliate was awarded this statewide single MCO child welfare program in 2013 and began serving members on March 3, 2014. During implementation, our affiliate successfully transitioned more than 27,000 children, youth, and young adults into managed care. The dedicated implementation team was able to achieve readiness with systems, staffing, provider network, and infrastructure a full three months prior to the operational start date.

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			The success of this implementation and ongoing operations was validated in 2015 when, during a competitive procurement, our affiliate was selected to continue as the sole MCO administering Georgia Families 360° after the state reviewed proposals from six MCOs, including three incumbents. Our Georgia affiliate has achieved impressive results over the last five years. For example, well-child screenings improved nine percentage points between reporting years 2014 and 2018 (79% to 88% respectively). Improvements in the treatment of mental health conditions include: • 9% reduction in admission rate from emergency room to inpatient behavioral health facilities from 2016 to 2017 • 18.7% admissions reduction from 2014 to 2017 for psychiatric residential treatment facilities • 20% decrease in psychotropic medication from 2014 to 2018 Our organizational structure encourages the sharing of accomplishments, innovations, best practices, and lessons learned between affiliates, enabling UniCare to better serve our members in West Virginia. Additionally, the Foster Care Collaboration team, launched in 2015 by our ultimate parent company, is a dedicated team of experts that researches,

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			develops, and refines initiatives and programs. The team is deeply involved with UniCare and our affiliates, helps evaluate lessons learned and best practices, and incorporates them into an overall approach and model adapted to the unique requirements and characteristics of each local market.
The Vendor must have at least three (3) years' experience implementing the proposed approach with an organization similar size and scope to the State, in an MCO and/or ASO capacity, in compliance with all federal and state regulations.	**YES**	**NO**	Our affiliates have successfully implemented and operationalized our proposed approach in 13 markets serving members in child welfare programs in a primary MCO, or primary support to an MCO, capacity for nearly two decades. Implementations are similar in size and scope, managing comprehensive health benefits for individuals in child welfare programs, to the Program. Our national Implementation Management Office (IMO) supports implementations for UniCare and our affiliates, and has successfully executed more than 250 implementations since 1999. In that time, the IMO has not missed a readiness review nor member operational start date. In partnership with our affiliates, the IMO has delivered publicly funded health care programs, service area expansions, and program enhancements in compliance with all federal and state regulations. The IMO supported foster care program

Mandatory Qualification Item(s)	Vendor Meets?		Provide A Brief Narrative To Demonstrate Fulfillment Of Requirement
			implementations in 13 affiliate markets.

Supplemental Document B.2-1: UniCare's Staffing Roles and Responsibilities

Role	Description of Responsibilities	Skill Sets
Contract Liaison/Medicaid Administrator	The Contract Liaison/Medicaid Administrator is expected to be a key staff position throughout the entire Contract term, and will be responsible for overall delivery of the project. This individual serves as a liaison with the West Virginia Department of Health and Human Resources (DHHR), and will attend DHHR meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers, as needed. The position is also charged with establishing and maintain strong ties with stakeholders and DHHR, as our client. The Contract Liaison/Medicaid Administration will provide timely and informed responses to operational and administrative inquiries that arise from DHHR and other State agencies. The position will also drive decision-making across contractual, operational, and financial areas, including, but not limited to, claims payment and provider relations/contracting. This position will respond to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy or medical management, care coordination, and issues related to the health, safety, and welfare of the member.	At least five years of experience in Medicaid managed care contract oversight as well as substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Must hold a bachelor's degree or higher. This position is based in West Virginia.
DHHR Liaison	Serve as point-of-contact for operational questions and issues regarding community engagement. This Liaison will represent UniCare at DHHR and other State agency meetings as delegated by or in conjunction with the Contract Administrator.	Requires a Bachelor of Arts (BA)/Bachelor of Science (BS) degree in a related field; five to eight years of process or project related experience that includes experience in successfully developing and managing projects with fairly significant operating budget and knowledge of process redesign; or any combination of education and experience that would provide an equivalent background.
Chief Financial Officer	The Chief Financial Officer (CFO) will oversee all financial activities of the project, including managing provider payment arrangements, including alternative payment models (APMs). The CFO signs data certification forms, which includes all encounter data and financial data and reporting for payments to contracted providers. The CFO will also certify payment information to be used for rate-setting or any payment-related data required by DHHR.	At least five years of experience serving as a financial lead for a managed care entity or other health insurance provider. Must also hold a bachelor's degree or higher. This position is based in West Virginia.

Role	Description of Responsibilities	Skill Sets
Financial Analyst	The Financial Analyst provides financial analysis and works with management to provide decision support analysis. The Analyst conducts and documents complex financial and business-related analyses and researches fields including financial and expense performance, rate of return, depreciation, working capital, and investment. Their focus is on business improvement initiatives and leading and directing projects.	Requires a bachelor's in accounting or finance; at least five years of budgeting, forecasting, and accounting financial reporting experience; or any combination of education and experience that would provide an equivalent background. Master of Business Administration (MBA), Certified Public Accountant (CPA), Certified Management Accountant (CMA), Fellow of the Society of Actuaries (FSA), and/or Chartered Financial Analyst (CFA) preferred.
Data Reporting Analyst	The Data Reporting Analyst is responsible for analyzing, reporting, and developing recommendations on data related to multiple, varied business metrics. The position's primary duties include creating and maintaining databases to track business performance; analyzing data and summarizing performance using summary statistical procedures; developing and analyzing business performance reports (for example, for claims data, provider data, utilization data); and providing notations of performance deviations and anomalies. The Data Reporting Analyst will create and publish periodic reports, make necessary recommendations, and develop ad hoc reports as needed. The position may also include taking business issues and devising the best way to develop appropriate diagnostic and/or tracking data that will translate business requirements into usable decision support tools.	Requires a bachelor's degree in a related field, plus two to four years of related operational and/or data analysis experience; experience in database structures, and standard query and reporting tools; or any combination of education and experience that would provide an equivalent background.
Human Resources Business Partner	Responsible for solving organizational challenges through people-related solutions. Must understand every aspect of the business and be a thought leader on human capital and organizational topics. Create and implement the end-to-end human capital strategy that will drive the business to meet its goals. This role requires strategic reasoning and thinking, use of data to guide work, being comfortable challenging convention and, in some cases, influencing leaders to reassess how work is done.	Requires a BA/BS degree; five to eight years of relevant work experience, including Human Resources (HR) experience, business partner, or generalist experience with data, analysis, trends, and reports; or any combination of education and experience that would provide an equivalent background. HR designation preferred (SHRM-CP or SHRM-SCP).

Role	Description of Responsibilities	Skill Sets
Administrative Assistant	Provides administrative support to an individual or department with primary duties that include, but are not limited to: maintaining general files, ordering supplies, screening phone calls, and coordinating meetings. The Assistant compiles and distributes meeting minutes, coordinates travel plans, and submits expense reports. The role is also responsible for compiling and assembling meeting/presentation materials and using various software packages to produce professional quality reports, letters, presentations, and other documents. The role also performs various technical support duties such as information gathering, reporting, tracking, and researching.	Requires a high school diploma or GED, plus two years of administrative experience that include proficiency with personal computer and appropriate software, minimum typing skills of 45 words per minute and good proofreading skills; or any combination of education and experience that would provide an equivalent background.
Provider Relations Director	The Provider Relations Director is responsible for communicating with the provider community and supporting ongoing provider relationships. This position monitors and responds to provider inquiries, complaints, and communications from providers; develops training for providers and their staff on the Contract and the special needs of children and families in the Specialized Managed Care for Children and Youth Program (the Program); and designs and implements the provider manual and provider satisfaction surveys.	Requires at least three years of experience as a provider relations manager or specialist. Also requires a bachelor's degree or higher. The position is based in West Virginia.
Network Development Director	The Network Development Director oversees all activities related to network development and contracting for physical health (PH) and behavioral health (BH) services. Primary duties of the role include establishing and maintaining a comprehensive, accessible provider network across West Virginia; ensuring that members have access to the full range of provider types and specialties in accordance with covered benefits and Contract standards; and developing reports on provider network adequacy. This position also develops APMs as part of contracting; oversees credentialing activities; and reports to DHHR on access to care and development needs for socially necessary services (SNS) providers.	Requires at least five years of experience serving as a network manager in a health insurance role plus a bachelor's degree or higher.

Role	Description of Responsibilities	Skill Sets
Network Development Analyst	The Network Development Analyst manages statewide provider development activities, which include managing networks of assigned health care providers and developing strategies and plans for internal and external provider communications and development. The Analyst implements the development strategies for professional provider networks, identifies network access deficiencies and recommends corrective actions, and oversees the negotiation of favorable contracts to include fee for service and capitation. The Analyst also analyzes provider utilization data and recommends strategies to remove poor performers from the networks.	Requires a bachelor's degree, plus seven years experience, or any combination of education and experience that would provide an equivalent background.
Network Relations Manager	The Network Relations Manager oversees activities related to the development and maintenance of the provider delivery system through provider relations representatives. The Manager's primary duties include managing processes for communication and complaint resolution between physicians, hospitals, members, and the public as well as managing the work flow of the provider relations area.	Requires a bachelor's degree, plus three years of experience, or any combination of education and experience that would provide an equivalent background.
Network Relations Consultant	The Network Relations Consultant develops and maintains positive relationships with providers and strategies for recruitment and contracting. The role is responsible for duties that may include, but are not limited to: developing and maintaining positive relationships with the provider community by periodic on-site visits, communicating administrative or programmatic changes, and facilitating the resolution of provider issues. Recruits providers to build a cost-effective, high-quality provider network. Conducts negotiations and leads contracting efforts with providers to build and maintain a cost-effective, accessible provider network. Researches, analyzes, and recommends resolution for contract dispute, non-routine claim issues, billing questions, and other practices. Coordinates communication process on such issues as administrative and medical policy, reimbursement, and provider utilization patterns. Conducts seminars to support the understanding of managed care and UniCare policies and procedures. Identifies network access and deficiencies and develops recruitment and contracting strategies. Coordinates and conducts provider training.	Requires a bachelor's degree, plus three years of related experience (provider relations, network management, customer service, sales-negotiation); prior negotiation experience; or any combination of education and experience that would provide an equivalent background.

Role	Description of Responsibilities	Skill Sets
Care Delivery Transformation Consultants	The Care Delivery Transformation (CDT) Consultants maintain responsibility for consulting with providers to improve the effectiveness and efficiencies of provider practices and clinical processes. Their primary duties may include analyzing practice specific cost and quality data and reports for cost of care and quality opportunities; helping practices to target high-risk members and gaps in care based on reports provided; supporting practice implementation of population health management, care coordination, and care management strategies; identifying action plans for providers to implement to improve cost, quality, and the patient experience; and participating in design, development, and implementation of community learning forums. These CDT Consultants serve as the point of contact for providers and primary care practices for program onboarding and the facilitation of routine meetings between UniCare and the provider office.	Requires a bachelor's degree along with five to ten years of health care experience; or any combination of education and experience that would provide an equivalent background. Physician environment experience in practice transformation/quality improvement, ambulatory care setting quality and efficiency metrics, population health and care management structures, data analytics, and electronic health records is preferred. Clinical background and/or MBA not required but a plus.
Patient Centered Care Consultants	The Patient Centered Care Consultant provides support to providers to improve the effectiveness and efficiencies of provider practices. Primary duties may include analyzing quality metrics and reports for care opportunities and supporting practice implementation of care coordination and care management. These Consultants also collaborate with the Patient Centered Primary Care team and they participate in developing program recommendations and action plans (internal). They support the efforts of providers and practice teams on office-based care delivery interventions, resulting in cost of care savings and improved health outcomes for patients, and they promote practice transformation to team-based patient-centered care delivery. The role also provides education for practices to develop expertise with metrics and data review for quality improvement.	Requires a bachelor's degree plus three years of health care experience; or any combination of education and experience that would provide an equivalent background. Physician environment experience in practice transformation/quality improvement, ambulatory care setting quality and efficiency metrics, and electronic health records preferred.

Role	Description of Responsibilities	Skill Sets
Project Administrator	The Project Administrator is responsible for supporting projects and the project staff in a dedicated project management business unit. This is the entry level position in the project management career path, and primary duties include building and maintaining a project plan and schedule, contributing to ensuring project deliverables are met, and assisting in documentation and project status tracing. This role monitors activities to ensure project objectives are met within established timeframes and budgets. Additional responsibilities will include scheduling, conducting and attending meetings, supporting management in overall objectives, assessing costs and savings, and assisting in the payments of vendor invoices.	Requires a high school diploma or GED plus three to five years of business experience in health care or a related field; or any combination of education and experience that would provide an equivalent background. A bachelor's degree is preferred.
Program Integrity Lead	The Program Integrity Lead will oversee compliance, program integrity, and fraud-related activities. The Program Integrity Lead will be responsible for creating internal controls, policies, and procedures to prevent and detect fraud and abuse; developing a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones; and establishing and maintaining a Special Investigations Unit (SIU) to investigate possible acts of fraud, waste, or abuse for all services provided under the Contract. The Program Integrity Lead will also serve as primary contact person for all DHHR Program Integrity and Medicaid Fraud Control Unit (MFCU) record requests. The position must also monitor potential fraud for under- or over-utilization of services. The position will also establish written procedures for maintaining data confidentiality.	Requires at least three years of experience working on Medicaid fraud projects, plus a bachelor's degree or higher. The position is based in West Virginia.
Subcontractor Oversight Manager	The subcontractor oversight manager maintains responsibility for managing relationships with multiple vendors to ensure business goals are achieved. Duties include managing the day-to-day execution of vendor agreements to ensure compliance, monitor quality, and when necessary, develop corrective action plans. This role also reconciles vendor invoices, and may participate in fact-based negotiations of agreements and/or participate or lead cross-functional teams to implement vendor services.	Requires a bachelor's degree in business or related field required, plus five to seven years of increasingly responsible professional level contract management/vendor management experience; or any combination of education and experience that would provide an equivalent background.

Role	Description of Responsibilities	Skill Sets
Claims Payment Director	The Claims Payment Director oversees all PH and BH claims payment and encounters-related activities. Primary duties include ensuring timely and accurate payment of provider claims for PH and BH services, and monitoring claims processing activities for these services. The Claims Payment Director also oversees the reprocessing of claims due to rate changes or claims resubmissions.	Requires at least three years of experience in claims processing and encounters with a health insurer, plus a bachelor's degree or higher.
Claims Processing Analyst	The Claims Processing Analyst is responsible for keying, processing, and/or adjusting health claims in accordance with claims policies and procedures. They review, analyze, and process claims/policies related to events; and they research claims issues and respond to inquiries.	Requires a high school diploma or equivalent plus one to three years of claims processing experience; previous experience using PC, database system, and related software (word processing, spreadsheets, etc.); or any combination of education and experience that would provide an equivalent background.
Information Technology Director/HIPAA Compliance Officer	The Information Technology Director is responsible for all systems, data, and hardware activities. Primary duties include submitting required reports, requests for information, documentation, ad hoc reports, data certification forms, or any other data required as requested by DHHR within the time frames provided by the Contract. This position also maintains reasonable safeguards again loss, destruction, or alteration of data. Additional duties include managing systems configuration, testing, and implementation activities; maintaining a health information system that collects, analyzes, and reports necessary data; and overseeing all systems-related activities (such as electronic medical record, claims processing, and provider data systems).	Requires at least three years of experience working in Medicaid IT solutions, with an emphasis on data integrity, plus a bachelor's degree or higher. This role is based in West Virginia.
IT Field Support	The IT Field Support team is responsible for providing installation, repair, and maintenance for desktop PC technologies and systems, including the hardware, operating systems, applications and peripheral equipment. Primary duties may include, but are not limited to, evaluating hardware and software issues and assisting in identifying requirements for solutions. May provide basic training to users for new installations.	Requires an associate's degree in IT or Technical School education in computers, plus one to two years of experience with PC and operating systems; or any combination of education and experience that would provide an equivalent background. Familiarity with computer technology. Microsoft A+ and Network + certifications desired. Strong analytical, communication and interpersonal skills required.

Role	Description of Responsibilities	Skill Sets
Compliance Manager	Responsible for managing foundational and strategic compliance responsibilities with consistent excellence that supports the team and management. Primary duties for this managing level position, with moderate to advanced complexity and broad/enterprise scale, may include, but are not limited to: Manages/oversees projects, initiatives, regulatory audits or exams, internal audits, accreditations, on-site reviews, risk assessments; audit planning, conducting mock audits, conducting audit training, managing audit evidence preparation, and assessing audit preparedness. Establishes project plans, gap analysis, milestone dates, and other significant aspects, and provide leadership updates. Maintains knowledge of laws, regulations, company strategies to assess impact, and consult with clients as subject matter expert. Conducts complex investigations, document findings, and ensure corrective actions are made. Interfaces with external clients, regulators, vendors, supplier; internal stakeholders, high level of management.	Requires a BA/BS; Master of Science (MS)/MBA/Juris Doctorate (JD) or professional designation preferred; at least six years of health care, regulatory, ethics, compliance, or privacy experience; or any combination of education and experience that would provide an equivalent background.
Special Investigations Unit Lead	Coordinating and conducting case reviews for quality assurance, investigative sufficiency, and case data management; and directing day-to-day operations as assigned by management. Through use of appropriate system tools, the SIU Lead will also provide training for and analysis of data to detect fraudulent, abusive, or wasteful payments to providers and subscribers. The SIU Lead will also prepare statistical/financial analyses and reports to document findings and maintain up-to-date case files for management review, and will prepares final report and notification of findings letter suitable for distribution to providers and legal counsel. The SIU Lead will create and present settlement offers for provider issues for review and approval by management and/or legal. Additionally, the SIU will communicate with all customers, internal and external, regarding findings, provide recommendation in support of the development of policy and/or procedures to prevent loss of company assets, and prepare and deliver training to internal and external entities.	Requires a bachelor's degree plus eight or more years of related experience in health care insurance and investigation; or any combination of education and experience that would provide an equivalent background. Professional certifications (Certified Fraud Examiner [CFE], Accredited Health Care Fraud Investigator [AHFI], Certified Professional Coder [CPC], Paralegal, Registered Nurse [RN], Juris Doctorate [JD]) or other job-related designation preferred. Knowledge of plan policies and procedures in all facets of benefit programs management with heavy emphasis in negotiation is also preferred.

Role	Description of Responsibilities	Skill Sets
Behavioral Health Medical Director	The Behavioral Health Medical Director oversees the BH clinical and quality activities of the project, and will be available for BH service utilization review decisions. The Director will be authorized and equipped to respond to BH clinical issues, utilization review, and behavioral quality of care inquiries.	At least five years of experience in serving as Behavioral Health Lead or Expert for a Medicaid program and five years of experience working in BH clinical care, including trauma and substance use. Must have an active West Virginia medical license in a related BH specialty. This position is based in West Virginia.
Medical Director	The Medical Director oversees medical and care coordination activities of the project, and is responsible for responding to DHHR requests from their Medical Director or Contract Administrator within three business days. The Medical Director also performs utilization management activities in collaboration the Medical Management and Behavioral Health Medical Director. Additionally, this position oversees and participates in the Quality Assurance and Performance Improvement Committee. This position will attend DHHR meetings and hearings of legislative committees, and other State agencies, as needed.	At least five years of experience in serving as Medical Director for a Medicaid program and five years of experience working in pediatric care. Must hold an active West Virginia medical license and professional liability insurance in the amount of at least one million dollars. This position is based in West Virginia.
Pediatric Medical Director	The Pediatric Medical Director is an interim position that will provide support to the Medical Director and will work in conjunction to provide day-to-day guidance, support, and leadership of clinical and quality activities, and ensure the clinical integrity of broad and significant clinical programs to serve children and families.	Requires a medical degree or doctor of osteopathy, plus current board certification approved by the American Board of Medical Specialties required. Must also hold an active, unrestricted medical license and at least 10 years of clinical experience in pediatrics.
Dental Director	The Dental Director is responsible for the oversight of the administration of dental services within the contract. The Dental Director performs oversight of the utilization of covered dental services under this Contract, and is employed by our subcontractor, SKYGEN. The Dental Director conducts dental utilization review decisions and is authorized to respond to dental clinical issues, utilization review, and dental quality of care inquiries.	At least five years of experience in serving as a dental manager or director for a Medicaid program. Must hold an active license to practice dentistry in West Virginia.

Role	Description of Responsibilities	Skill Sets
Health Plan Pharmacist	The Pharmacist supports disease management programs and Fostering Healthy Lives Care Plans through drug therapy evaluation and consultation for members and their parents/caregivers. Primary duties may include, but are not limited to, evaluating prescription needs and therapies through review of medication history to determine if medications are appropriate. The Pharmacist also assesses compliance with plan through direct contact with members (and parents/caregivers) and their physicians; determines potential barriers to compliance; and identifies solutions to overcome barriers. In addition, the Pharmacist ensures that members understand appropriate use of current prescriptions, reviews medications with physicians when therapies do not meet national standards, and counsels physicians around alternative medications.	Must be a Registered Pharmacist currently licensed with at least two years of clinical experience; or any combination of education and experience that would provide an equivalent background. Doctor of Pharmacy preferred. Experience with direct patient counseling or education is also preferred.
Care Management Director	The Care Management Director oversees all care management activities for the program, including managing and driving the integration of care; referral processes for medically necessary and socially necessary services; early and periodic screening, diagnosis, and treatment services; and health risk assessments completion. The Director establishes and monitors all care coordination staffing ratios, and helps ensure the continuity and coordination of care for members in the Program.	At least five years of experience working as a case manager or care coordinator for a Medicaid program. Must also be an RN or Licensed Clinical Social Worker (LCSW) in West Virginia, and have demonstrated ability to communicate with members who have complex needs and may also have communication barriers.
Medicaid Member Advocate	The Medicaid Member Advocate interacts with members, parents or caregivers, providers, and other stakeholders, ensuring members are referred and connected to appropriate resources. The Medicaid Member Advocate also collaborates with the Care Management Director, Care Coordinators, and the SNS Liaison; provides support to children and youth in the child welfare system and families/caregivers related to enrollment, access, and continuity of care issues; supports members throughout any grievance or appeal activities; and assists them in obtaining materials in alternative formats as needed.	At least five years of experience in health care, which must include working with children and youth in the child welfare system. Must also hold a bachelor's or higher. This position is based in West Virginia.

Role	Description of Responsibilities	Skill Sets
Peer Support Specialist	The Peer Support Specialist is responsible for care coordination and/or care management activities. Primary duties may include, but are not limited to, identifying opportunities for engagement of members and their families in forming a supportive, recovery network. The role works collaboratively with our clinical team as a member advocate in discharge planning education, resolution of barriers, and service transitions. The role also acts a resource for staff on decision-making and problem-solving.	Requires an associate's degree plus two years of experience in health services or BH field or in a peer support services role, knowledge of care coordination and case management concepts; or any combination of education and experience that would provide an equivalent background. BA/BS or MBA preferred. Peer Specialist Certification required.
Social Services Director	The Social Services Director will be an expert in multidisciplinary treatment team efforts and will serve as the Child Protective Services Coordinator. The Social Service Director oversees all activities related to social services referrals and connections. This role as serves as the subject matter expert to multidisciplinary teams and caseworkers throughout the care coordination process. The role also oversees SNS and coordinates with the SNS Liaison.	At least three years of experience supporting a child welfare program, interacting with social services agencies, and strong understanding of BH needs of children, youth, and families requiring specialized care. Must be a Master's Level Social Worker (MSW) or LCSW in West Virginia. This position is based in West Virginia.
Socially Necessary Services Liaison	The SNS Liaison is responsible for coordinating all SNS, monitoring the use of and access to these services, and collaborating with the Bureau for Children and Families (BCF) and all SNS providers to facility access and enhance health and social outcomes. This role also supports administration of retrospective reviews of SNS providers.	At least three years of experience working with SNS providers. Must also hold a bachelor's degree or higher in a related field. This position is based in West Virginia.
Member Services Director	The Member Services Director manages activities related to call center operations, grievances, and other member-related inquiries and matters. The Member Services Director oversees the Fostering Healthy Lives Concierge Line and Concierge Representatives and will communicate with members, social workers, and State agencies, providers, foster care parents, and other stakeholders to address questions and complaints. The Director will be responsible for ensuring the Concierge Line meets minimum performance requirements, and will also oversee the enrollment and welcome activities for new members.	At least three years of experience working with the public in an educational capacity on health insurance-related matters, plus experience working in or overseeing a call center. This position must also hold a bachelor's degree or higher. The position is based in West Virginia.

Role	Description of Responsibilities	Skill Sets
Fostering Healthy Lives Concierge Representatives	The Fostering Healthy Lives Concierge team will have two main functions: handling any inbound calls from members, providers caregivers, or social workers; and coordinating assessments, scheduling, and verification or identification of correct member contact information. Our Concierge Representatives will make sure care planning begins with as much information from the member as possible.	Must have at least five years' experience supporting member services, a high school diploma or GED, or an equivalent combination of education and experience. Our Representatives will have demonstrated experience acting as a trusted advisor on health care-related inquiries and coaching members on plan benefits and appropriate programs and offerings.
Medical Management Director	The Medical Management Director oversees utilization management activities of the project and is responsible for medical management activities and utilization management (including management of the referral and pre-authorization process and appeals procedures). The Medical Management Director responds to all DHHR Medical Director or Contract Administrator requests within three business days.	At least five years of experience working as a utilization management manager or specialist for a Medicaid program. Must also be an RN or an LCSW in West Virginia. This position is based in West Virginia.
Physical Health Utilization Management (UM) Care Manager	The UM Care Manager is responsible for ensuring medically appropriate, high-quality, cost-effective care through assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out-of-network services, and appropriateness of treatment setting using applicable medical policy and industry standards, accurately interpreting benefits and managed care products, and steering members to the most appropriate providers, programs, or community resources. The UM Care Manager works with the Medical Director in interpreting appropriateness of care and accurate claims payment, and may also manage appeals for services denied. Additional duties include conducting pre-certification, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to ensure compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts.	Requires current active unrestricted RN license to practice as a health professional within the scope of practice, plus two years of acute care clinical experience. Requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Behavioral Health UM Care Managers	This position is responsible for managing psychiatric and substance use or SUD facility-based and outpatient professional treatment health benefits through telephonic or written review. Primary duties may include using appropriate screening criteria knowledge and clinical judgment to assess member needs to ensure access to medically necessary quality BH care in accordance with clinical guidelines and the Contract. These Care Managers conduct psychiatric and substance use or SUD	Requires a master's in social work, counseling, or a related BH field or a degree in nursing, plus three years of experience with facility-based and/or outpatient psychiatric and substance use or substance use disorder (SUD) treatment; or any combination of education and experience that

Role	Description of Responsibilities	Skill Sets
	assessment, coordination, case planning, monitoring, and evaluating to promote quality member outcomes, optimize member health benefits, and promote effective use of health benefits and community resources.	would provide an equivalent background. Current active unrestricted license as an RN, LCSW, Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor (LMHC), Licensed Professional Counselor (LPC), Licensed Behavior Analyst (LBA) (as allowed by applicable State laws), Licensed Marriage and Family Therapist (LMFT), or Clinical Psychologist to practice as a health professional within the scope of licensure.
UM Clinicians	Responsible for collaborating with health care providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources. Ensures medically appropriate, high-quality, cost-effective care through assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out-of-network services, and appropriateness of treatment setting by utilizing the applicable medical policy and industry standards accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs, or community resources. Works with medical directors in interpreting appropriateness of care and accurate claims payment. May also manage appeals for services denied. Primary duties may include, but are not limited to: conducting pre-certification, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to ensure compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts. Ensures member access to medical necessary, quality health care in a cost-effective setting according to Contract. Consults with clinical reviewers and/or medical directors to ensure medically appropriate, high-quality, cost-effective care throughout the medical management process. Collaborates with providers to assess members' needs for early identification of and proactive planning for discharge planning. Facilitates member care transition through the health care continuum and refers treatment plans/Care Plan to clinical reviewers as required and does not issue non-certifications. Facilitates accreditation by knowing, understanding, correctly interpreting, and accurately applying accrediting and regulatory requirements and standards.	Requires current active unrestricted RN license to practice as a health professional within the scope of practice in applicable state(s) or territory of the United States and two years acute care clinical experience. Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Role	Description of Responsibilities	Skill Sets
Pharmacy Service Coordination	Responsible for being the primary contact and liaison for and between the company's medical partners and the pharmacy vendor for implementing and de-implementing client Rx benefits. Primary duties may include, but are not limited to: researching and interpreting claims issues while ensuring good, accurate, and timely customer service for our Anthem pharmacy clients. Understands the intricacies of prescription drug benefits and how they adjudicate. Understands and interprets client requests for new benefit designs. Coordinates, conducts, and/or supports internal and external client meetings or training sessions as needed. Works with multiple departments and sources in order to accommodate the needs of our clients; this includes claim processing, customer service, and medical account management. Oversees benefit set up process to ensure pharmacy product changes occur with minimal disruption. Develops, reviews, and researches capabilities of pharmacy system to accommodate drug benefit design requested by clients or suggested by medical teams. This includes attendance and support for processes to review new plan design requests (for example, Customer Exception Process and National Accounts Approval Process), and collaborating with the Product Development, Proposal Development, Customer Exception, and Sales departments. Creates or coordinates the delivery of standard and custom reports for internal and external clients, such as claims, drug utilization, and impact reports to our clients in compliance with performance guarantees and client requests.	Requires a BA/BS degree; five years of customer service, claims, and/or membership experience in health care; three years of related pharmacy experience with working knowledge of pharmacy benefit management industry; or any equivalent combination of education and experience that would provide an equivalent background.
Nurse Advice Line Nurses	Nurse Advice Line Nurses are responsible for telephone triage to assess callers' needs and provide relevant health information to assist callers in making health care decisions. Primary duties may include, but are not limited to, establishing and maintaining supportive relationships with callers and their families and assessing caller's needs with accurate, concise documentation. This role conducts thorough symptom assessment of the caller's situation using established criteria and protocol, and applies established software, written materials, online resources and nursing background to provide callers with appropriate medical information. The role also provides callers with appropriate community resources as necessary, and refers more complex issues as needed for consultation.	Requires an associate's or bachelor's degree in nursing, plus two years of acute clinical experience; or any combination of education and experience that would provide an equivalent background. Current unrestricted RN license in applicable state(s) is also required. A Bachelor of Science in Nursing and previous triage experience preferred.

Role	Description of Responsibilities	Skill Sets
Behavioral Health (BH) Hotline Representatives	BH Hotline Representatives are responsible for answering all incoming hotline calls and immediately assessing and responding to safety needs of all callers who may be experiencing a crisis. The Representatives apply clinical criteria to authorize BH care, pre-certify services, and conduct concurrent reviews.	Must be an RN, Clinical Psychologist, or master's level clinician, such as an LCSW, LMFT, or LPC. Must also have experience with adolescents who have severe emotional disturbances, SUD, dual diagnosis, and severe and persistent mental illness. Minimum of three years of experience in BH, case management, discharge planning, or clinical supervision.
Care Coordination Team Managers	Care Coordination Team Managers direct a team of physical and/or BH practitioners responsible for coordinating member service, utilization, access, care management, and/or concurrent reviews so that members have access to necessary services and supports. Primary duties may include managing the team responsible in case finding and coordinating cases that involve co-morbid conditions; coordinating service delivery to include member assessment of physical and psychological factors; and partnering with providers to meet the member needs. Managers also identify members with potential high risk of complications.	Requires a bachelor's plus five years of experience in health care management; or any combination of education and experience that would provide an equivalent background. Must hold a current active unrestricted license as an RN, physician assistant, licensed social worker, LCSW, LPC, LMHC, or other accepted license. Master's degree in a related field preferred. Certified Case Manager Certification preferred.
Fostering Healthy Lives Care Coordinators and Behavioral Health Specialists	Responsible for the overall management of member's Care Plan within the scope of position, and develops, monitors, and revises the member's Care Plan to meet the member's needs, with the goal of optimizing member health and well-being across the care continuum. Responsible for performing telephonic or face-to-face history and program needs assessments using a tool with pre-defined questions for the identification, evaluation, coordination, and management of the member's care planning needs.	BA/BS in social work, social science, or related field; two years of experience working with a social work agency; child welfare (including lived) experience or any combination of education and experience that would provide an equivalent background. Knowledge of local social support services/organizations and demonstrated understanding and sensitivity of child welfare population, including impact of trauma and trauma-based approaches.

Role	Description of Responsibilities	Skill Sets
BH Clinicians	Uses appropriate screening criteria knowledge and clinical judgment to assess member physical and BH needs. Conducts assessments to identify individual needs and develops Care Plan to address objectives and goals as identified during assessment. Monitors and evaluates effectiveness of Care Plan and modifies plan as needed. Supports member access to appropriate quality and cost-effective care. Coordinates with internal and external resources to meet identified needs of the members and collaborates with providers.	Must possess a master's degree in social work, counseling, or a related BH field or nursing. This role must have at least three years of BH experience or combined equivalent education or experience. Our BH Clinicians will be required to possess an unrestricted license in West Virginia as a RN, LMSW or LCSW, LPC, LMFT, or Clinical Psychologist. Experience in case management or in-person coaching with members with a broad range of complex psychiatric, SUD, or medical disorders is preferred.
Nurse Care Managers	Nurse Care Managers conduct care management within the scope of their licensure for members with complex and chronic care needs by assessing, developing, implementing, coordinating, monitoring, and evaluating Care Plans designed to optimize member health care across the care continuum. They perform duties telephonically or on-site such as at hospitals for discharge planning. Primary duties may include making sure members have access to services appropriate to their health needs, and conducting assessments to identify individual needs and a specific care management plan to address objectives and goals as identified during assessment. Nurse Care Managers also implement Care Plans by facilitating authorizations/referrals as appropriate within benefits structure or through extra-contractual arrangements; coordinate internal and external resources to meet identified needs; monitor and evaluate effectiveness of the care management plan and modify it as necessary. They interface with Medical Directors and Physician Advisors on the development of care management treatment plans.	Requires a bachelor's in a health-related field, plus three years of clinical experience; or any combination of education and experience that provide an equivalent background. Must have a current, unrestricted RN license. Certification as a Case Manager is preferred.
Fostering Independence Coordinators	Dedicated to helping transition age youth successfully move into adulthood and teaching self-management skills to achieve successful independence.	Must have a master's degree in social work and at least three years' experience in care management in a health care environment or a combination of equivalent education and experience. Our Fostering Independence Coordinators will hold current, unrestricted licensure as an LMSW or LCSW in West Virginia.

Role	Description of Responsibilities	Skill Sets
Dental Liaison	Responsible for providing clinical and educational services to meet the oral health care needs of individuals and groups of patients, under the general direction and supervision of a dentist. Primary duties may include, but are not limited to: assists dentist in providing oral health care to patients by cleaning, scaling, and polishing teeth. Records evaluation of mouth condition and extent of prophylaxis on dental chart. Provides dental health education including instructing patients in brushing and flossing techniques, teaching patients about the care of removal appliances and bridges, instructing patients in periodontic care, instructing patients in diet and nutrition as it relates to oral health, explaining etiology of caries and periodontal diseases to patients, giving oral habit therapy, and providing patients with dental health education materials.	Requires Associate of Arts (AA) degree in dental hygiene; one year of experience; or any combination of education and experience that would provide an equivalent background. Current, active, unrestricted dental hygienist license required. Current Basic Life Support and CPR certificate required. BA in dental hygiene preferred. Nitrous oxide certification preferred.
Quality Director	The Quality Director oversees the quality assurance program and related activities, which include developing, administering, and overseeing the Quality Assessment and Performance Improvement program; overseeing accreditation activities; participating in Quality Committee meetings; and maintaining quality improvement projects that focus one or more quality indicators. The Quality Director is also responsible for developing an approach to monitoring provider performance, in collaboration with Provider Relations Staff.	At least five years of experience in overseeing a Medicaid quality program, either with a Managed Care Organization (MCO), an Administrative Services Organization (ASO), a state Medicaid agency, or an External Quality Review Organization. Must also hold a bachelor's degree or higher. This position is based in West Virginia.
Clinical Quality Compliance Analyst	Responsible for coordinating Quality Management (QM) activities related to compliance and accreditation for an assigned SBU. Primary duties may include, but are not limited to: Develops and maintains pertinent compliance plans. Monitors adherence to plans and prepares status reports. Conducts audits, identifies training and communication needs, and implements related programs. Ensures all policies and procedures are updated as legislation or accreditation standards change. Implements standardization of procedures and documentation within SBU. Develops and delivers executive level presentations and represents senior management on compliance issues and related committees.	Requires a bachelor's degree plus three years of compliance, audit or quality improvement experience; or any combination of education and experience that would provide an equivalent background. Experience with regulatory/accreditation audits and knowledge of regulatory/accreditation standards in a health or managed care environment is preferred. Ability to travel overnight maybe required.

Role	Description of Responsibilities	Skill Sets
Business Information Analyst	Responsible for analyzing, reporting and developing recommendations on data related to multiple, varied business metrics. Primary duties may include, but are not limited to: Creates and maintains databases to track business performance. Analyzes data and summarizes performance using summary statistical procedures. Develops and analyzes business performance reports (for example, for claims data, provider data, utilization data) and provides notations of performance deviations and anomalies. Creates and publishes periodic reports, makes necessary recommendations, and develops ad hoc reports as needed. May require taking business issues and devising best way to develop appropriate diagnostic and/or tracking data that will translate business requirements into usable decision support tools.	Requires a BS/BA degree in related field; two to four years' related operational and/or data analysis experience; experience in database structures, and standard query and reporting tools; or any combination of education and experience that would provide an equivalent background.
QM Practice Consultants	QM Practice Consultants are responsible for creating a partnership relationship with providers and other initiatives and implementing the concept of a Medical Home for our members to achieve this fully integrated and accountable system of care. Primary duties may include assessing current practice patterns, assets and challenges using Medical Home Index, NCQA Standards, HEDIS® audits, site reviews, and medical records reviews. In partnership with the primary care provider (PCP), these Consultants evaluate results of the initial assessment, establish a project plan with the practice outlining goals and objectives for improvement. They also provide ongoing practice support and regularly meet to track progress.	Requires an associate's in nursing, plus five years of managed care experience; two years of clinical experience; two years of professional presentations to small and large audiences; or any combination of education and experience that would provide an equivalent background. Current, unrestricted clinical license appropriate to field of specialty. Bachelor's or master's in nursing preferred.
Peer Support Specialist	Responsible for care coordination and/or care management activities focused on the wellness and recovery of members. Primary duties may include, but are not limited to: Identifies opportunities for engagement of members and their families in forming a supportive, recovery network. Develops and implements provision of on-site psychiatric discharge planning education at Recovery and Resiliency sites. Collaborates with Stabilization teams as a member advocate in discharge planning education, resolution of barriers, and service transitions. Acts as a resource for staff on decision-making and problem-solving. Initiates and maintains contact with assigned individuals and providers to determine members' response to services.	Requires an Associate's degree; two years of experience in health services or BH field or in a peer support services role, knowledge of care coordination and case management concepts; or any combination of education and experience that would provide an equivalent background. BA/BS or MBA preferred. Peer Specialist Certification required.

Role	Description of Responsibilities	Skill Sets
Member Liaisons	Responsible for coordinating the denials and appeals process, including tracking, trending, and reporting all denials and appeals and for assuring that all regulatory, State, and contractual requirements are met. Primary duties may include, but are not limited to: Maintains data base and monitors the queues for Performance Improvement Initiatives. Assists in monitoring, writing, tracking, and sending out denial letters according to Grier Consent Decree. Assists in preparing additional reports and presentations to support the Quality and HCMS departments. Functions as a liaison between the health plan, Concierge Representatives, State agency contacts, and providers. Conducts telephonic and/or home visit education with members to provide information on how to access preventive and health maintenance services while identifying barriers to care.	Requires an AA/Associate of Science (AS); three or more years of experience in a social or health related service-oriented industry; or any combination of education and experience that would provide an equivalent background.
Community Engagement Director	The Community Engagement Director is responsible for marketing, public relations, and community engagement activities. This position develops and maintains marketing policies and procedures in adherence to State and federal regulations, to keep Program participants and their families informed. The role is also responsible for developing and submitting all marketing and engagement materials to DHHR for approval, developing a written communication plan, and ensuring that prohibited marketing activities do not occur. The Director engages with the community and will provide a wealth of information and education for outreach events, in accordance with Contract requirements and marketing guidelines.	At least three years of experience in working with the general public to better understand the health care environment and insurance. Preference given to a candidate with familiarity with West Virginia and its population characteristics. Must hold a bachelor's degree or higher. This position is based in West Virginia.
Justice/Court Liaison	Our Liaison will have an experience or understanding of trauma-informed care, Medicaid services, and managed care.	This position must also hold a bachelor's degree plus five years of experience in social work or a related role working with local government entities. This position requires experience in the child welfare system and juvenile justice, specifically as it pertains to the interactions between child welfare and the courts, including working with court or justice-related advocacy groups and court programs.

Role	Description of Responsibilities	Skill Sets
Engagement and Training Representatives	Our Training and Education Representatives will demonstrate understanding of West Virginia's child welfare system processes, as well as knowledge of local stakeholders. These Representatives will have experience in building community relationships, delivering community training programs, building and developing materials, and coordinating community organizations.	This team will be required to have at least four years of experience, including an understanding of Medicaid health plan functions and services. These positions will also be required to have at least an associate's degree, or combination of equivalent experience.
Career Development Specialist	Ensure youth in foster care are prioritized and have access to resources through new and existing workforce development opportunities, and will help create additional career paths for the youth in foster care.	At least four years of experience partnering with community resources to develop workforce programs. Understanding of Medicaid health plan functions and services. Required to have at least an associate's degree, or combination of equivalent experience.

3. EXISTING BUSINESS RELATIONSHIPS WITH THE STATE

Describe any existing or recent (within the last five [5] years) business relationships the Vendor or any of its affiliates or proposed Subcontractors have with the State, the State's counties, and/or the State's local municipalities.

In this section, we describe business relationships that UniCare, our affiliates, or proposed subcontractors have with the State, the State's counties, or the State's local municipalities. We provide information on existing (or current) business relationships, as well as those completed within the last five years (July 1, 2014 through June 30, 2019).

UniCare is an MCO currently serving West Virginia members statewide as part of the West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) programs.

UniCare or its affiliates have existing relationships with 26 county health departments for services related to health care delivery:

- Barbour County Health Department
- Beckley-Raleigh Health Department
- Berkeley-Morgan Health Department
- Boone County Health Department
- Clay County Health Department
- Doddridge County Health Department
- Grant County Health Department
- Greenbrier County Health Department
- Hampshire County Health Department
- Hancock County Health Department
- Hardy County Health Department
- Harrison Clarksburg Health Department
- Jackson County Health Department
- Kanawha-Charleston Health Department
- Lewis County Health Department
- Lincoln County Health Department
- Marshall County Health Department
- McDowell County Health Department
- Mercer County Health Department
- Mineral County Health Department
- Monongalia County Health Department
- Pendleton County Health Department
- Randolph-Elkins Health Department
- Tucker County Health Department
- Wayne County Health Department
- Wetzel-Tyler Health Department

Proposed Subcontractors

VSP discloses the following business relationships for which they provide vision care administration:

- Existing
  - Child Protect of Mercer County, Inc.
  - City of Wheeling
  - Harrison County Emergency Squad
  - Star City Volunteer Fire Department
  - Wetzel County Committee on Aging
- Recent
  - City of Hinton (ended November 1, 2016)
  - City of New Martinsville (ended October 1, 2017)
  - City of Vienna (ended July 1, 2017)
  - Monongalia County Solid Waste Authority (ended December 1, 2015)
  - Wayne County Community Services (ended July 1, 2016)
  - Wetzel County Emergency Ambulance Authority (ended August 1, 2015)

Exela reports an existing business relationship with the state to provide data capture services.

4. BUSINESS DISPUTES

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

Participation in public health care programs inherently brings a high level of scrutiny, accountability, and oversight for performance. As such, and as part of the ordinary course of business, UniCare and our affiliates operating managed care contracts have received regulatory actions, sanctions, deficiencies, audit findings, or recommendations related to the numerous requirements of any public program contract.

UniCare believes that actions of these types support a meaningful dialogue that can strengthen our program through efficiency of administration and oversight. We educate employees, subcontractors, and providers; develop and update policies and procedures; implement monitoring and audit mechanisms; and enforce strict guidelines to comply with Contract requirements.

In the sections below, we provide information on regulatory actions, sanctions, citations, deficiencies, audit findings, investigations, or recommendations received by UniCare or our Medicaid affiliates in any state within the last two years (July 1, 2017, through June 30, 2019). We follow our disclosure with a discussion of the actions we take to maintain compliance in our West Virginia program.

UniCare

In the last two years, UniCare has received one Corrective Action Plan (CAP) on March 1, 2019, and one assessment of liquidated damages on December 14, 2018. UniCare has also been subject to two External Quality Review (EQR) audits in the last two years, auditing calendar years 2017 and 2018. In each case, UniCare took prompt action to maintain compliance with contract requirements.

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

On December 14, 2018, UniCare was assessed $5,000 in liquidated damages for not notifying impacted provider(s), as directed by the Bureau for Medical Services (BMS), of the revised drug testing policy and the prorated testing limits allowed before prior authorization is required. UniCare quickly engaged with providers directly to ensure they understood the revised policy and to address questions. Going forward, we have increased our provider education efforts through newsletters, bulletins, and fax blasts to keep providers informed of policy and operational changes. For example, with the recent carve-in of the substance use disorder (SUD) benefit, we posted information to our provider website to educate providers on the SUD waiver and where they can get additional information. We have posted more than 25 individual bulletins, invitations, and updates to the "Provider Manual and Important Updates" section of our provider website since the beginning of 2019.

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

On March 6, 2019, UniCare's EQR for 2018 was conducted. The review focused on grievances, appeals, and denials. The March 15, 2019, Exit Letter described six issues that UniCare quickly addressed by updating internal grievance and appeals policies to align with contractual requirements. As of August 1, 2019, UniCare has not yet received the final 2018 System Performance Review report.

Affiliates

As indicated in Addendum Number 6, Question ID Q111, we provide information on all requested actions received by our Medicaid affiliates within the last two years in Supplemental Document B.4-1: Affiliate Regulatory Actions.

Our Investment in Compliance in West Virginia

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

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

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

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

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

Our West Virginia Compliance team benefits from oversight and guidance and sharing best practices across all affiliate health plans. An outline of the components of our West Virginia program and support resources using the USDOJ framework follows.

1. Implementing Written Policies, Procedures, and Standards of Conduct

Policies and Procedures. UniCare maintains a robust library of policies and procedures that address our regulatory, contractual, and other program requirements. Functional managers throughout the organization develop our policies in consultation with our dedicated Compliance Officer and Compliance Manager. These policies play a major role in guiding health plan activities and operations. We regularly monitor and review policies and procedures and publish them on an internal website accessible by all employees.

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

2. Designating a Compliance Officer and Compliance Committee

Compliance Officer. Our Compliance Officer partners with health plan leadership to provide extensive and focused engagement on issues, including education and training; risk identification and mitigation; and development and oversight of corrective actions. The Compliance Officer provides executive-level oversight and works collaboratively across all functional areas to infuse compliance into everything we do.

Compliance Manager. Our Compliance Manager is our primary liaison with DHHR for day-to-day contract management and oversight issues. Our Compliance Manager manages submission of all required regulatory reporting and serves as our internal subject matter expert and resource on UniCare's contractual and regulatory obligations.

Compliance Committee. Chaired by our CEO and led by our Compliance Officer, our Compliance Committee comprises our executive-level leadership, the Compliance Manager, as well as leaders from various departments, including Quality, Utilization Management, Care Coordination, Operations, Network Management, Marketing, Government Relations, and Human Resources. The Committee meets at least quarterly and provides a forum for health plan leadership to review and discuss emerging issues and upcoming activities, assess potential risks, and provide input into mitigation activities and corrective action plans. The Committee reviews compliance activities and oversees our West Virginia Compliance program.

3. Conducting Effective Training and Education

Extensive Compliance Training. All employees receive mandatory compliance training at initial hire and annually. The training covers the requirements of current agreements or corrective action; FWA; HIPAA; and other aspects of the program, such as the Code, Cultural Competency, Drug Free Work Place policies and procedures, and any contractually required training. We track and monitor completion of all required training through our online learning systems. The Compliance team follows up directly with employees to confirm completion.

Continuing Education and Awareness. We conduct additional compliance education and awareness activities throughout the year to reinforce the role of all UniCare employees. An annual *Ethics, Compliance, and Privacy Awareness Week* includes activities and information highlighting how employee commitment supports overall success. In addition, our national Medicaid Special Investigations Unit sponsors periodic awareness initiatives that include educational materials and activities to help employees better understand how they can help identify and prevent FWA.

4. Conducting Internal Monitoring and Auditing

Compliance Program and Work Plan. Our Compliance Officer develops and maintains a Compliance program and Work Plan. The Compliance Committee reviews and approves the Work Plan each year and receives regular progress updates. The core functions of the Work Plan track the seven elements of an effective compliance program: written standards, structured program, training and education, auditing and monitoring, reporting and investigation, enforcement and discipline, and response and prevention.

National Medicaid Compliance Officer. As part of our ultimate parent company's National Medicaid Division, UniCare has ready access to the resources of our national Medicaid Compliance Officer and the Medicaid Compliance program Services department. Collectively, this team manages Medicaid Compliance Program initiatives, including effectiveness reviews, standardized risk identification, prioritization and mitigation framework, and overall direction and guidance by sharing best practices with our Compliance Officer and committees.

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

5. Reporting and Investigating

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

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

6. Enforcing Standards Through Well-publicized Disciplinary Guidelines

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

7. Responding Promptly to Detected Offenses and Undertaking Corrective Action

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

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

Compliance 360 Supports Contract Compliance Activities

UniCare is committed to continuing to maintain high performance and meet DHHR's expectations and requirements under our current contracts. To augment our compliance

program and activities, we maintain a systematic approach to assessing, tracking, and reporting adherence to our contractual obligations, assisted by our Compliance 360 tool.

We use Compliance 360 to make sure we comply with new or revised regulatory requirements. Whenever there is a new or revised requirement, such as a contract amendment, policy update, or provider rate change, our Compliance Manager creates an alert and disseminates it to a wide range of employees and stakeholders. Leads from each functional area who are designated as Assessors evaluate alerts to determine whether the regulatory content affects their units. If it does, Assessors list planned tasks to meet contract requirements and document their completion. Our Compliance Officer monitors timely assessments and task completion. In 2018, UniCare issued 117 alerts and through July, 2019, has issued 48 alerts.

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

In this section, we provide information for UniCare and our affiliates (other managed care affiliates of our ultimate parent company) with Medicaid, Medicare, or any other federal managed care contracts held in the past five years (July 1, 2014, through June 30, 2019). Together, UniCare and our affiliates currently serve more than 10.7 million members across the country through Medicaid, Medicare, or other federal health program managed care contracts.

Within each of these contracts, UniCare and our affiliate health plans have been reliable and accountable sources of managed health care for a variety of populations. ***UniCare and our affiliates have never had all or part of a Medicaid managed care contract partially or fully terminated or not renewed for any reason***.

In the interest of transparency, we are disclosing the voluntary termination of a contract by one of our affiliates. In 2015, our New York affiliate, HealthPlus HP, LLC (HealthPlus) was operating under a three-year Fully Integrated Duals Advantage Demonstration contract with CMS and the New York State Department of Health (NY DOH). By mutual agreement with CMS and NY DOH, and in accordance with contract provisions, HealthPlus ended participation in the project after the first year in order to focus resources on the successful carve-in of additional benefits and programs under their core Medicaid contracts, such as the Health and Recovery Plans product. HealthPlus cooperated with CMS to provide covered services to participants until successful transition. The address for HealthPlus is 14 Wall Street, New York, New York 10005, and the telephone number is 212-563-5570.

Affiliate Regulatory Actions

Audit Findings

Audit findings for Medicaid affiliates for audits conducted within the last two years (July 1, 2017 through June 30, 2019).

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
6/17/19	CA	Medical Audit	This 2018 audit identified five findings related to case management policies and procedures, medical director review of quality of care grievances, breach reporting, and provider training tracking.	Developed and executed action plan to address findings, such as review, update, and submission of policies and procedures; retroactive review of 2018 clinical grievances; implementing new internal controls related to breach reporting; and new provider training tracker.
6/7/19	MD	External Quality Review	The 2018 audit had an overall composite score of 95% with opportunities for improvement related to oversight of delegated entities, utilization review, and policies and procedures.	Executed action plan to address findings, such as updating policies and procedures to reflect revised contractual requirements and clearer roles and responsibilities, increased communication to providers on program updates, and modification of internal service level standards.
5/14/19	IA	External Quality Review	Achieved overall compliance score of 95%, with four of 80 elements identified as "not met" across three compliance monitoring standards: Availability of Services: Grievances, Appeals, and State Fair Hearings; and Quality Assessment and Performance Improvement.	Executed action plan to address findings, such as ensuring that optometry service appointment times meet standards, treating oral appeals in the same manner as written appeals, documenting reasonable efforts to provide oral notice of expedited appeal resolution, and as part of QM/QI program, monitoring the prescribing patterns of psychotropic medication to children.
5/2/19	DC	External Quality Review	In this performance measure validation audit of Early and Periodic, Diagnosis, and Treatment (EPSDT) form CMS-416 performance measures, all but three elements met requirements.	No corrective action plan issued by the state. Reviewed findings and recommendations to improve the training and supervision of the medical record review process.
4/18/19	TN	Regulator Audit	The fall CHOICES member record review received an overall score of 97%, with two elements scoring less than 90%.	No corrective action plan issued by the state. Reviewed findings and recommendations to identify opportunities for improvement.
3/14/19	TN	Regulator Audit	The fall Employment and Community First (ECF) CHOICES enrollee record review received an overall score of 96%, with three elements scoring less than 90%.	No corrective action plan issued by the state. Reviewed findings and recommendations to identify opportunities for improvement.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
3/13/19	KY	External Quality Review	Findings in several areas, including member handbook information, updating policies with new contract language, missing documentation for pharmacy, required updates to anti-fraud plan, and missing information from the utilization management (UM) and credentialing and recredentialing policies.	Developed and executed action plan to address findings.
3/5/19	CA	Regulator Audit	Findings across several areas, including credentialing (policies, file review), provider training (cultural and linguistic), claims processing (oversight, dispute resolution process, third-party liability), member grievances, and pharmacy (denial/appeal file review).	Created and executed corrective action plans to address findings across deficient areas.
2/11/19	DC	External Quality Review	Findings across several areas, including adding additional information to the hard copy provider directory and updating the policy; corrective actions for provider non-compliance with timely access standards; and review/update of member notice content and compliance with timing requirements.	Executed action plan to address findings, such as updating the provider directory policy and working with subcontractors to ensure compliance with provider directory requirements, adding corrective action process to the appointment guidelines policy, and updating member notice content and implementing monitoring reports to confirm timeliness.
11/27/18	TX	Regulator Audit	The audit had findings in three areas: reporting of medical and prescription expenses, improving financial reporting process, and pharmacy claims payment timeliness.	Executed action plan to address findings, such as developing new analytic programs and databases to support accurate classification of costs and placing the pharmacy subcontractor on a corrective action plan (CAP) to improve performance.
11/19/18	FL	Regulator Audit	Findings included one related to claims rate cells and deficiencies in actuarial reporting.	Executed action plan to address findings, such as correcting actuarial findings and having the premium reconciliation team run a monthly report comparing 834 and 820 files at a member level and report under/overpayments to the state.
11/16/18	MD	FSR Exam	Findings on the HealthChoice Financial Monitoring report in several areas, including incentive payments, Federally Qualified Health Center (FQHC) payments, medical expenses paid, inpatient days, and other expenses.	Developed and executed action plan to address findings.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
10/5/18	WA	Regulator Audit	Findings in several areas, including provider networks (providing evidence of monthly excluded provider monitoring, credentialing decisions following nondiscrimination policy), member information (tracking distribution of materials in alternative formats, policy and processes on provider billing of members), care management (inconsistent notification system for emergency room [ER] or inpatient stay admission/discharge), and pharmacy authorization deficiencies.	Executed action plan to address findings, such as providing requested documentation and policies, developing a new tracking process for member collaterals, and implementing remediation actions for pharmacy authorizations.
9/18/18	NJ	External Quality Review	This Managed Long-term Services and Supports nursing facility care management audit identified several opportunities for improvement.	Developed and executed action plan to address findings related to plan of care in an institutional setting, including documentation of agreement/disagreement with the plan of care, member goals including all five components, member inclusion in on-site visits, and that the plan of care is updated for a significant change.
9/12/18	IA	External Quality Review	Findings related to care management (providing care plan to primary care provider [PCP]), provider network (processes to monitor wait times, access, and timeliness), and grievances and appeals (update letters/notices).	Executed action plan to address findings, such as updating care plan policy, updating network monitoring policies, expanding provider types for appointment wait time survey, and revising grievance resolution and notice of action letters.
9/7/18	NJ	External Quality Review	This care management audit identified two categories/populations that scored below 80% for the 2016 findings: preventive services for the general population and for children — lead screening. Improvement was noted in the 2017 audit for both categories/populations.	Developed and executed action plan to address findings and continue efforts to improve results across all categories/populations.
8/31/18	FL	External Quality Review	Policies and procedures for member grievances and appeals need updates and the member handbook should include additional information about filing grievances and appeals.	Executed an action plan to address findings, such as updating the member complaints and grievances policy and procedure and the member handbook.

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

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

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
4/2/18	IA	Regulator Audit	This Encounter Data/Program Integrity audit identified seven post-audit action items, such as providing detailed documentation regarding pharmacy encounters, sending a list of claim IDs to be removed from the missing reconciliation list, and determining a plan for correcting outstanding rejects related to missing National provider Identifiers (NPIs) in transportation encounters.	Completed all action items as documented.
3/30/18	DC	External Quality Review	Findings across several areas, including subcontractor agreement language, including additional information in provider directory and making it available on the website, cultural competency training, member rights and responsibilities policy, and member notices (such as adverse benefit determination).	Executed action plan to address findings, such as adding fields for URL, Americans with Disabilities Act (ADA), and cultural competency to the provider directory and loading a machine-readable file format to the website, adding required language to the rights and responsibilities policy, and amending subcontractor agreements.
3/30/18	NJ	Agreed Upon Procedure	The audit had two findings related to claims. For one pharmacy claim in the sample, the paid amount did not match the supporting documentation. For two other claims, interest was not paid on late claims.	Developed and executed action plan to address findings.
3/16/18	NJ	Operational Audit	One routine and one retrospective core Medicaid UM file were untimely.	Reviewed findings and implemented procedures to ensure that services are authorized and retrospective authorizations are completed in a timely manner.
3/7/18	IA	External Quality Review	Findings included minor gaps in performance measure validation and use of incorrect specifications.	Improved measure calculations to better align with recommendations and state expectations.
2/1/18	TN	Regulator Audit	Instances of non-compliance noted in two regions for failure to administer Home and Community-based Services (HCBS) within prescribed timeframes.	Revised authorization process to include a standard operating procedure and trained the care coordination team.
2/1/18	TN	Regulator Audit	In the Abortion, Sterilization, and Hysterectomy (ASH) audit, one region did not achieve 100% compliance because three records reviewed were non-compliant due to issues with payment of claims or completion of the proper form for ASH procedure.	Reprocessed claims, as necessary, and delivered education to applicable providers on proper processing and filing of ASH claims.
2/1/18	TN	Regulator Audit	In the Q1 critical incident audit, non-compliance noted in all three regions for providers' failure to report critical incidents within the proper timeframes.	Critical incident reports continue to be reviewed daily. Non-compliant providers are issued a notice of non-compliance.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
1/19/18	NY	Operational Audit	Findings covered multiple areas, including care management (lack of a back-up plan), operations (Board of Directors meeting minutes lacked detail), member correspondence (no evidence of annual notification of certain information and not routinely sending written notices on grievances not resolved immediately), and assessments (not routinely finalized within required timeframe).	Executed action plan to address findings, such as adding additional information to the annual member notice, implementing new process for non-same day grievances, including review of minutes during board meetings, and creating a new report and centralized function to monitor assessment finalization.
11/1/17	NY	Regulator Audit	Provider directory was found to have inaccurate information (such as telephone or address) and did not list the specialty pedodontists.	Executed action plan to address findings, such as updating provider information, as indicated; making site visits to provider offices, and implementing a new quality control process.

Other Actions

Disclosure of other actions received by Medicaid affiliates within the last two years (July 1, 2017 through June 30, 2019).

Date	State	Type	Description	Response/Plan of Correction
6/27/19	CO	CAP	Website is not readily accessible per Section 508 guidelines (two regions).	CAP actions included: 1) website document accessibility course for communications team members; 2) hiring of Section 508 and accessibility lead for print and web materials; and 3) review of website using accessibility tool and implementation of enhancements.
6/27/19	CO	CAP	Need to enhance provider communication about EPSDT-related BH services and update EPSDT medical necessity criteria to align with updated definition (two regions).	CAP actions included: 1) updating the BH provider manual with all appropriate EPSDT-related services, including developmental screenings and provision of diagnostic services in addition to treatment; and 2) updating the UM policy and procedure to ensure all EPSDT-related requirements are captured and provided the updated policy to UM staff.
6/25/19	TN	Fine	Failure to comply with pick-up and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
6/20/19	NJ	Fine	Low EPSDT screening rate in 2017.	Reviewed missed measures and implemented additional provider and member outreach strategies to close gaps.
6/19/19	KY	Fine	May 2019 did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
6/19/19	KY	CAP	Dental vendor did not properly implement a requirement and was calculating copayments incorrectly.	CAP actions included: 1) correcting the copay configuration date of service logic to comply with state requirement; 2) reprocessing impacted provider claims; 3) notifying impacted providers; and 4) implementing a three-level quality control check process.
6/19/19	KY	Fine	Late response to a request for an update on a provider complaint.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
6/7/19	MD	CAP	During a system performance review, elements related to oversight of delegated entities were not met.	The CAP included revising delegation policies, as appropriate, to specify the committee at the local health plan that has responsibility for review and approval of delegate reports on a quarterly basis.

Date	State	Type	Description	Response/Plan of Correction
6/7/19	MD	CAP	During a system performance review, elements related to member materials/enrollee rights were not met.	The CAP included activities to: 1) clearly document in the Member Grievance Policy the process for notifying members in writing of the grievance determination, even if the notification was previously provided verbally; 2) inform all providers of the CAHPS results annually; and 3) revise the Member ID Card Policy to include: the contents of the new member packet, how mailing of packets is tracked and trended, employee responsible for monitoring the mailing of the packets, the committee information is reported to, and actions taken if packets are not mailed timely.
6/7/19	MD	CAP	During a system performance review, elements related to availability and accessibility (including call center) were not met.	The CAP included activities to revise specific policies: 1) add to the Telephonic Access and Services Policy details reflecting the current practice for the frequency of reporting, department responsible for monitoring, quality committee performance is reported to, and action taken in response to non-compliance; 2) revise the Health Services Needs Information Policy to add a process for trending and analysis of the Health Need Service Information (HSNI)/In-home Aide Services (IHAS) data that includes the responsible parties for trending and analyzing the data, the committees responsible for review and monitoring the data, and a corrective action process if the HSNI/IHAS forms are not completed timely.
6/7/19	MD	CAP	During a system performance review, elements related to utilization review were not met.	CAP activities included: 1) demonstrating that the Medical Advisory Committee reviews and approves medical necessity criteria and guidelines on an annual basis consistent with its UM program and any related policies; 2) revising the Healthcare Management Services Denial — Core Process Policy and the Pharmacy Prior Authorization Policy to reflect adverse determination notification time frames consistent with Code of Maryland Regulation; 3) revising the Corrective Managed Care Policies to include medical reviewer qualifications and the exception to use of a designated pharmacy for specialty drugs.
6/7/19	MD	CAP	During a system performance review, elements related to fraud and abuse were not met.	The CAP activities include: 1) evidence of review of routine and random reports by the Compliance Officer and Compliance Committee at each meeting; and 2) defining the committee is responsible for annual review and approval health plan and delegate compliance plans, and providing documentation of approval in committee minutes.

Date	State	Type	Description	Response/Plan of Correction
6/5/19	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
6/5/19	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
6/4/19	KY	Fine	Late response to a request for an update on a provider complaint.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
6/4/19	KY	Fine	Late response to a request for an update on a provider complaint.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
5/29/19	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
5/29/19	TN	Fine	Failure to comply with urgent trip requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
5/21/19	FL	Fine	Provider network file identifies deficiencies in specific specialties and specific regions.	Focused network development to close gap.
5/21/19	TN	Fine	Exceeded 2% threshold for members without PCP assignment on file submitted to the state. The health plan is appealing the fine.	Educated business owner on importance of verifying accuracy of data files prior to submission. Data files included as part of ongoing business owner report cards.
5/21/19	TN	Fine	October 2018 claims payment accuracy for nursing facilities in one region were below standard.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
5/20/19	KY	Fine	April 2019 did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.

Date	State	Type	Description	Response/Plan of Correction
5/20/19	TN	CAP	Annual quality study found that performance metric was missed for credentialing and UM notice of action letters.	CAP actions included: 1) for the credentialing issue, revising credentialing reporting logic to include a review of any multi-market provider files to ensure the reporting includes only the applicable status and initial credentialing or recredentialing for Tennessee CHOICES provider files; and 2) for the UM denial issue, performed staff retraining and implemented a daily pend authorization report and review process.
5/17/19	TX	CAP	Did not meet the 100% threshold for clinician-administered drugs for Q3 State Fiscal Year (SFY) 2018.	Actions included correcting processing error to make sure the National Drug Code (NDC) is populated on clinician administered drug encounters. Resubmitted corrected records. Additionally, conducted employee retraining on clinician administered drug claims process.
5/16/19	FL	Fine	An unapproved webpage was used to provide information on a health plan name change.	Conducted on-the-job training for marketing team on contract requirements related to advance approval (where applicable) and internal/external document review and approval process.
5/16/19	FL	Fine	Distribution of unapproved materials at three marketing events.	Conducted on-the-job training for marketing team on contract requirements related to advance approval (where applicable) and internal/external document review and approval process.
5/7/19	FL	Fine	Care Coordinator failed to attend a scheduled multidisciplinary team meeting.	Revised process to ensure back-up identified for meetings and that escalation protections working properly.
4/29/19	CA	Fine	Distributed an incorrect "Your Rights" document to members, providers, and facilities. The penalty has been appealed.	Reviewed existing materials to verify correct notice used when communicating with members.
4/26/19	TN	CAP	March 2019 claims payment accuracy for nursing facilities was below standard.	CAP actions included: 1) for partial month and claims in history patient liability system issues, performed system recoding and testing; and 2) for manual claim errors, conducted claims staff retraining. Reprocessed all affected claims.
4/22/19	CA	CAP	Encounter data did not meet quality standards.	After review, identified specific submitters contributing to encounter quality issues and began working directly with them to identify the root cause and resolution of the deficiencies.
4/22/19	TN	CAP	January 2019 Focused Claims — claims were affected by a system error and did not re-process correctly for one region.	CAP actions included making a system configuration change to update Level 1 nursing facility authorization requirement. Additionally, a review of all affected services paid when there was an incorrect system authorization override to ensure an authorization was in place.

Date	State	Type	Description	Response/Plan of Correction
4/19/19	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during March 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
4/19/19	NY	CAP	Did not meet encounter data quality measures.	Implemented manual and automated fixes to prevent recurrence. A senior analyst will review files until automated process is in place. Increased oversight of dental subcontractor.
4/17/19	FL	Fine	Untimely notification of a security incident that occurred with a subcontractor.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
4/12/19	DC	CAP	For 2018, did not meet the required 85% medical loss ratio, resulting in a required audit.	CAP included actions: to 1) hire contractor; 2) submit work plan within 30 business days from the start of the study; and 3) submit CAP within 30 business days from completion of the study.
4/12/19	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
4/12/19	TN	Fine	February 2019 claims payment accuracy for nursing facilities was below standard.	Reviewed front-end audit configuration for accuracy and updated as necessary. Conducted on-the-job training of claims processor on correct disposition.
4/11/19	TN	CAP	Q1 2019 — did not achieve accuracy rate for telephone numbers on the provider enrollment file.	CAP actions included educating providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve the accuracy of missing or incomplete provider data elements.
4/2/19	LA	Fine	Transportation vendor did not meet prompt pay metrics for February 2019.	Increased vendor oversight/monitoring with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
4/1/19	TN	Fine	Did not meet January 2019 prompt pay requirements for HCBS claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
3/26/19	TN	CAP	February 2019 claims accuracy for nursing facilities was below standard.	CAP actions included: 1) for partial month patient liability claims system issues, performed system recoding and testing; and 2) for manual claim errors, conducted claims staff retraining. Reprocessed all affected claims.

Date	State	Type	Description	Response/Plan of Correction
3/25/19	TN	CAP	December 2018 Focused Claims — claims were affected by a system error and did not re-process correctly for 1 region.	CAP actions included cleanup of all providers linked to the incorrect NPI and reprocessed any claims affected by the linking error.
3/22/19	TN	Fine	Q4 2018 — did not achieve accuracy rate for telephone numbers on the provider enrollment file.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
3/19/19	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
3/19/19	TN	Fine	Missed private duty nursing shifts for one member from July 10, 2018 to November 28, 2018.	Conducted on-the-job training for assigned care coordinator and provider on contractual standards. Worked with vendor on corrective action.
3/15/19	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during February 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
3/14/19	NJ	CAP	Did not close out all outstanding assessments within the required timeframe.	CAP submitted with explanation for the outstanding assessments and actions to complete.
3/13/19	FL	Fine	Transportation vendor was late for member pick-up.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
3/13/19	IA	Fine	Inaccurate or incomplete submission of four reports.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
3/13/19	IA	Fine and CAP	Appeals processing did not meet timeliness standards.	The Grievance and Appeal Manager developed a daily report to track and monitor appeal resolution timeliness.
3/13/19	IA	Fine and CAP	Member call center had 98% of calls answered, missing the 99% metric.	Underreporting by a subcontractor resulted in a missed contractual standard as reported. Subcontractor corrected reports going forward. If the calls are not answered by a person within 30 seconds they are answered by an electronic device. Increased monitoring of subcontractor.
3/12/19	TX	Fine	Q4 SFY 2017 — did not correct duplicate claims issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.

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3/12/19	TX	Fine	Q4 SFY 2017 — did not correct encounter issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
3/12/19	TX	Fine	Q4 SFY 2017 — untimely processing of CHIP vision claims in one service area.	Increased vendor oversight/monitoring with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
3/12/19	TX	Fine	Q4 SFY 2017 — submission of late and/or inaccurate financial statistical reports.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
3/12/19	TX	Fine	Q4 SFY 2017 — did not comply with the requirements of the state-approved fraud, waste, and abuse (FWA) compliance plan.	Worked with the applicable functional lead team to identify the root cause of, and implement processes to correct, the error.
3/12/19	TX	Fine	Q4 SFY 2017 failure to respond to Inspector General request for information in the manner and format requested.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
3/11/19	CA	Fine and CAP	UM vendor did not make timely authorization decisions in accordance with contract requirements.	CAP actions included: 1) conducting annual UM audits on-site and include tour of operations floor and sitting with front-line staff; 2) assessing quality auditing process and encourage separation of duties between UM and quality and compliance oversight teams; 3) developing biographical and operational questionnaire to collect key demographic information; 4) assessing staffing models for each role in UM to help ensure adequate staffing by reviewing organizational charts and observing while on-site; and 5) issuing CAPs as needed when turnaround times are not being met and conduct monthly follow up to ensure full remediation.
3/11/19	IN	Fine	In Q4 2018, did not meet the timeliness standards for processing paper claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
3/11/19	IN	Fine	In Q4 2018, missed metric for new member health screenings.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
3/7/19	TX	CAP	The state's 2018 appointment and availability study found that the vision vendor missed the vision appointment standard for one population group.	Created fax blasts to educate vision providers of appointment and availability and referral requirements and instructed vision subcontractor to educate providers on standards. Incorporated Vision into Internal Workgroup initiatives to address non-compliant providers as part of action plans. Also increased continuous auditing of provider directories to assure accurate information. Finally, added vision as a specialty to conduct appointment and availability surveys.
3/6/19	TN	Fine	Failure to comply with pick-up and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
3/1/19	DC	Fine	Did not receive the 2% incentive payment (withheld from capitation rates) due to not meeting one of the three pay for performance measures.	Current projects are in place to continue improving results throughout next year.
3/1/19	TX	CAP	A 2018 audit of state fiscal year 2016 had findings related to the allocation of medical expenses and administrative costs.	Actions included working with Internal Audit and IT departments to develop analytic programs and databases to help identify misclassified costs. The Internal Audit team data mine the General Ledger using key words to identify any potential unallowable costs.
2/27/19	NJ	CAP	During Q3 2018, exceeded 5% threshold of assessment outcomes of Not Authorized overturned after agency reassessment.	The CAP included creating a report that mimics the state not authorized report to more closely monitor rates. A 100% review of assessments completed by clinical staff with an RFI rate greater than 5%. The clinical management team also developed a detailed workflow outlining staff expectations for New Jersey Choice submission.
2/25/19	FL	Fine	Multiple occurrences between September and December 2018 of member complaints related to late transportation pick-ups and drop offs.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/25/19	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/25/19	TN	CAP	Did not achieve 100% compliance with 2018 ASH claims payment audit.	CAP actions included medical management staff training and recoupment for one improperly paid ASH claim.
2/22/19	NJ	CAP	Use of an unauthorized tool for medical day care determinations.	The CAP included identifying affected members and reassessing and authorizing medical day services, as appropriate, to members denied or partially approved. Reports every two weeks report progress.

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2/22/19	NJ	CAP	Plan was using an unapproved adjunct assessment tool to authorize/deny medical day care services.	CAP action included cessation of the use of the adjunct assessment tool and reassessment of denied medical day care cases using the approved tool.
2/21/19	TN	CAP	Did not meet January 2019 prompt pay requirements.	CAP actions included re-educating the Electronic Data Interchange (EDI) team and updating instructions to ensure that no special characters are in the file naming convention. Additionally, implemented an overall front-end edit in production.
2/21/19	TN	Fine	Failure to comply with the approval and scheduling requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
2/21/19	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/20/19	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during January 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
2/19/19	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/18/19	FL	Fine	Encounter data not submitted within seven days of adjudication for one week in November.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
2/18/19	FL	Fine	Encounter data not submitted within seven days of adjudication for one week in October and one week in November.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
2/18/19	FL	Fine	Did not meet timely notice of appeal resolution for two members.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting.
2/15/19	FL	Fine	Suspected fraud and abuse was not reported within the required number of days.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
2/15/19	LA	Fine	Secret shopper survey for Q4 2018 found that provider directory information accuracy did not meet the 90% standard.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.

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

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1/10/19	TN	CAP	Q4 2018 — did not achieve accuracy rate for telephone numbers on the provider enrollment file.	CAP actions included educating providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve the accuracy of missing or incomplete provider data elements.
12/28/18	CA	CAP	Deficiencies found in provider data quality.	The CAP required submission of: 1) corrected provider network files; 2) improvement strategies on data collection and reporting requirements; 3) an analysis of reporting deficiencies with an improvement strategy; and 4) a detailed implementation process timeline.
12/28/18	FL	Fine	Review of long-term care (LTC) case records revealed incidents of non-compliance with contract requirements.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
12/21/18	KY	Fine	Did not meet performance measures for encounters submitted during November 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
12/20/18	TN	Fine	Failure to comply with pick-up and delivery standards.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/12/18	TX	CAP	During an SFY2017 information controls and security audit the health plan did not provide requested information timely. During the review, monitoring of data center badge access was out of compliance with state guidelines.	Actions included drafting a new monthly process to review data center physical access logs that cover employee and visitor access. Upon review and if further action is needed, data center management engages with corporate security to investigate and/or address the issue.
12/11/18	IN	Fine	Did not return 100% of after-hours member calls within one business day in Q3 2018.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
12/11/18	IN	Fine	Did not meet metric to provide health needs screen to new members within 90 days of enrollment in Q3 2018.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
12/7/18	TN	Fine	Late submission of requested ad hoc report.	Educated business owner on need to adhere to internal and external due dates identified for ad hoc reports.

Date	State	Type	Description	Response/Plan of Correction
12/6/18	NY	CAP	Q3 2018 encounter data completeness percent change was greater than 10% quarter over quarter.	Discussed dental encounters with the state; will resubmit encounters as needed. For institutional and professional, will review how the new logic handles administrative denials, and if claims are being excluded from encounter submissions, logic will be fixed and encounters resubmitted.
12/5/18	TX	CAP	For Q4 SFY 2018, network adequacy for time and distance did not meet threshold for several provider types in some contracted counties and service areas.	The CAP included validating provider profile panel information for accuracy. The health plan explained to the state that in some counties providers are not available for contracting and members seek services in neighboring counties. The health plan will continue to offer transportation to the closest in-network and open panel practitioner.
12/4/18	LA	Fine	Two 2017 performance measures fell below benchmarks: cesarean rate for low-risk first birth women and ambulatory care ER visits. All five MCOs missed the ER target by a considerable margin.	Identified root cause of poor performance and implemented process improvements and additional outreach to increase score on measures.
12/4/18	NY	CAP	Of 150 providers called, 40 did not meet compliance measure. The rate of 73.3% is below the state's 75% threshold.	Actions include conducting periodic scheduled and unscheduled site visits and "secret shopper" calls and sending an informational letter to providers detailing the standard requirements.
12/4/18	NY	CAP	Out of 105 providers called, 29 providers failed the after-hours access requirement. Failure reasons included told to leave a message and timeframe not specified, no answering service, and no live voice at second number.	Actions include conducting periodic scheduled and unscheduled site visits and "secret shopper" calls and sending an informational letter to providers detailing the standard requirements.
12/4/18	TN	Fine	Failure to comply with transportation urgent trips requirement for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/4/18	TX	CAP	Participation rate for members (birth through age 20) receiving timely EPSDT checkups fell below 50% in some service areas for SFY 2016.	Actions include continuing to use a variety of outreach efforts to members and providers. Outreach methods include: outbound calls to members about timely checkups, how to get help with transportation or scheduling appointments, and answer questions; reminders sent to members via text message; an award program that rewards members receiving timely exams; educational and training sessions/programs; and generating Missed Opportunity Panel reports for providers.

Date	State	Type	Description	Response/Plan of Correction
11/30/18	TN	CAP	September 2018 focused claims audit found claims denied incorrectly due to a system error that did not route claims appropriately for adjudication.	CAP actions included: Correction of medical coding edit causing claims to be denied incorrectly, and weekly claims sweep implemented to identify impacted claims for reprocessing.
11/28/18	IN	Fine	Did not meet the required 98% threshold for institutional paper claims processed within 30 days (rate was 97%).	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
11/28/18	IN	Fine	In Q1 2018, 100% of after-hours member calls were not returned within one business day.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
11/28/18	IN	Fine	Did not meet the prior authorization timeliness threshold in Q1 2018.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/28/18	IN	Fine	For Q1 2018, did not meet metric to provide health needs screen to new members within 90 days of enrollment.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/28/18	IN	Fine	In Q1 2018, 100% of after-hours provider and member calls were not returned within one business day.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
11/28/18	IN	Fine	For Q2 2018, did not meet metric to provide health needs screen to new members within 90 days of enrollment.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/26/18	TN	Fine	Did not comply with transportation pick-up and delivery standards for eight members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
11/26/18	TN	Fine	Failure to comply with transportation urgent trips requirement for two members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/26/18	TN	CAP	October 2018 payment accuracy for nursing facilities in one region were below standard due, primarily, to manual processing errors.	CAP actions included staff retraining for manual claims processing errors and reprocessing affected claims paid incorrectly.

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11/16/18	KY	Fine	Did not meet performance measures for encounters submitted during October 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
11/9/18	IA	Fine	Prior authorizations did not meet contractual standards in Q4 SFY 2018.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/7/18	FL	Fine	Did not meet the minimum standards for some HEDIS® performance measures in 2017.	Identified root cause of poor performance and implemented process improvements and additional outreach to increase score on measures.
11/7/18	FL	Fine	Review of submitted continuity of care data found deficiencies.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
11/2/18	TN	CAP	August 2018 focused claims audit found that claims were not processed appropriately due to a file not being loaded timely.	CAP actions included loading backlog files into claims system and reprocessing impacted claims.
10/30/18	IN	Fine	Did not meet the encounter data completeness threshold in Q3 2017.	Conducted a detailed review of the variance, including root cause analysis.
10/30/18	KY	CAP	Vision vendor failed to load member eligibility file correctly, impacting the ability of members to receive services.	Vision vendor implemented additional controls to ensure immediate identification of any issues (for example, eligibility file monitoring process and errors being worked immediately) and converted from full eligibility files to incremental enrollment files to allow for faster and cleaner quality review.
10/26/18	TN	Fine	Did not comply with transportation pick-up and delivery standards for four members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
10/19/18	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during September 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
10/11/18	TN	CAP	Q3 2018 provider data did not meet accuracy rate for telephone numbers.	CAP actions included: educating providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve the accuracy of missing or incomplete provider data elements.

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10/10/18	DC	Fine	Did not fulfill subcontracting requirements for small and local businesses.	Continued efforts to identify and contract with potential certified small and local business partners.
10/3/18	CA	Fine	Distributed an incorrect "Your Rights" document to members, providers, and facilities. The penalty has been appealed.	Reviewed existing materials to verify correct notice used when communicating with members.
10/2/18	TN	Fine	Did not comply with transportation pick-up and delivery standards for three members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
10/1/18	FL	Fine	Did not meet provider network standards specified in the contract.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
10/1/18	NY	Deficiency Notice	Health plan entered into an agreement without prior review and approval.	Reminded business owner of contractual requirements and timeframes for state approval.
10/1/18	NY	Deficiency Notice	Delegated claims payment and utilization review functions without state approval.	Reminded business owner of contractual requirements and timeframes for state approval.
9/28/18	FL	Fine and CAP	Between February 2016 and September 2017, there were instances where hospice claims were erroneously denied or payed incorrectly.	The CAP includes activities to ensure accurate and timely payment of hospice claims such as addressing all identified problem areas, training of employees, hospice claims processing audit, and potential reprocessing claims.
9/27/18	TN	CAP	August 2018 payment accuracy for nursing facility claims did not meet the 97% threshold in one region.	Made configuration change to add a warning message for Change of Ownership (CHOW) long-term services and supports (LTSS) nursing facility (NF) providers and updated the NF claims processing instructions. Established update to knowledge library to ensure the CHOW list posted is current. Reprocessed affected claims.
9/25/18	FL	Fine	Failure to timely comply with enrollee resolution requirements.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting.
9/25/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/25/18	FL	Fine	One expedited appeal was not resolved within 72-hour timeframe.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting.
9/21/18	NJ	Fine	The 2016 dental screening rate did not meet the standard.	Reviewed missed measures and collaborated with dental vendor to implement additional outreach strategies to close gaps.
9/19/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.

Date	State	Type	Description	Response/Plan of Correction
9/14/18	KY	Fine	August 2018 encounter submission did not meet requirements.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
9/14/18	TN	Fine	Q2 2018 provider data file did not meet accuracy requirement for telephone numbers.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
9/14/18	TN	Fine	Transportation vendor was two days late with notification of an accident.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/7/18	TN	Fine	Semi-annual report was late.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
8/27/18	NY	CAP	Did not submit encounter data for Q2 2018 in accordance with contract requirements.	Added control that identifies accepted vendor claims from previous batches and will not allow them to be included an outbound file.
8/24/18	TN	Fine	Response to ad hoc report was not the information requested.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
8/22/18	TN	CAP	May 2018 focused claims found errors related to a Centers for Medicare and Medicaid Services (CMS) locality change not updated in the claims processing system.	The CAP included reprocessing claims affected by the system error a review of the end-to-end CMS fee schedule change process. The review formalized a process to notify key stakeholders of a potential delay between effective date and load date of changes to allow proactive manual mitigation.
8/20/18	NY	Deficiency Notice	The 2018 operational survey found deficiencies in provider notifications. Did not notify provider 60 days prior to potential contract termination and did not provide evidence of provider phone notification of adverse determination in three of 24 cases.	Reminded business owners of contractual requirements and timeframes related to provider notifications.
8/20/18	NY	Deficiency Notice	The 2018 operational survey found that the health plan did not provide approval letters to the state for all contracts.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
8/20/18	NY	Deficiency Notice	2018 operational survey found one provider in the fourth quarter submission that was no longer participating.	Reviewed situation to identify root cause and implement corrective action.

Date	State	Type	Description	Response/Plan of Correction
8/20/18	NY	Deficiency Notice	The 2018 operational survey found that vendor did not make sure clinical rationale was member specific or send written notice of determination to enrollees' providers.	Worked with vendor on contract requirements and increased oversight.
8/20/18	NY	Deficiency Notice	The 2018 operational survey found that notices to members did not contain the correct fair hearing information and did not fully comply with Managed Care Action Taken requirements in all cases.	Reviewed existing materials to verify correct notice used when communicating with members.
8/18/18	KY	Fine	July 2018 encounter submission did not meet requirements.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
8/10/18	TX	CAP	Did not meet the performance standard for timely submission of pharmacy encounters.	Improvement actions include increased frequency for the submission cycle and enhanced monitoring controls. The Texas Health and Human Services Commission (HHSC) recently agreed that only certain types of denied encounters should be submitted. With the clarification of the pharmacy submissions, the health plan's internal control report indicates it is now compliant for timeliness of pharmacy encounter submissions.
8/1/18	NY	CAP	LTC member services department provided incorrect answers on two questions.	The CAP includes employee retraining, monitoring via secret shopper calls, and updates to member services representative resources.
8/1/18	TN	Fine	Untimely response to prior authorization request.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
7/31/18	IA	Fine	Five reports submitted were late, inaccurate, or incomplete.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders and on importance of verifying accuracy and completeness prior to submission.
7/31/18	IA	CAP	Member pharmacy helpline performance did not meet performance standards.	The CAP includes a reevaluation of staffing needs to meet service level requirements, identified need for additional staff and cross-training additional resources, and monitoring hourly to make resource adjustments as needed during the day.

Date	State	Type	Description	Response/Plan of Correction
7/25/18	KS	Fine	In the 2016 Pay For Performance program, earned 60.6% of the amount at risk due to unmet metrics including HEDIS measures, BH national outcomes measures, and operational (claims/encounters) measures.	Reviewed unmet metrics and created action plans to improve performance.
7/25/18	KY	Fine	Did not meet accuracy measures for encounters submitted in June 2018.	Conducted a detailed review of the variance, including root cause analysis.
7/24/18	TN	CAP	File submission included only one record.	This CAP included an additional process to perform a file conversion related to a company system conversion from FTP to SFTP.
7/19/18	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
7/19/18	TN	CAP	Vision vendor did not meet prompt pay benchmark to pay 100% of claims within 60 days, paying 33 claims late.	This CAP included the vision vendor establishing a daily claims queue monitoring process where the vision vendor's claims management team monitors the queue to ensure claims processors are researching and resolving claims in a timely manner.
7/17/18	TN	Fine	Failure to comply with pick-up and delivery standards (two instances).	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
7/16/18	TN	CAP	Special Investigations Unit (SIU) investigators conducted an on-site visit of a provider without obtaining written permission from the state.	The CAP included re-education of SIU investigators to ensure written permission is obtained from the state before conducting an on-site visit of a provider under state investigation.
7/16/18	TN	CAP	Q2 2018 provider data file did not meet accuracy requirement for telephone numbers.	This CAP included education to providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve the accuracy of missing or incomplete provider data elements.
7/10/18	TN	CAP	In fall 2017 audit (August 2016–July 2017), health plan fell below the compliance threshold in risk assessment and caregiver assessment.	CAP actions included: staff training; implementation of Person Centered Support Plan (PCSP), which includes fields for completing a risk assessment and caregiver assessment; launch of PCSP via iPad® care management platform; development of guidance document; and development of PCSP internal audit process to monitor appropriateness of PCSP completion, including risk assessment and caregiver assessment.

Date	State	Type	Description	Response/Plan of Correction
7/9/18	CA	CAP	Network data did not reflect adequate access for various provider types in some zip codes.	The CAP response provided additional alternate access standards, out-of-network policy and procedures, call center scripts, and staff training materials pertaining to out-of-network access.
7/3/18	TN	Fine	Failure to comply with pick-up and delivery standards (four instances).	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
6/25/18	LA	Fine	Secret shopper survey identified inaccuracies in provider directory information.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
6/22/18	FL	Fine	Did not respond timely to an ad hoc request for submission of policies and procedures.	Educated business owner on need to adhere to internal and external due dates identified for ad hoc reports.
6/21/18	FL	Fine	Did not meet provider network standards.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
6/20/18	FL	Fine	Encounter data submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
6/18/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
6/15/18	KY	Fine	May 2018 encounters did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
6/12/18	TX	CAP	A review of certain quarterly reports by a state-contracted third party identified four recommendations to improve the documentation of reported data.	Implemented internal corrective actions when reporting issues were identified in the audit. State conducted a training session for all Texas MCOs in May 2018 and health plan is reviewing recommendations and corrective actions requested of all MCOs.
6/11/18	TX	CAP	2016 BH appointment availability study findings show availability standards.	Providers who indicate they do not have appointments available will receive individualized training to reiterate the appointment requirements, make sure they know they hold an active contract, and to provide timely notification of changes in status.
6/8/18	FL	Fine	Deficient submission of LTC case records.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the detail expected in care plans. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
6/8/18	KY	Fine	Provider request for an external independent review not submitted to the state within the required five days.	Conducted on-the-job training of impacted staff of process, documentation requirements, and completeness standard.
6/4/18	TX	CAP	Failed to timely update a provider's agreement to include a fee schedule so that the provider could be reimbursed at an LTSS benefit level for a service that is provided as acute care service and LTSS.	Amended the provider's agreement and put in place measures to make sure such agreements are not overlooked when revisions are needed. Also developed a tool to help the authorization team issue authorizations based on the terms of each provider's agreement.
5/24/18	NY	CAP	Q1 2018 pharmacy encounter data did not meet performance measures.	The CAP includes Pharmacy Operations working with the pharmacy benefit manager (PBM) to develop new encounter reports to monitor ongoing compliance.
5/24/18	NY	CAP	Q1 2018 failed to submit encounter data in accordance with contract requirements.	Actions included updating encounter procedures with additional controls.
5/24/18	TX	Fine	Failure to correct encounter issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
5/24/18	TX	Fine	Appealed claims processing did not meet 98% adjudicated within 30 days.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
5/24/18	TX	Fine	Claims processing did not meet 98% adjudicated within 10 days for nursing facility clean claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
5/24/18	TX	Fine	Pharmacy encounter data submitted late.	Worked with the pharmacy vendor to clarify their contractual requirement to submit timely encounter data to the health plan. Implemented additional monitoring to alert the encounter team to missing pharmacy encounter files or encounters submitted past the requirement.
5/24/18	TX	Fine	Financial Statistical report submitted inaccurately.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
5/24/18	TX	Fine	Claims Lag reports submitted inaccurately.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.

Date	State	Type	Description	Response/Plan of Correction
5/24/18	TX	Fine	Did not respond accurately to Inspector General request for information.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
5/24/18	TX	Fine	Medical necessity level of care assessment not submitted within 45 days.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
5/24/18	TX	Fine	EPSDT annual report not submitted timely and accurately.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders and on importance of verifying accuracy and completeness prior to submission.
5/24/18	TX	Fine	Did not timely provide an administrative service.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
5/24/18	TX	Fine	Vision subcontractor did not process 98% of clean claims within 30 days.	Increased vendor oversight/monitoring with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
5/24/18	TX	Fine	Did not timely provide a covered service.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
5/22/18	TN	CAP	Annual Quality Study identified areas of non-compliance.	The CAP includes activities to revise the credentialing policy to address a specific group and creating a denial log workflow for UM.
5/18/18	KY	Fine	April 2018 encounters did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
5/4/18	FL	Fine	Weekly provider network file uploaded incorrectly.	Educated business owner on importance of verifying accuracy of data files prior to submission. Data files included as part of ongoing business owner report cards.
5/4/18	FL	Fine	Encounter data submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
5/2/18	TX	CAP	For Q4 SFY17, submitted encounters for clinician administered drugs with invalid NDCs.	Activities include updating internal configuration and processes and submitting corrected records. Conducted additional employee education on NDC requirements to prevent manual errors.

Date	State	Type	Description	Response/Plan of Correction
4/30/18	FL	Fine	Did not meet provider network standards for ear, nose, and throat (ENT) (one region), pediatric nephrology (two regions), and rheumatology (one region).	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
4/30/18	VA	Fine	Missing NDC code problem in March 2018; encounters not cleared within 30 days.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
4/30/18	VA	Fine and CAP	Encounter submission schedule was not followed, resulting in a lag day violation for backlogged encounters in March 2018.	The CAP includes activities to improve the process for communication and approval with the state when data needs to be held. This includes new reports that track pended claims.
4/23/18	FL	Fine	Review of BH inpatient case records showed non-compliance with contract requirements.	Focused provider education/training on requirements related to developing and recording an individualized discharge plan.
4/20/18	FL	Fine	Did not submit a report indicating changes in event schedule start/end time.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
4/20/18	FL	Fine	Inaccurate LTC reports submitted in November 2017, December 2017, and January 2018.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
4/20/18	KY	Fine	March 2018 encounters did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
4/20/18	TN	Fine	Did not provide an acceptable corrective action plan.	Educated business owner on importance of verifying accuracy and completeness of CAPs prior to submission.
4/20/18	TN	Fine	Report submitted one day late.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
4/19/18	TN	CAP	2017 EPSDT screening rates were deficient.	The CAP includes activities to improve screening rates for EPSDT age members, including a provider incentive pilot and embedding an employee in one region.
4/18/18	TN	Fine	Failure to comply with the approval and scheduling requirements for two members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
4/18/18	TN	Fine	Failure to comply with the urgent trips requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.

Date	State	Type	Description	Response/Plan of Correction
4/17/18	AR	Fine	A provider misrepresented member assignment and provided unapproved information to the member on how to change assignment.	Provider Relations educated provider on contract requirements, processes, and approved member materials.
4/13/18	FL	Fine	Q4 2017 provider complaint report identified non-compliance issues.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/13/18	FL	Fine	Review of provider hospital contracts identified instances where it did not meet requirements.	Reviewed situation to identify root cause and implement corrective action.
4/13/18	TN	Fine	Missed home health aide shifts for a member between December 9, 2017 and January 12, 2017.	Conducted on-the-job training for assigned care coordinator and provider on contractual standards. Worked with vendor on corrective action.
4/12/18	TN	CAP	Q1 2018 provider data file did not meet accuracy requirement for telephone numbers.	The CAP includes activities to improve provider telephone accuracy in the provider file, including continued work with data vendors and regular provider visits to validate each element on the provider file.
4/11/18	IA	Fine	Submission of three untimely, inaccurate, or incomplete reports.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
4/10/18	CA	Fine	Between 2014 and 2017, failure to identify, timely process, and resolve grievances.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
4/10/18	FL	Fine	Did not include data in two required fields of the provider network file in April 2018.	Educated business owner on importance of verifying accuracy of data files prior to submission. Data files included as part of ongoing business owner report cards.
4/10/18	IN	Fine	For Q4 2017, did not respond to 100% of member grievances within the required timeframe.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/10/18	IN	Fine	For Q4 2017, did not resolve to 100% of member appeals within the required timeframe.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/10/18	IN	Fine	For Q4 2017, did not meet prior authorization metric.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
4/10/18	IN	Fine	For Q4 2017, did not return all after-hours helpline calls within one business day.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
4/10/18	IN	Fine	For Q4 2017, did not meet health needs screen requirements for newly enrolled members.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
4/9/18	IA	Fine	Did not meet contractual standards for grievances and appeals.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/9/18	IA	Fine	Did not meet contractual standards for prior authorizations.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
4/5/18	FL	Fine	Did not meet provider network standards specified in the contract.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
4/5/18	VA	Fine and CAP	Q4 2017 financial report submitted 7 days late.	Updated internal tracking database to break out filing requirement of standardized report under each contract.
4/5/18	VA	Fine and CAP	Missing NDC problem in February; 2018 encounter file not cleared timely.	The CAP included activities to refresh the claims controls in place to help proactively mitigate sending invalid encounters.
4/3/18	NY	Deficiency Notice	Did not renew management services agreement with vendor prior to expiration.	Reminded business owner of contract requirements.
4/3/18	TX	CAP	For SFY 2017, PCP network did not meet thresholds for appointment wait times.	Providers who indicate they do not have appointments available will receive individualized training to reiterate the appointment requirements, make sure they know they hold an active contract, and to provide timely notification of status changes.
3/16/18	FL	Fine	Non-compliance issues found in the Enrollee Complaints, Grievances, and Appeals report.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
3/16/18	KY	Fine	Encounter submissions for February 2018 did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
3/16/18	TN	CAP	ASH claims payment audit did not achieve 100% compliance for one region.	The CAP included the following activities: reprocessing two claims denied in error; obtaining a valid form for one claims; and claims staff education reminders.

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3/15/18	FL	Fine	Did not meet provider network standards specified. Examples include nephrology, rheumatology, and otolaryngology.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
3/15/18	FL	Fine	Review identified discrepancies between the provider network verification file and the online provider directory.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
3/15/18	TN	Fine	Q4 2017 provider data file did not meet accuracy requirement for telephone numbers.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
3/13/18	FL	Fine	In week one of January 2018, encounter data was submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
3/9/18	FL	Fine	Encounter data was submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
3/9/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
3/6/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
3/5/18	TN	CAP	Semi-annual audit found that critical incidents were not reported timely and untimely initiation of HCBS to members.	For critical incidents, actions included refresher training, manager review of charts and one-on-one care coordinator re-education, and a workgroup to evaluate the process and initiate improvement. For HCBS, actions included developing a new authorization process.
3/1/18	FL	Fine	Transportation vendor used non-credentialed providers.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
2/27/18	MD	CAP	Inaccuracies found in the online provider directory.	The CAP included activities to: 1) outreach to providers for confirmation or changes; 2) educate providers on process to update demographic information and changes to practice affiliations; 3) and notify providers of surveys conducted by the state or health plan and encourage participation.

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2/16/18	KY	Fine	Untimely and inaccurate encounter submissions in January.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
2/16/18	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/12/18	FL	Fine	For Q3 of 2017, did not meet standards for timely processing of nursing facility and hospice claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
2/7/18	TX	CAP	For Q4 SFY17, did not meet the 75% GeoAccess threshold for cardiovascular disease, ENT, prenatal care, and psychiatrist provider types.	Confirmed areas where providers have already been added to the network since the time of the review, noted where qualified providers are not available, and defined an outreach plan for recruiting newly available providers.
2/7/18	TX	CAP	SFY 2017 audit found insufficient internal controls and quality assurance processes for management and timely provision of LTSS.	Enhanced controls and processes include an automated tracking system, improved training, hiring a dedicated Service Coordination trainer, hiring additional Service Coordinators, and developing a quick response process to address any issues.
2/6/18	FL	Fine	Did not meet provider network standards specified. Examples include nephrology, rheumatology, and ophthalmology.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
2/5/18	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/2/18	FL	Fine	Deficient submission of requested LTC case records to the state.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the detail expected in care plans. Increased oversight monitoring.
1/30/18	TN	Fine	Private duty shifts were missed for a member.	Conducted on-the-job training for assigned care coordinator and provider on contractual standards. Worked with vendor on corrective action.
1/26/18	FL	Fine	Inaccurate August 2017 submission of enrollee complaints, grievances, and appeals report.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.

Date	State	Type	Description	Response/Plan of Correction
1/26/18	FL	Fine	Inaccurate submission of ad hoc report request.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
1/23/18	IN	Fine and CAP	In Q2 2017, did not meet the encounter reconciliation completeness metric.	CAP activities: 1) performed claim reconciliations of encounters to financial and state data for dental, pharmacy, and outpatient; 2) executed an automated reconciliation of cash disbursement journal to inbound vendor encounter files; and 3) reconciled cash disbursement journal to state accepted 837 files for vendor data.
1/19/18	FL	Fine	Incomplete submission of provider complaint report.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
1/19/18	FL	Fine	Incorrect denial of Medicare crossover claims for timely filing.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
1/19/18	NY	Deficiency Notice	Did not provide evidence that: at least 20% of board members are enrollees; member advisory council is established; or board approval of the quality plan.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
1/19/18	NY	Deficiency Notice	Did not provide evidence of providing annual notice to enrollees.	Reminded business owners of contractual requirements and timeframes related to member notifications.
1/19/18	NY	Deficiency Notice	Did not consistently assess non-dual enrollees as eligible for nursing facility level of care.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/19/18	NY	Deficiency Notice	Did not consistently advise enrollees of the voluntary benefit of Consumer Directed Personal Assistance Services upon enrollment or notify them in writing of the patient centered services plan.	Reminded business owners of contractual requirements and timeframes related to member notifications.
1/19/18	NY	Deficiency Notice	Did not routinely provide universal assessments within the required timeframes.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/19/18	NY	Deficiency Notice	Some patient centered services plans lacked sufficient detail and did not provide a back-up plan in the event that regular services are unavailable.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the detail expected in care plans. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
1/19/18	NY	Deficiency Notice	Did not routinely send written acknowledgement or determination notices to enrollees.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/19/18	TN	Fine	Failure to comply with pick-up and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
1/18/18	TN	CAP	Q4 2017 provider data file did not meet accuracy requirement for telephone numbers.	The CAP includes activities to improve provider telephone accuracy in the provider enrollment file, including continued work with data vendors, and continued regular provider visits to validate each element on the provider file.
1/17/18	IN	Fine	For Q1 2017, did not meet the call abandonment metric of 5%.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
1/17/18	IN	Fine	Did not meet the 100% metric for resolving member appeals within 30 days in one program during Q1 and Q2 2017.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
1/17/18	IN	Fine	Did not meet the 100% metric for resolving member appeals within 30 days in one program during Q2 2017.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
1/17/18	IN	Fine	In Q1 2017, did not meet the metric for returning 100% of provider calls received after-hours within one business day.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
1/17/18	IN	Fine	In Q1 and Q2 2017, did not meet the metric for timely processing of prior authorization requests.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/17/18	IN	Fine	In Q1 2017, did not meet the metric for performing a health needs screening on new members.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/17/18	IN	Fine	Did not meet the average speed of answer metric for some programs in Q1 and Q2 2017.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
1/16/18	TN	Fine	Failure to comply with pick-up and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.

Date	State	Type	Description	Response/Plan of Correction
1/12/18	FL	Fine	Manual processing error caused claims to deny for no authorization when an authorization was present.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
1/10/18	TN	Fine	Rejected encounters not resubmitted within 45 days.	Reviewed encounters process and rejection reasons against contract requirements. Implemented changes to address rejections. Increased alerts to notify encounters team to aging data.
1/9/18	TN	Fine	12/31/17 reporting period — rejected encounters not resubmitted within 45 days.	Reviewed encounters process and rejection reasons against contract requirements. Implemented changes to address rejections. Increased alerts to notify encounters team to aging data.
1/9/18	TN	Fine	11/30/17 reporting period — rejected encounters not resubmitted within 45 days.	Reviewed encounters process and rejection reasons against contract requirements. Implemented changes to address rejections. Increased alerts to notify encounters team to aging data.
1/9/18	TN	Fine	10/31/17 reporting period — rejected encounters not resubmitted within 45 days.	Reviewed encounters process and rejection reasons against contract requirements. Implemented changes to address rejections. Increased alerts to notify encounters team to aging data.
1/5/18	TN	Fine	Private duty shifts were missed for a member.	Conducted on-the-job training for assigned care coordinator and provider on contractual standards. Worked with vendor on corrective action.
1/5/18	TX	CAP	Vision vendor did not process 98% of clean claims within 30 days.	Worked with vision vendor to increase daily monitoring and reporting, as well as assign dedicated resources to monitor claims inventories.
1/4/18	FL	Fine	Did not update the online provider directory for adult psychiatrists in one region.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
1/4/18	IN	Fine	Did not meet the 100% metric for resolving member grievances within 20 business days, resolving 98.27%.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
1/4/18	IN	Fine	For Q3 2017, did not meet the 100% metric for resolving member appeals within 20 business days.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
1/4/18	IN	Fine	Did not meet the timely processing of prior authorization requests in Q3 2017.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/4/18	IN	Fine	In Q1 2017, did not meet the metric for performing a health needs screening on new members.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
1/4/18	IN	Fine	For Q3 2017, did not meet the meet the 97% timely processing metric for prior authorizations.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/3/18	IN	Fine	Late response to a request from the state for information.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
12/21/17	TN	Fine	Failure to comply with pick-up and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/20/17	KY	CAP	Untimely notification to the state of a provider's request for an external independent review and did not appropriately notify the provider of appeal rights.	Activities included the following steps: conducted quality review of external independent review identification and administrative procedure to confirm safeguards are in place; remediation training of staff responsible for processing requests; and implemented new process to monitor quality before delivery to the state.
12/20/17	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/19/17	TN	Fine	Failure to comply with urgent trip requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/19/17	TN	Fine	Failure to comply with pick-up and delivery standards.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/18/17	CA	Fine and CAP	Failure to authorize prescription drug.	The CAP included the following activities: 1) added self-injectable drug to formulary; 2) resolved any Issues regarding financial responsibility for the drug; and 3) discussed matter with the employees responsible for failing to timely initiate, acknowledge, and resolve the grievances.
12/15/17	KY	Fine	April 2017 program integrity report submitted late or incomplete and performance deficiencies in prior authorization and claims processing.	Educated business owner on need to adhere to internal and report external due dates identified on monthly reminders. Reviewed authorization and claims processing measures, workload, and process against contractual requirements.
12/12/17	TN	Fine	Q3 2017 provider data file did not meet accuracy requirement for telephone numbers.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.

Date	State	Type	Description	Response/Plan of Correction
12/11/17	FL	Fine	Weekly average timeliness for encounter data was more than seven days after the date of adjudication in November 2017.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
12/8/17	FL	Fine	Did not meet 2016 HEDIS measures for child health checkup and preventive dental services.	Reviewed missed measures and implemented additional provider and member outreach strategies to close gaps.
12/8/17	FL	Fine	2016 LTC performance measures did not meet standards for documentation, face to face encounters, case manager training, and timeliness of services.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
12/8/17	FL	Fine	2016 call answer timeliness did not meet standard.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
12/7/17	KY	CAP	Incomplete application package submitted to the state for three providers.	The action plan included a quality review of all applications; improvements to the quality review process; and staff retraining.
12/4/17	FL	Fine	Weekly average timeliness for encounter data was more than seven days after the date of adjudication in October 2017.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
12/1/17	FL	Fine	Inaccurate submission of the Achieved Savings Rebate report.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
12/1/17	FL	Fine	Untimely reporting of accidental disclosure of protected health information (letter intended for another individual).	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
12/1/17	FL	Fine	Did not update the online provider directory for adult psychiatrists in one region.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
11/30/17	IA	Fine and CAP	Q1 SFY 2018 reports were submitted late, inaccurate, or incomplete.	Action steps included: 1) staff re-education and training on when to request an extension or deny prior authorization requests due to lack of sufficient information to make determination; 2) manager notification of missed expedited prior authorization request turnaround time and employee re-education; and 3) provider update notice to remind them of expedited prior authorization process.

Date	State	Type	Description	Response/Plan of Correction
11/30/17	VA	Fine and CAP	Returned ID card report submitted 1 day late.	The CAP included implementing a new quality check process that requires all reports to be reviewed by two employees prior to submission to the state.
11/29/17	IN	Fine	The revised financial quarterly report was not submitted timely.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
11/29/17	TN	Fine	September 2017 claims accuracy rate for nursing facilities in one region was 96% and did not meet the 97% standard.	Reviewed front-end audit configuration for accuracy and updated as necessary. Conducted on-the-job training of claims processor on correct disposition.
11/27/17	FL	Fine	Did not successfully import the provider network file on one day in November 2017.	Worked with the applicable functional lead team to identify the root cause of, and implement processes to correct, the error.
11/17/17	FL	Fine	Untimely reporting of unauthorized disclosure of protected health information.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
11/17/17	KY	Fine	October 2017 encounters did not meet timeliness and accuracy standards.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
11/17/17	TN	Fine	Failure to comply with pick-up and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
11/17/17	TN	Fine	Failure to comply with approval and scheduling requirements for two members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/13/17	FL	Fine	Claims incorrectly paid to provider ineligible to participate in Medicaid.	Reviewed situation to identify root cause and implement corrective action.
11/13/17	TX	CAP	Secret shopper appointment availability study findings showed failure to meet availability standards in OB/GYN and vision.	Providers who indicate they do not have appointments available will receive individualized training to reiterate the appointment requirements for Medicaid/CHIP, make sure they know they hold an active contract, and to provide timely notification of changes in their status.
11/13/17	TX	CAP	Investigation of encounters found that paying a provider for a service that is not separately reimbursable.	Additional configuration implemented to enforce billing requirements on providers who may not follow typical billing patterns.
11/13/17	TX	Fine	Failure to correct encounter issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.

Date	State	Type	Description	Response/Plan of Correction
11/13/17	TX	Fine	Submitted Provider Termination report on the incorrect template in Q2 of SFY 2017.	Reminded business owner of templates and need to provide report using correct and most current template.
11/13/17	TX	Fine	Submitted Provider Network and Capacity report on the incorrect template.	Reminded business owner of templates and need to provide report using correct and most current template.
11/13/17	TX	Fine	Q2 SFY 17 — Submitted GeoAccess report on the incorrect template.	Reminded business owner of templates and need to provide report using correct and most current template.
11/13/17	TX	Fine	Appealed claims processing did not meet 98% adjudicated within 30 days.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
11/13/17	TX	CAP	Submission of inaccurate Third Party Recovery report.	Updated internal configuration and processes to correctly utilize the new state template.
11/13/17	TX	Fine	Claims processing did not meet 98% adjudicated within 10 days for nursing facility clean claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
11/13/17	TX	Fine	Did not meet pharmacy encounter performance standard.	Worked with the pharmacy vendor to clarify their contractual requirement to submit complete encounter data to the health plan. Implemented additional monitoring to alert the encounter team to incomplete pharmacy encounter data.
11/13/17	TX	Fine	Late submission of BH claims summary report.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
11/13/17	TX	Fine	Inaccurate submission of acute claims summary report.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
11/1/17	NY	Deficiency Notice	Telephone survey of randomly chosen providers in the provider directory failed to confirm participation at a rate lower than required.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
11/1/17	NY	Deficiency Notice	Inaccuracies found in provider directory related to telephone number and address. Directory did not list providers by the pedodontist specialty type.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.

Date	State	Type	Description	Response/Plan of Correction
10/31/17	VA	Fine	Outstanding pharmacy rebate errors from May/June 2017 still evident.	Worked with the pharmacy vendor to clarify their contractual requirement to submit complete encounter data to the health plan. Implemented additional monitoring to alert the encounter team to incomplete pharmacy encounter data.
10/31/17	VA	Fine	Two claims from June were paid beyond 365 days, violating prompt pay requirements.	Reviewed claims process with the claims team and communicated need to meet contractual requirements. Increased monitoring of claims process.
10/30/17	IN	Fine and CAP	Did not meet 98% completeness threshold for encounters.	CAP Activities include identifying the source of the largest variances and working to resolve. Dental, vision, and transportation vendors are evaluating their claims feeds against encounter edit requirements.
10/26/17	FL	Fine	Claims system was inappropriately denying anesthesia claims.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
10/26/17	TN	Fine	July 2017 claims payment accuracy rate for LTC NF HCBS did not meet standard.	Reviewed front-end audit configuration for accuracy and updated as necessary. Conducted on-the-job training of claims processor on correct disposition.
10/26/17	TN	CAP	September 2017 claims payment accuracy rate for nursing facilities in one region was 96%, missing the 97% performance standard.	The CAP included claims analyst re-education, updated duplicate claims check logic for claims submitted on the same day, and reprocessing affected claims.
10/26/17	TN	CAP	September 2017 claims payment accuracy was 96%, missing the 97% performance standard.	The CAP included re-education of staff to address manual claims processing errors and implementation of a system change to duplicate check logic.
10/25/17	FL	Fine	Did not update the online provider directory for adult psychiatrists in one region.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
10/20/17	FL	Fine	Q2 2017 did not comply with the 10-day standard for payment of nursing facility and hospice clean claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
10/20/17	KY	Fine	September 2017 encounters did not meet timeliness and accuracy standards.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.

Date	State	Type	Description	Response/Plan of Correction
10/20/17	TX	CAP	Did not meet the minimum threshold for timely EPSDT medical checkups for the SFY 2015 reporting period.	Developed two new activities to improve participation rates: a multimodal communication campaign for member reminders and a task force to examine additional barriers to members achieving timely visits.
10/16/17	TN	Fine	Failure to comply with pick-up and delivery standards for five members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
10/11/17	FL	Fine	Weekly average timeliness for encounter data was more than seven days after the date of adjudication in August 2017.	Worked with the pharmacy vendor to clarify their contractual requirement to submit timely encounter data to the health plan. Implemented additional monitoring to alert the encounter team to missing pharmacy encounter files or encounters submitted past the requirement.
10/10/17	TN	CAP	Q3 2017 provider data file did not meet accuracy requirement for telephone numbers.	The CAP includes activities to improve provider telephone accuracy in the provider enrollment file, such as continued work with data vendors and regular provider visits to validate information.
10/4/17	KY	CAP	PBM was uploading provider files weekly, rather than daily, resulting in complaints from pharmacies.	Implemented a reconciliation process to verify the PBM is correctly processing the daily provider file and reviewing data pulls and configuration to confirm correct claims processing. Validation of remediation is in process and the health play continues to provide state with regular updates and verification findings.
9/29/17	VA	Fine	August 2017 newborn reconciliation report contained format errors.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
9/29/17	VA	Fine and CAP	July 2017 claims report submitted with errors.	The claims team implemented additional quality reviews to the report prior to submitting to regulatory.
9/29/17	VA	Fine and CAP	May, June, and July encounter submissions contained pharmacy rebate errors.	The CAP included activities to void encounters with errors and submit corrected encounters without pharmacy rebate critical errors.
9/20/17	KY	CAP	Did not adequately address prior CAP within required timeframe.	CAP addressed need for state approval of provider letter and outlined process to notify and monitor provider compliance.
9/20/17	KY	Fine	Withhold of capitation payment due to non-compliance with several contract requirements.	Worked with the applicable functional lead team to identify the root cause of, and implement processes to correct, the error.

Date	State	Type	Description	Response/Plan of Correction
9/18/17	KY	Fine	August 2017 encounters did not meet timeliness and accuracy standards.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
9/14/17	TN	Fine	Q2 2017 provider data file did not meet accuracy requirement for telephone numbers.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
9/12/17	TN	Fine	Failure to comply with urgent trip requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/12/17	TN	Fine	Failure to comply with pick-up and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
9/5/17	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
8/30/17	VA	Fine and CAP	July 2017 claims report submitted late.	The claims team added additional report quality reviews prior to submitting to regulatory.
8/30/17	VA	Fine and CAP	Report submitted one day late.	The CAP included implementing a two level review for changes in due dates for reports in the Technical Manual.
8/30/17	VA	Fine and CAP	May 2017 dashboard showed one claim paid after 365 days of receipt.	Additional claims reporting was developed and implemented.
8/30/17	VA	Fine	July 2017 encounter submission contained pharmacy rebate issues.	Worked with the pharmacy vendor to clarify their contractual requirement to submit complete encounter data to the health plan. Implemented additional monitoring to alert the encounter team to incomplete pharmacy encounter data.
8/30/17	VA	Fine	June 2017 encounter submission contained pharmacy rebate issues.	Worked with the pharmacy vendor to clarify their contractual requirement to submit complete encounter data to the health plan. Implemented additional monitoring to alert the encounter team to incomplete pharmacy encounter data.
8/29/17	VA	Fine and CAP	Did not follow established encounter submission schedule in August.	Analysis determined that this was due to human error. Coached the employee to follow existing processes and implemented additional reporting monitoring.

Date	State	Type	Description	Response/Plan of Correction
8/28/17	NY	CAP	Encounter files did not meet accuracy and completeness measures.	Activities included automating a batch process to further reduce errors due to manual intervention. The procedures include a sign off at multiple stages and a final peer review prior to release. An additional person was trained to allow for three person deep knowledge.
8/25/17	IA	Fine and CAP	June 2017 ER report submitted late or incomplete and performance did not meet standards in several areas.	The CAP included hiring and training additional pharmacy member helpline staff, outlining member outreach attempts for initial health screening, and accountability and timeliness for level of care assessment completion.
8/25/17	IA	CAP	Q4 SFY 2017 — two reports submitted late and performance did not meet standards in several areas.	Actions include addressing reporting problems; implementing a minimum of three outreach attempts to new members to complete an initial health risk assessment; and process to notify and monitor provider compliance of 24-hour access requirements.
8/25/17	IA	CAP	June 2017 pharmacy member call center did not meet standards.	Worked with pharmacy vendor to create a new staffing model for the member call center. Updated reports and metrics to better monitor performance.
8/23/17	IN	Deficiency Notice	For Q1 2017, timeliness of institutional paper claims was 97.79%, missing the 98% standard.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
8/23/17	IN	Fine	For Q2 2017, 99% of grievances were processed within 20 days, not meeting the 100% standard.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
8/22/17	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
8/22/17	TN	Fine	Failure to comply with pick-up and delivery standards.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
8/18/17	TN	CAP	Did not meet July 2017 prompt pay benchmark for LTSS clean claims.	The CAP included activities to enhance claim identification logic, adjust claim queue hierarchy, and new daily report to identify affected claims.
8/17/17	TN	CAP	July 2017 claims payment accuracy rate for LTC NF HCBS did not meet standard. Deficiencies mainly due to provider incorrect pricing agreement assignment.	The CAP included modifying pricing data, reprocessing affected claims, and re-education of the pricing team.

Date	State	Type	Description	Response/Plan of Correction
8/16/17	KY	Fine	July 2017 encounters did not meet timeliness and accuracy standards.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
8/15/17	TN	Fine	Private duty shifts were missed for a member.	Conducted on-the-job training for assigned care coordinator and provider on contractual standards. Worked with vendor on corrective action.
8/11/17	FL	Fine	Weekly average timeliness for encounter data was more than seven days after the date of adjudication in July 2017.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
8/11/17	FL	Fine	Did not ensure that private duty nursing services were provided to one enrollee with reasonable promptness.	Conducted on-the-job training for assigned care coordinator and provider on contractual standards. Worked with vendor on corrective action.
8/11/17	FL	Fine	Handed out an approved marketing brochure at a public event where distribution was not permitted.	Conducted on-the-job training for marketing team on contract requirements related to advance approval (where applicable) and internal/external document review and approval process.
8/11/17	TN	Fine	July 2017 LTC semi-annual audit found late reporting of critical incidents in August 2016.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
8/10/17	TN	CAP	July 2017 LTC semi-annual audit found deficiencies in face to face visits, critical incident reporting, and timely reporting to the pre-admission evaluation system.	The CAP included creation of a new desktop processing procedures and manager and employee re-education.
8/8/17	IN	Deficiency Notice	Did not meet claims timeliness standard for Q2 2017.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
8/7/17	TN	CAP	May 2017 focused claims found an incorrect ID loaded for a provider.	The CAP includes configuration changes to prevent the reoccurrence of a claims processing error and to re-process any affected claims.
7/31/17	TN	Fine	Failure to comply with pick-up and delivery standards.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.

Date	State	Type	Description	Response/Plan of Correction
7/31/17	VA	Fine	May 2017 encounter data submission had several pharmacy rebate issues.	Worked with the pharmacy vendor to clarify their contractual requirement to submit complete encounter data to the health plan. Implemented additional monitoring to alert the encounter team to incomplete pharmacy encounter data.
7/28/17	TN	Fine	Q2 2017 member newsletters mailed one day late and did not comply with required mailing timeframe.	Reminded business lead on importance of meeting contract standard.
7/27/17	TN	Fine	Failure to comply with pick-up and delivery standards.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
7/24/17	IA	CAP	May 2017 Non-emergency Medical Transportation report submitted late or incomplete and claims performance did not meet standards.	Updated previous claims CAP to reflect improved claims processing turnaround times and remediation efforts to revise claims reprocessed period report.
7/21/17	KY	Fine	June 2017 encounters did not meet timeliness and accuracy standards.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
7/20/17	TN	CAP	Did not meet June 2017 prompt pay benchmark for LTSS clean claims.	The CAP included a configuration upgrade and reprocessing affected claims.
7/20/17	TX	Fine and CAP	Failure to correct encounter issues by the due date.	Executive steering committee added new scenarios to the existing CAP to ensure all discrepancies noted by HHSC were included. HHSC confirmed the resolution of each individual item on the CAP based on detailed reviews and site visits.
7/20/17	TX	Fine	Inaccurate submission of out-of-network report.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
7/20/17	TX	Fine	Late submission of provider files for the quarter.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
7/20/17	TX	Fine and CAP	Submitted Provider Termination report on the incorrect template.	Realigned staff to support a dedicated reporting team and improved quality review processes.
7/20/17	TX	Fine	Member hotline did not meet 80% of calls answered within 30 seconds.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.

Date	State	Type	Description	Response/Plan of Correction
7/20/17	TX	Fine	BH hotline did not meet 80% of calls answered within 30 seconds.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
7/20/17	TX	Fine	Pharmacy encounter data submitted late.	Worked with the pharmacy vendor to clarify their contractual requirement to submit timely encounter data to the health plan. Implemented additional monitoring to alert the encounter team to missing pharmacy encounter files or encounters submitted past the requirement.
7/20/17	TX	Fine	Claims processing did not meet 98% adjudicated within 10 days — nursing facility clean claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job training for applicable processors. Increased monitoring of claims aging and system alerts.
7/20/17	TX	Fine	Submitted inaccurate Claims Summary Reports for pharmacy claims.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
7/18/17	NY	CAP	Low encounter submission records in January 2017.	Actions included working closely with the pharmacy subcontractor and the state to develop new workflows, conduct internal and external testing, and submit complete encounter files to the state.
7/18/17	NY	Deficiency Notice	2016 IPRO access and availability survey found regions where the combined results from each call type did not meet the standard.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
7/17/17	NY	Deficiency Notice	2016 annual access and availability study identified three appointment time measures that did not meet requirements.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
7/13/17	TN	CAP	April 2017 — focused claims found manual processing errors on three claims.	The CAP includes activities to prevent the reoccurrence of a claims processing errors, such as re-education and revision of claims processing instructions.
7/11/17	TN	CAP	Q2 2017 provider data file did not meet accuracy requirement for telephone numbers.	The CAP includes activities to improve provider telephone accuracy in the provider enrollment file, such as continued work with data vendors and regular provider visits to validate information.
7/10/17	NJ	Fine	Low Calendar Year (CY) 2015 EPSDT dental screening rate.	Reviewed missed measures and collaborated with dental vendor to implement additional outreach strategies to close gaps.

Date	State	Type	Description	Response/Plan of Correction
7/10/17	NY	Deficiency Notice	May 2017 on-site operational survey documented findings and deficiencies related to adverse determination notification, appeal process, and notifications to social services.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
7/5/17	WA	CAP	2017 contract monitoring site review found several areas that did not meet or only partially met requirements.	Actions being reviewed into 2018 audit cycle include: 1) level of care crosswalk; 2) policies and procedures on initial health screenings; 3) grievance and appeals insert; 4) appeal oral notification process; 5) action/appeal documentation standards; 6) monitoring plan for emergency contraceptive benefits; 7) performance standard monitoring; 8) UM annual evaluation; 9) information sharing content form; and 10) pharmacy additional information from providers.

5. REFERENCES

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

5.1 Vendor (Prime) References Form

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

Vendor should include client description, contract dates, and contact information (customer points of contact, addresses, telephone numbers, and email addresses). The Vendor should explain whether it performed the work as a prime contractor or as a subcontractor.

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

The Vendor may add additional Reference Tables as necessary.

Table 9: Vendor References

Vendor Information		
Vendor Name: AMGP Georgia Managed Care Company, Inc. (Amerigroup Georgia)	Contact Name:	Mel Lindsey
	Contact Phone:	678-587-4846
Customer Information		
Customer Organization: Georgia Department of Community Health (DCH)	Contact Name:	Blake T. Fulenwider
	Contact Title:	Deputy Commissioner, Chief, Medical Assistance Plans
Customer Address: 2 Peachtree Street NW, Atlanta, GA 30303	Contact Phone:	404-657-7793
	Contact Email:	blake.fulenwider@dch.ga.gov
Project Information		
Total Vendor Staff:	292 staff supporting Georgia Families and Georgia Families 360°	
Project Objectives: DCH's goals for the Georgia Families 360° program are to provide enhanced care coordination and service integration for children in foster care, adoption assistance, and those in Department of Juvenile Justice custody while residing in community residential facilities. Specific goals include: • Enhancing coordination of care and access to services • Improving health outcomes • Developing and utilizing meaningful and complete electronic medical records • Complying fully with regulatory reporting requirements		

Project Description: The Georgia Families 360° program is a foster care and adoption assistance program. The program includes full provision of PH, BH, care coordination, long-term care, dental, vision, and pharmacy services.

Vendor's Involvement: Amerigroup Georgia is the single statewide MCO for the Georgia Families 360° program under a prime contract with DCH. Upon award of a contract in 2013, Amerigroup Georgia began executing a plan to migrate members to managed care for a March 3, 2014, start of operations. In 2015, DCH initiated a competitive procurement process that resulted in re-award of the single statewide MCO contract to Amerigroup Georgia. The current contract includes five one-year options to renew.

Project Benefits: Being the single MCO for the program, coupled with Georgia's inclusion of behavioral health and pharmacy benefits in managed care, has allowed Amerigroup Georgia to:

- Develop strong partnerships with Medicaid, child welfare, education, juvenile justice, and other critical agencies
- Coordinate care more efficiently and effectively to have greater impact on members' access to services
- Reduce the already significant burden on other entities that have responsibilities to coordinate the different systems that serve youth in foster care

Amerigroup Georgia has achieved impressive results over the last five years, including:

- Measurement Year (MY) 2017 (HEDIS® 2018)
  - 15 measures increased from MY 2016
  - 5 measures at 75th percentile
  - 5 measures at 90th percentile
- MY 2018 (HEDIS® 2019)
  - 9 measures increased from MY 2017
  - 9 measures at 75th percentile
  - 1 measure at 95th percentile
- EPSDT well-child screenings improved nine percentage points between reporting year 2014 and 2018 (79% to 88%, respectively)

Additionally, improvements in the treatment of behavioral health conditions include:

- 9% reduction in admission rate from emergency room to inpatient behavioral health facilities from 2016-2017
- 18.7% admissions reduction from 2014-2017 for psychiatric residential treatment facilities
- 20% decrease in psychotropic medication from 2014-2018

Key Personnel	
Name: Mel Lindsey	Role: Chief Executive, ultimate authority over contract performance
Name: Sam Howard	Role: Chief Financial Officer, oversees all budget and accounting systems
Name: Dr. William Alexander	Role: Medical Director, licensed Georgia physician actively involved in all major clinical programs
Name: Leticia Mayfield	Role: Compliance Officer, responsible for general adherence with contract requirements

Project Measurements:				
Projected Membership of Vendor's Contract: 34,000		Actual Membership of Vendor's Contract: 33,914		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	07/2018	To:	06/2019 DCH indicated renewal is in progress
Actual Start & Completion Dates:	From:	07/2018	To:	06/2019 DCH indicated renewal is in progress
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: Amerigroup Georgia has been performing this work as the prime contractor since the start of operations on March 3, 2014.				

Table 9: Vendor References

Vendor Information		
Vendor Name: AMERIGROUP Maryland, Inc. (Amerigroup Maryland)	Contact Name:	Vincent Ancona
	Contact Phone:	410-981-4001
Customer Information		
Customer Organization: Maryland Department of Health	Contact Name:	Jill Spector
	Contact Title:	Director, HealthChoice and Acute Care Administration
	Contact Phone:	410-767-5248

Customer Address: 201 W. Preston Street, Baltimore, MD 21201	Contact Email:	jill.spector@maryland.gov

Project Information	
Total Vendor Staff:	178 staff supporting the Amerigroup Maryland programs

Project Objectives: HealthChoice, which began in 1997, is Maryland's statewide mandatory managed care program. The HealthChoice program provides health care to most Medicaid recipients. Eligible Medicaid recipients enroll in the MCO of their choice and select a PCP to oversee their medical care.

Project Description: HealthChoice MCOs are responsible for the provision of PH, service coordination, long-term care, vision, and pharmacy services. Covered populations include TANF, CHIP, ABD, and Medicaid Expansion.

Vendor's Involvement: Amerigroup Maryland is one of the state's largest MCOs and the largest in three counties: Baltimore, Montgomery, and Prince George's. The health plan delivers meaningful value through provider collaborations and engagement, enhanced affordability through cost of care and care management, and superior solutions for a better, more personalized health care experience.

Project Benefits: Amerigroup Maryland has achieved great success with quality initiatives, with more than 19% of measures above the 90th percentile and 15% above the 75th percentile in MY 2017 (HEDIS 2018). Specific results include:

- Adolescent Well Care Visits (AWC): 72.99 / 90th percentile
- Well Child Visits in the
  - First Fifteen Months of Life (6+ visits) – W15: 72.02 / 75th percentile
  - Third, Fourth, Fifth, and Sixth Year of Life – W34: 88.78 / 90th percentile
- Children and Adolescents Access to PCP
  - Age 12 to 19 years: 93.64 / 90th percentile
  - Age 25 months to 6 years: 93.54 / 90th percentile

Amerigroup Maryland's staff includes a Special Needs Coordinator who operates as the single point of contact for the local Department of Social Services in each county to facilitate the sharing of information.

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

Key Personnel	
Name: Vincent Ancona	Role: Chief Executive, ultimate authority over contract performance
Name: Kevin Criswell	Role: Chief Financial Officer, oversees all budget and accounting systems

Name: Dr. Bradley Jackson	Role: Medical Director, licensed Maryland physician actively involved in all major clinical programs
Name: Sameria Cornish	Role: Compliance Officer, responsible for general adherence with contract requirements
Project Measurements:	
Projected Membership of Vendor's Contract: 278,000 (3,500 in foster care)	Actual Membership of Vendor's Contract: 278,777 (3,552 in foster care)
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	01/2019	To:	12/2019
Actual Start & Completion Dates:	From:	01/2019	To:	12/2019

Reason(s) for difference between Estimated and Actual dates: N/A
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: Amerigroup Maryland has been performing this work as the prime contractor since 1999.

Table 9: Vendor References

Vendor Information		
Vendor Name: HealthKeepers, Inc. (HealthKeepers)	Contact Name:	Jennie Reynolds
	Contact Phone:	804-354-4485
Customer Information		
Customer Organization: Virginia Department of Medical Assistance Services (DMAS)	Contact Name:	Daniel Plain
	Contact Title:	Director, Health Care Services Division
Customer Address: 600 East Broad Street, Richmond, VA 23219	Contact Phone:	804-588-4883
	Contact Email:	Daniel.Plain@dmas.virginia.gov

Project Information	
Total Vendor Staff:	402 staff supporting the HealthKeepers' programs

Project Objectives: Medallion 4.0 represents DMAS' continued improvements to the managed care delivery system. Medallion 4.0 includes TANF, CHIP, foster care, and adoption assistance. Some of the key goals of Medallion 4.0 include:

- Improving quality of life and health outcomes for members
- Providing a seamless, one-stop system of services
- Facilitating communication between providers to improve the quality and cost-effectiveness of care

The Coordinated Commonwealth Care (CCC) Plus program serves children and adults with disabilities and complex needs. CCC Plus includes dual eligibles, ABD, and managed long-term services and supports (LTSS).

Project Description: Medallion 4.0 MCOs are responsible for the provision of PH, BH, service coordination, vision, pharmacy, and non-emergency medical transportation services.

CCC Plus MCOs are responsible for the provision of PH, BH, LTSS, dental (routine cleaning/x-ray benefit), pharmacy, and non-emergency medical transportation.

Vendor's Involvement: HealthKeepers began serving Virginia members on July 1, 1996. HealthKeepers was the first MCO to be approved statewide in 2013 under Medallion II, and they continue to operate statewide under the Medallion 4.0 and CCC Plus programs.

In 2011, HealthKeepers participated in a Richmond-based foster care pilot, ultimately assisting DMAS in the expansion of the foster care and adoption assistance managed care program to the entire state in 2014. On June 1, 2014, HealthKeepers began serving members in foster care or receiving adoption assistance across the Commonwealth of Virginia.

Project Benefits: HealthKeepers has achieved success with quality initiatives with more than 11% of measures above the 75th percentile in MY 2017 (HEDIS 2018). Specific HEDIS results include:

- Immunizations for Adolescents – TDAP/TD: 94.16 / 90th percentile
- Children and Adolescents Access to PCP – Age 7 to 11 years: 94.43 / 75th percentile
- Asthma Medication Ratio – AMR TOTAL: 70.32 / 75th percentile

HealthKeepers trained all staff, clinical and non-clinical, in trauma-informed care, leveraging materials developed by the Georgia health plan.

HealthKeepers also actively works with youth nearing aging out of foster care. HealthKeepers begins at age 17 years old and works with the youth to help them successfully transition to independence.

Key Personnel	
Name: Jennie Reynolds	Role: Chief Executive, ultimate authority over contract performance
Name: Susan Sulzbach	Role: Chief Financial Officer, oversees all budget and accounting systems

Name: Dr. Paul Gibney	Role: Medical Director, licensed Virginia physician actively involved in all major clinical programs
Name: Nancy Kaplan	Role: Compliance Officer, responsible for general adherence with contract requirements
Project Measurements:	
Projected Membership of Vendor's Contract: 385,000 (3,900 in foster care and adoption assistance)	Actual Membership of Vendor's Contract: 384,983 (3,901 in foster care and adoption assistance)
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	07/2019	To:	06/2020
Actual Start & Completion Dates:	From:	07/2019	To:	06/2020

Reason(s) for difference between Estimated and Actual dates: N/A
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: HealthKeepers has been performing work as the prime contractor since 1996.

5.2 Subcontractor References (if applicable)

If the Vendor's proposal includes the use of Subcontractor(s), provide three (3) references for each subcontractor. **The State prefers references that demonstrate where the Prime and Subcontractors have worked together in the past.**

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

The Vendor may add additional Reference Tables as necessary.

Table 10: Subcontractor References

Anthem Reference #1

Subcontractor Information		
Vendor Name: Anthem, Inc., operating through our affiliate, Amerigroup Partnership Plan, LLC (Anthem)	Contact Name:	Robert Spadaccini
	Contact Phone:	803-382-5653
Customer Information		
Customer Organization: BlueChoice Health Plan of South Carolina, Inc. (BlueChoice)	Contact Name:	Tim Vaughn
	Contact Title:	President
Customer Address: 4101 Percival Road, Columbia, SC 29229	Contact Phone:	803-264-3364
	Contact Email:	Tim.Vaughn@bcbssc.com

Project Information	
Total Vendor Staff:	81

Project Objectives: BlueChoice is an MCO for South Carolina's Health Connections Medicaid managed care program supporting TANF, ABD, and uninsured adults.

Project Description: Amerigroup Partnership Plan, an affiliate of Anthem, provides administrative support functions to BlueChoice for medical services under the Healthy Connections program.

Vendor's Involvement: Amerigroup Partnership Plan began supporting South Carolina Medicaid members in 2008 as a subcontractor to BlueChoice. It provides technical infrastructure, administrative services, operational support, and support for health plan management. Specific responsibilities include:

- Member enrollment data maintenance
- Member and provider call center operations
- Claims processing and fee-for-service pricing and benefit configuration
- Encounter data submission
- Medical management, including utilization, care, and disease management
- Grievance and appeal processing and reporting
- Regulatory and management reporting
- Quality management
- Marketing and member field support

Project Benefits: In the first six months of 2019, Amerigroup Partnership Plan demonstrated strong performance across claims processing, member call center, provider call center, and member appeals areas.

- Claims Processing – 481,133 claims

- Average turnaround time of 3.49 days
  - 75.35% auto-adjudication rate
  - 99.90% paid within 30 days
  - 94.57% received electronically
- Member Call Center – 32,540 calls
  - 6 second average speed of answer
  - 0.29% abandonment rate
- Provider Call Center – 29,256 calls
  - 18 second average speed of answer
  - 0.84% abandonment rate
- Member Appeals – 99.33% resolved within 30 days

Key Personnel	
Name: Robert Spadaccini	Role: Chief Executive, ultimate authority over contract performance
Name: Neal Miller	Role: Director of Operations, oversees all program operations and compliance with contract requirements
Name: Dr. Imtiaz Khan	Role: Medical Director, licensed physician actively involved in all major clinical programs
Name: Leticia Mayfield	Role: Compliance Officer, responsible for general adherence with contract requirements

Project Measurements:	
Projected Membership of Vendor's Contract: 121,000	Actual Membership of Vendor's Contract: 121,363
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	06/2019	To:	05/2020
Actual Start & Completion Dates:	From:	06/2019	To:	05/2020

Reason(s) for difference between Estimated and Actual dates:
N/A

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

Amerigroup Partnership Plan provides service to BlueChoice as a subcontractor to its contract with the South Carolina Department of Health and Human Services. Subcontracted activities include technical infrastructure, administrative services, operational support, and support for health plan management.

Table 10: Subcontractor References

Anthem Reference #2

Subcontractor Information		
Vendor Name: Anthem, Inc., operating through our affiliate, Amerigroup Partnership Plan, LLC (Anthem)	Contact Name:	Victoria Mora
	Contact Phone:	512-495-7504
Customer Information		
Customer Organization: Seton Health Plan, Inc. d/b/a Dell Children's Health Plan (Dell Children's)	Contact Name:	Trent Bruce
	Contact Title:	Chief Executive Officer
Customer Address: 4515 Seton Center Parkway, Suite 300, Austin, TX 78759	Contact Phone:	512-324-3051
	Contact Email:	tbruce@ascension.org

Project Information	
Total Vendor Staff:	Amerigroup Partnership Plan has five dedicated full-time employees at Dell Children's, with additional support from shared resources equivalent to 12 FTEs.
Project Objectives: Dell Children's is an MCO for the Texas STAR (TANF) and CHIP programs.	
Project Description: Amerigroup Partnership Plan, an affiliate of Anthem, provides administrative support to Dell Children's for the STAR and CHIP programs.	
Vendor's Involvement: Amerigroup Partnership Plan began supporting members on December 1, 2016 as a subcontractor to Dell Children's. It provides technical infrastructure, administrative services, operational support, and support for health plan management. Specific responsibilities include: • BH provider network maintenance • Member enrollment data maintenance • Member and provider call center operations • Claims processing • Encounter data submission • Medical management, including utilization, care, and disease management • Grievance and appeal processing and reporting • Program integrity, including Special Investigations Unit • Marketing and community outreach	

• Regulatory and management reporting

Project Benefits: In the first six months of 2019, Amerigroup Partnership Plan demonstrated strong performance across claims processing and member and provider call center areas.
• Claims Processing – 167,333 claims
  •Average turnaround time of 4.5 days
  •91.80% auto-adjudication rate
  •99.86% paid within 30 days
  •91.40% received electronically
• Member Call Center – 7,248 calls
  •7 second average speed of answer
  •0.55% abandonment rate
• Provider Call Center – 7,764 calls
  •25 second average speed of answer
  •0.7% abandonment rate

Key Personnel	
Name: Patrick Sturdivant	Role: Chief Executive, ultimate authority over contract performance
Name: Victoria Mora	Role: Director of Operations, oversees all program operations and compliance with contract requirements
Name: Dr. Cealee Thomas	Role: Medical Director, licensed Texas physician actively involved in all major clinical programs
Name: Misty Arayata	Role: Operations, responsible for day-to-day deliverables

Project Measurements:	
Projected Membership of Vendor's Contract: 35,000	Actual Membership of Vendor's Contract: 34,777
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	12/2016	To:	06/2021
Actual Start & Completion Dates:	From:	12/2016	To:	06/2021
Reason(s) for difference between Estimated and Actual dates: N/A				

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: Amerigroup Partnership Plan provides service to Dell Children's as a subcontractor to its contract with the Health and Human Services Commission. The scope of subcontracted activities includes providing technical infrastructure, administrative services, operational support, and support for health plan management.

Table 10: Subcontractor References

Anthem Reference #3

Subcontractor Information		
Vendor Name: Anthem, Inc., operating through our affiliate, Amerigroup Partnership Plan, LLC (Anthem)	Contact Name:	Jeffrey Lowry
	Contact Phone:	716-796-2642
Customer Information		
Customer Organization: HealthNow New York, Inc. dba BlueCross BlueShield of Western New York (HealthNow)	Contact Name:	Jared Gross
	Contact Title:	Senior Vice President
Customer Address: 257 West Genesee Street, Buffalo, NY 14202-2657	Contact Phone:	716-796-2642
	Contact Email:	gross.jared@bcbswny.com
Project Information		
Total Vendor Staff:	56	
Project Objectives: HealthNow is an MCO for the New York Medicaid Managed Care and Child Health Plus programs serving TANF, ABD, and CHIP populations.		
Project Description: Amerigroup Partnership Plan, an affiliate of Anthem, provides administrative support to HealthNow for medical services under the New York Medicaid Managed Care and Child Health Plus programs.		
Vendor's Involvement: Amerigroup Partnership Plan began supporting members on November 1, 2016 as a subcontractor to HealthNow for their Medicaid Managed Care and Child Health Plus contracts. It provides technical infrastructure, administrative services, operational support, and support for health plan management. Specific responsibilities include: • Network development and management • Member enrollment data maintenance		

- Member and provider call center operations
- Claims processing
- Encounter data submission
- Medical management, including utilization, care, and disease management
- Grievance and appeal processing and reporting
- Program integrity, including Special Investigations Unit
- Compliance, regulatory, and management reporting

Project Benefits: In the first six months of 2019, Amerigroup Partnership Plan demonstrated strong performance across claims processing, member and provider call centers, and member appeals areas.

- Claims Processing – 323,203 claims
  - Average turnaround time of 6.5 days
  - 78.99% auto-adjudication rate
  - 99.07% paid within 30 days
  - 89.24% received electronically
- Member Call Center – 40,762 calls
  - 7 second average speed of answer
  - 0.26% abandonment rate
- Provider Call Center – 21,482 calls
  - 15 second average speed of answer
  - 0.59% abandonment rate
- Member Appeals – 99.52% resolved within 30 days

Key Personnel	
Name: Jeffrey Lowry	Role: Chief Executive, ultimate authority over contract performance
Name: Dan Maciejewski	Role: Operations, oversees all program operations and compliance with contract requirements
Name: Dr. James Poss	Role: Medical Director, licensed physician actively involved in all major clinical programs
Name: Michele LoPorto	Role: Compliance Officer, responsible for general adherence with contract requirements

Project Measurements:				
Projected Membership of Vendor's Contract: 40,000		Actual Membership of Vendor's Contract: 40,218		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	11/2016	To:	09/2021
Actual Start & Completion Dates:	From:	11/2016	To:	09/2021
Reason(s) for difference between Estimated and Actual dates: N/A				

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

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

Table 10: Subcontractor References

AMR Reference #1

Subcontractor Information		
Vendor Name: Advanced Medical Reviewers, LLC (AMR)	Contact Name:	Amanda Markle
	Contact Phone:	310-907-9395
Customer Information		
Customer Organization: Kern Health Systems	Contact Name:	Deborah Murr
	Contact Title:	Senior Director of Health Services
Customer Address: 9700 Stockdale Highway, Bakersfield, CA 93311	Contact Phone:	661-664-5141
	Contact Email:	deborah.murr@khs-net.com

Project Information	
Total Vendor Staff:	Approximately 75
Project Objectives: AMR coordinates advisory peer reviews regarding medical necessity and experimental/investigational treatment to assist in Kern Health Systems benefit determination process.	
Project Description: AMR's panel of physician and allied health professionals review medical records to make recommendations related to care.	
Vendor's Involvement: AMR provides medical review services to Kern Health Systems. Various physician specialists review cases to make recommendations on questions related to medical necessity, treatment plans, experimental/investigational, and more.	
Project Benefits: • Capability to handle quick turnaround times • Wide range of specialists • Ability to rapidly scale increased volume	
Key Personnel	
Name: Douglas Hayward	Role: Chief Executive Officer
Project Measurements:	
Projected Membership of Vendor's Contract: 30,000	Actual Membership of Vendor's Contract: 30,000

Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	04/2018	To:	Ongoing
Actual Start & Completion Dates:	From:	04/2018	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: AMR provides medical peer review services.				

Table 10: Subcontractor References

AMR Reference #2

Subcontractor Information		
Vendor Name: Advanced Medical Reviewers, LLC (AMR)	Contact Name:	Amanda Markle
	Contact Phone:	310-907-9395
Customer Information		
Customer Organization: Allegiance Benefit Plan Management, Inc.	Contact Name:	Jeannie Anderson
	Contact Title:	Medical Review Manager
Customer Address: 2806 South Garfield Street, Missoula, MT 59801	Contact Phone:	406-721-2222 x3325
	Contact Email:	jeannie.anderson@askallegiance.com
Project Information		
Total Vendor Staff:	Approximately 75	
Project Objectives: AMR coordinates advisory peer reviews regarding medical necessity and experimental/investigational treatment to assist its customer in the customer's benefit determination process.		

Project Description: AMR's panel of physician and allied health professionals review medical records to make recommendations related to care.				
Vendor's Involvement: AMR provides medical review services to Allegiance Benefit Plan Management, Inc. Various physician specialists review cases to make recommendations on questions related to medical necessity, treatment plans, experimental/investigational, and more.				
Project Benefits: • State and specialty matched physicians • Independent assessments • Efficient, secure technology				
Key Personnel				
Name: Dirk Visser		Role: Chief Executive Officer		
Project Measurements:				
Projected Membership of Vendor's Contract: 25,000		Actual Membership of Vendor's Contract: 25,000		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	07/2016	To:	Ongoing
Actual Start & Completion Dates:	From:	07/2016	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: AMR provides medical peer review services.				

Table 10: Subcontractor References

AMR Reference #3

Subcontractor Information		
Vendor Name: Advanced Medical Reviewers, LLC (AMR)	Contact Name:	Amanda Markle
	Contact Phone:	310-907-9395
Customer Information		
Customer Organization: St. Francis Hospital	Contact Name:	Melissa Berry
	Contact Title:	Quality Management
Customer Address: 1 Saint Francis Drive Greenville, SC 29601-3955	Contact Phone:	864-255-1549
	Contact Email:	melissa_berry@bshsi.org

Project Information	
Total Vendor Staff:	Approximately 75
Project Objectives: AMR coordinates advisory peer reviews regarding quality of care.	
Project Description: AMR's physician reviewers conduct advisory independent peer reviews regarding the treating physician's quality of care.	
Vendor's Involvement: AMR's physician reviewers give feedback on another clinician's medical appropriateness, level of care and quality, as an independent, unbiased third-party.	
Project Benefits: • Increase quality • Independent, unbiased review • Wide range of specialists and subspecialists	
Key Personnel	
Name: Matthew Caldwell	Role: President
Project Measurements:	
Projected Membership of Vendor's Contract: N/A, client is a hospital	Actual Membership of Vendor's Contract: N/A
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	02/2012	To:	Ongoing
Actual Start & Completion Dates:	From:	02/2012	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: AMR provides medical peer review services.				

Table 10: Subcontractor References

Exela Technologies, Inc. Reference #1

Subcontractor Information		
Vendor Name: Exela Technologies, Inc. (Exela)	Contact Name:	Christy Hudson
	Contact Phone:	303-249-1268
Customer Information		
Customer Organization: Midlands Choice, Inc.	Contact Name:	Greta Vaught
	Contact Title:	President & CEO
Customer Address: 8420 W. Dodge Road, Suite 210, Omaha, NE 68114-3492	Contact Phone:	402-390-1589
	Contact Email:	gvaught@midlandschoice.com

Project Information	
Total Vendor Staff:	7
Project Objectives: For providers and multiple clients, utilize technology to streamline front-end processes and reduce cost.	
Project Description: Claims front end services for claims submission to include provider portal.	
Vendor's Involvement: For providers and multiple clients, utilize technology to streamline front-end processes and reduce cost.	
Project Benefits: Provider portal innovation implemented, increased efficiency, and reduced cost.	
Key Personnel	
Name: Trudy Knapp-Rhodes	Role: Business Analyst
Project Measurements:	
Projected Membership of Vendor's Contract: N/A; 35,000 based on annual contract claims volume	Actual Membership of Vendor's Contract: N/A; 35,000 based on annual contract claims volume
Reason(s) for change in membership:	

N/A				
Estimated Start & Completion Dates:	From:	09/2006	To:	Ongoing
Actual Start & Completion Dates:	From:	09/2006	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: For providers and multiple clients, utilize technology to streamline front-end processes and reduce cost.				

Table 10: Subcontractor References

Exela Reference #2

Subcontractor Information		
Vendor Name: Exela Technologies, Inc. (Exela)	Contact Name:	Christy Hudson
	Contact Phone:	303-249-1268
Customer Information		
Customer Organization: Blue Cross and Blue Shield of North Carolina	Contact Name:	Kentreal Farrar
	Contact Title:	Manager, CGSO Vendor Services Delivery
Customer Address: 5901 Chapel Hill Road, Durham, NC 27707	Contact Phone:	919-765-2801
	Contact Email:	Kentreal.farrar@bcbsnc.com

Project Information	
Total Vendor Staff:	82
Project Objectives: Exela processes health care claims in front-end scope from data capture to output data files in standard format. They utilize portal technology for customer staff to review incomplete documents or verify information in exception queues. Once the customer has confirmed and updated claim data points, claims are released back into the workflow to deliver output in standard format. Exela processes health care claims in adjudication scope directly in customer mainframe applications via secure connections for the Medicare Advantage and Medicare Supplemental lines of business.	

Project Description: Claims data capture services utilizing portal technology for exception handling. Adjudication in customer systems.
Vendor's Involvement: Provides data capture, exception handling, and adjudication services.
Project Benefits: ▪ Better member outcomes and increased efficiency with exception handling in data capture process ▪ Reduce cost in both data capture and adjudication

Key Personnel	
Name: Mary Wynne	Role: Vendor Manager
Name: Betsy Harris	Role: Business Analyst

Project Measurements:	
Projected Membership of Vendor's Contract: N/A; 1.5 million based on annual contract claims volume	Actual Membership of Vendor's Contract: N/A; 1.5 million based on annual contract claims volume
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	12/2012	To:	N/A
Actual Start & Completion Dates:	From:	12/2012	To:	Present

Reason(s) for difference between Estimated and Actual dates: N/A
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: Provides data capture, exception handling, and adjudication services.

Table 10: Subcontractor References

Exela Reference #3

Subcontractor Information		
Vendor Name: Exela Technologies, Inc. (Exela)	Contact Name:	Christy Hudson
	Contact Phone:	303-249-1268
Customer Information		
Customer Organization: Health Plan Holdings, Inc.	Contact Name:	Vicki Jackson
	Contact Title:	Manager
Customer Address: 780 Brooksedge Plaza Drive, Westerville, OH 43081	Contact Phone:	614-212-7065
	Contact Email:	vicki.jackson@harringtonhealth.com

Project Information	
Total Vendor Staff:	10

Project Objectives:

Exela processes health care claims from mailroom services to output files in standard format. They utilize technology to streamline manual invention and introduced claims submission portal for customer service and claims processing staff to submit claims electronically.

Project Description:
Claims front-end services for claims submission to include document submission portal for customer staff.

Vendor's Involvement:
Claims front-end processing (mailroom, optical character recognition, electronic document submission portal).

Project Benefits:

- Document electronic document submission portal innovation implemented
- Increase efficiency
- Reduction in cost

Key Personnel	
Name: Eric Uhl	Role: Business Analyst

Project Measurements:	
Projected Membership of Vendor's Contract:	Actual Membership of Vendor's Contract:

N/A; 195,000 based on annual contract claims volume		N/A; 195,000 based on annual contract claims volume		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	06/2011	To:	Ongoing
Actual Start & Completion Dates:	From:	06/2011	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: N/A				

Table 10: Subcontractor References

SKYGEN Reference #1

Subcontractor Information		
Vendor Name: SKYGEN USA, LLC (SKYGEN)	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: Horizon Blue Cross Blue Shield New Jersey (Horizon)	Contact Name:	Dr. Fred DiOrio, DMD
	Contact Title:	Dental Director
Customer Address: 1427 Wyckoff Road Farmingdale, NJ 07727	Contact Phone:	732-256-5485
	Contact Email:	fred_diorio@horizonnjhealth.com

Project Information	
Total Vendor Staff:	Approximately 600

Project Objectives:
SKYGEN USA provides administrative dental services for Horizon's Medicaid members.

Project Description:

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

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

Vendor's Involvement:
SKYGEN USA has managed Horizon's Medicaid members since 2012, with a focus on holistic program integrity and stewardship. To address Horizon's most immediate needs, they used a combination of data analytics, fee schedule analysis, and geo-access reporting to analyze costs.

SKYGEN is delegated to perform the following activities for the dental program:

- Provider recruitment, credentialing, education and retention
- Authorizations
- Utilization review and management
- Claims processing and provider payment
- Call center services
- Reporting

- Member services
- Quality assurance
- Complaints, grievances, and appeals
- FWA

Project Benefits:

For Horizon, SKYGEN reduced their PMPM costs, resulting in significant saving while achieving over 80% provider satisfaction from 2015 to 2017. They also consulted with Horizon to improve their providers' performance and helped protect nearly one million members by reducing and preventing FWA.

Key Personnel	
Name: Mark Dasek	Role: Relationship Manager
Name: Arica Buretta	Role: Service Manager
Name: Nicole Martins	Role: Account Manager
Name: Lynn Kern	Role: Director of Claims Administration
Name: Marcel Tetzlaff	Role: Vice President, Provider Experience and Dental Benefits Management
Name: Kyle Koltz	Role: Senior VP Third Party Administration Operations

Project Measurements:	
Projected Membership of Vendor's Contract: 847,000	Actual Membership of Vendor's Contract: 847,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	12/2012	To:	Ongoing
Actual Start & Completion Dates:	From:	12/2012	To:	Ongoing

Reason(s) for difference between Estimated and Actual dates:

N/A

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

All services SKYGEN performs on behalf of Horizon are performed as a subcontractor. This includes provider recruitment, credentialing, education, and retention; authorizations; utilization review and management; claims processing and provider payment; call center services; reporting; member services; quality assurance; complaints, grievances, and appeals; and fraud, waste, and abuse monitoring.

Table 10: Subcontractor References

SKYGEN Reference #2

Subcontractor Information		
Vendor Name: SKYGEN USA, LLC (SKYGEN)	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: United Concordia Dental (United Concordia)	Contact Name:	Daniel J. Wright
	Contact Title:	SVP Government Business & CFO
Customer Address: 4401 Deer Path Road Harrisburg, PA 17110	Contact Phone:	717.260.7182
	Contact Email:	daniel.wright@highmark.com

Project Information	
Total Vendor Staff:	Approximately 600

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

Project Description:

SKYGEN is a dental administrative services organization. They perform all services necessary to administer the dental benefit to United Concordia in Pennsylvania, Ohio, Kentucky, North Carolina, and West Virginia, including implementation, member services, quality, and reporting.

In addition to policies and procedures that proactively ensure members receive appropriate services and treatment, SKYGEN has built sophisticated reporting and analytics into their dental benefits software system, the Enterprise System. SKYGEN's system allows them to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes.

Vendor's Involvement:
SKYGEN has been the dental administrator managing United Concordia's Medicaid members since 2012, currently totaling nearly 400,000 members.

SKYGEN USA performs the following activities for United Concordia:
- Authorizations
- Claims processing and provider payment
- Reporting
- Member services
- Quality assurance

Project Benefits:
SKYGEN USA has effectively managed the dental benefit program for United Concordia, creating efficiencies, working to increase provider and member satisfaction, and improving automated claims

processing. Project benefits include improving access to care, reducing program overhead, containing benefit costs, and safeguarding patients.				
Key Personnel				
Name: Mark Dasek	Role: Relationship Manager			
Name: Arica Buretta	Role: Service Manager			
Name: Cheryl Lightheart	Role: Account Manager			
Name: Lynn Kern	Role: Director of Claims Administration			
Name: Kyle Koltz	Role: Senior VP Third Party Administration Operations			
Project Measurements:				
Projected Membership of Vendor's Contract: 396,000	Actual Membership of Vendor's Contract: 396,000			
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	04/2012	To:	Ongoing
Actual Start & Completion Dates:	From:	04/2012	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: All services SKYGEN performs on behalf of United Concordia Dental are performed as a subcontractor. This includes authorizations, claims processing, provider payment, reporting, member services, and quality assurance.				

Table 10: Subcontractor References

SKYGEN Reference #3

Subcontractor Information		
Vendor Name: SKYGEN USA, LLC (SKYGEN)	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: Commonwealth Care Alliance	Contact Name:	Jessica Vida
	Contact Title:	Director of Dental, OTC Ancillary Programs
Customer Address: 30 Winter Street Boston, MA 02108	Contact Phone:	617-426-0600 x1001
	Contact Email:	jmedeiros@commonwealthcare.org

Project Information	
Total Vendor Staff:	Approximately 600

Project Objectives:
SKYGEN provides administrative dental services for Commonwealth Care Alliance's 31,000 Medicaid members.

Project Description:

SKYGEN is a dental administrative services organization. They perform all services necessary to administer the dental benefit to Commonwealth Care Alliance in Massachusetts, including implementation, claims processing, provider payment, reporting, call center, authorizations, quality assurance, complaints, appeals, and grievances.

Vendor's Involvement:
SKYGEN has been the dental administrator managing Commonwealth Care Alliance's Medicaid members since 2014.

SKYGEN performs the following activities for Commonwealth Care Alliance:
- Authorizations
- Claims processing and provider payment
- Reporting
- Member services
- Quality assurance

Project Benefits:
SKYGEN USA has effectively managed the dental benefit program for Commonwealth Care Alliance, creating efficiencies, working to increase provider and member satisfaction, and improving automated claims processing. Project benefits include improved access to care, reduced program overhead, containing benefit costs, and safeguarding patients.

Key Personnel	
Name: Mark Dasek	Role: Relationship Manager
Name: Crystal Seng	Role: Service Manager
Name: Autumn Stockton	Role: Account Manager
Name: Lynn Kern	Role: Director of Claims Administration
Name: Kyle Koltz	Role: Senior VP Third Party Administration Operations

Project Measurements:				
Projected Membership of Vendor's Contract: 31,000		Actual Membership of Vendor's Contract: 31,000		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	06/2014	To:	Ongoing
Actual Start & Completion Dates:	From:	06/2014	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: All services SKYGEN performs on behalf of Commonwealth Care Alliance are performed as a subcontractor. This includes claims processing; provider payment; reporting; authorizations; quality assurance; call center; and complaints, grievances, and appeals.				

Table 10: Subcontractor References

SPH Reference #1

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	Matt Smith
	Contact Phone:	248-737-3231
Customer Information		
Customer Organization: Alameda Alliance for Health	Contact Name:	Dr. Sanjay Bhatt
	Contact Title:	Quality Improvement Medical Director
Customer Address: 1240 S Loop Road, Alameda, CA 94502	Contact Phone:	510-747-6152
	Contact Email:	sbhatt@alamedaalliance.org

Project Information	
Total Vendor Staff:	5
Project Objectives: Conduct surveys to assess member and provider satisfaction.	
Project Description: Health risk assessment, CAHPS®, provider access, provider satisfaction, member satisfaction (clinician & group CAHPS) surveys.	
Vendor's Involvement: SPH provides survey administration services.	
Project Benefits: • Certification • Process improvement • Better member outcomes	

Key Personnel	
Name: Dr. Sanjay Bhatt	Role: Quality Improvement Medical Director

Project Measurements:	
Projected Membership of Vendor's Contract: 260,554	Actual Membership of Vendor's Contract: 260,554

Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	01/2012	To:	12/2019
Actual Start & Completion Dates:	From:	01/2012	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: SPH is not a subcontractor for this client.				

Table 10: Subcontractor References

SPH Reference #2

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	Matt Smith
	Contact Phone:	248-737-3231
Customer Information		
Customer Organization: Blue Shield Promise Health Plan (Previously Care1st Health Plan)	Contact Name:	Norma Perez
	Contact Title:	Senior Quality Improvement Accreditation Project Manager
Customer Address: 601 Potrero Grande Drive, Monterey Park, CA 91755	Contact Phone:	323-827-6627
	Contact Email:	Norma.Perez@blueshieldca.com
Project Information		
Total Vendor Staff:	5	
Project Objectives: Conduct surveys to assess member and provider satisfaction.		
Project Description: Clinician & group CAHPS, provider satisfaction, CAHPS 5.0H, Rx adherence outreach, Medicare CAHPS, HOS, call center satisfaction, Medicare CAHPS drill down surveys, care management & disease management satisfaction surveys.		

Vendor's Involvement: SPH Analytics provides survey administration services.				
Project Benefits: • Certification • Process improvement • Better member outcomes				
Key Personnel				
Name: Norma Perez		Role: Senior Quality Improvement Accreditation Project Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: 3,377,207		Actual Membership of Vendor's Contract: 3,377,207		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	01/2012	To:	12/2019
Actual Start & Completion Dates:	From:	01/2012	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: Not applicable				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: SPH is not a subcontractor for this client.				

Table 10: Subcontractor References

SPH Reference #3

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	Matt Smith
	Contact Phone:	248-737-3231
Customer Information		
Customer Organization: El Paso First Health Plans Inc.	Contact Name:	Edgar Martinez
	Contact Title:	Director of Member Services

Customer Address: 1145 Westmoreland Dr., El Paso, TX 79925	Contact Phone:	915-532-3778 x1064
	Contact Email:	edmartinez@elpasohealth.com

Project Information	
Total Vendor Staff:	5

Project Objectives:

Conduct surveys to assess member and provider satisfaction.

Project Description:

Commercial adult CAHPS, Medicaid adult CAHPS (STAR adult), Medicaid child (CHIP child and Medicaid), and provider satisfaction.

Vendor's Involvement:

SPH provides survey administration services.

Project Benefits:

- Certification
- Process improvement
- Better member outcomes

Key Personnel	
Name: Edgar Martinez, MBA	Role: Director of Member Services

Project Measurements:	
Projected Membership of Vendor's Contract: 71,846	Actual Membership of Vendor's Contract: 71,846

Reason(s) for change in membership:

N/A

Estimated Start & Completion Dates:	From:	01/2015	To:	12/2019
Actual Start & Completion Dates:	From:	01/2015	To:	Ongoing

Reason(s) for difference between Estimated and Actual dates:

Not applicable

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

SPH is not a subcontractor for this client.

Table 10: Subcontractor References

VSP Reference #1

Subcontractor Information		
Vendor Name: Vision Service Plan Insurance Company (VSP)	Contact Name:	Annie Mayo
	Contact Phone:	336-995-8417
Customer Information		
Customer Organization: Aetna Better Health of Ohio	Contact Name:	Matt Koblens
	Contact Title:	Vendor Manager
Customer Address: 7400 West Campus Road, New Albany, OH 43054	Contact Phone:	614-254-4681
	Contact Email:	Koblensm@aetna.com
Project Information		
Total Vendor Staff:	2,600	

Project Objectives:

Provide high-quality routine vision care services to members. Provide various reports on the customer's overall performance.

Project Description:

Maintain claims and provider systems to allow the customer's network of providers to obtain coverage information and submit claims for routine vision services.

Vendor's Involvement:

VSP provides network support, development (as needed) and credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.

Project Benefits:

- Provide highest level of routine vision care to members
- Capture member health information for reporting to the State for wellness initiatives
- Streamline benefit delivery system for ease of the member and provider interactions

Key Personnel	
Name: Gary Bach	Role: Manager, Health and Government Markets
Name: Natasha Strickner	Role: Program Manager

Project Measurements:				
Projected Membership of Vendor's Contract: 30,000	Actual Membership of Vendor's Contract: 30,000			
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	06/2014	To:	Ongoing
Actual Start & Completion Dates:	From:	06/2014	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: VSP provides network support, development (as needed), credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.				

Table 10: Subcontractor References

VSP Reference #2

Subcontractor Information		
Vendor Name: Vision Service Plan Insurance Company (VSP)	Contact Name:	Annie Mayo
	Contact Phone:	336-995-8417
Customer Information		
Customer Organization: BlueChoice HealthPlan of South Carolina	Contact Name:	Scott Timmons
	Contact Title:	Sr. Director Provider Networks
Customer Address: 4101 Percival Road, Columbia, SC 29229	Contact Phone:	803-264-2068
	Contact Email:	Scott.Timmons@bluechoicesc.com

Project Information	
Total Vendor Staff:	2,600
Project Objectives: Provide high-quality routine vision care services to members. Provide various reports on the customer's overall performance.	
Project Description: Maintain claims and provider systems to allow the customer's network of providers to obtain coverage information and submit claims for routine vision services.	
Vendor's Involvement: VSP provides network support, development (as needed) and credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.	
Project Benefits: • Provide highest level of routine vision care to members • Capture member health information for reporting to the state for wellness initiatives • Streamline benefit delivery system for ease of the member and provider interactions	
Key Personnel	
Name: Gary Bach	Role: Manager, Health and Government Markets
Name: Natasha Strickner	Role: Program Manager
Project Measurements:	
Projected Membership of Vendor's Contract: 125,000	Actual Membership of Vendor's Contract: 125,000
Reason(s) for change in membership: N/A	

Estimated Start & Completion Dates:	From:	07/2010	To:	Ongoing
Actual Start & Completion Dates:	From:	07/2010	To:	Ongoing

Reason(s) for difference between Estimated and Actual dates: N/A
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

VSP provides network support, development (as needed), credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.

Table 10: Subcontractor References

VSP Reference #3

Subcontractor Information		
Vendor Name: VSP	Contact Name:	Annie Mayo
	Contact Phone:	336-995-8417
Customer Information		
Customer Organization: Community Health Plan of Washington	Contact Name:	Julie Keeffe
	Contact Title:	Director, Marketplace Strategy
Customer Address: 1111 Third Avenue, Seattle, WA 98101	Contact Phone:	206-521-8834
	Contact Email:	Julie.keeffe@chpw.org
Project Information		
Total Vendor Staff:	2,600	
Project Objectives: Provide high-quality routine vision care services to members. Provide various reports on the customer's overall performance.		
Project Description: Maintain claims and provider systems to allow the customer's network providers to obtain coverage information and submit claims for routine vision services.		
Vendor's Involvement: VSP provides network support, development (as needed) and credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.		
Project Benefits: • Provide highest level of routine vision care to members		

• Capture member health information for reporting to the state for wellness initiatives • Streamline benefit delivery system for ease of the member and provider interactions				
Key Personnel				
Name: Gary Bach		Role: Manager, Health and Government Markets		
Name: Natasha Strickner		Role: Program Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: 500		Actual Membership of Vendor's Contract: 500		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	01/2013	To:	Ongoing
Actual Start & Completion Dates:	From:	01/2013	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: VSP provides network support, development (as needed), credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.				

Table 10: Subcontractor References

Wipro Reference #1

Subcontractor Information		
Vendor Name: Wipro LLC (Wipro)	Contact Name:	Paul Andrews
	Contact Phone:	573-635-2434 x5216
Customer Information		
Customer Organization: Missouri Department of Social Services, MO HealthNet Division (MO HealthNet)	Contact Name:	Darin Hackmann
	Contact Title:	Medicaid Enterprise Systems Chief Information Officer
Customer Address: 615 Howerton Court, Jefferson City, MO 65109	Contact Phone:	573-751-7996
	Contact Email:	Darin.M.Hackmann@dss.mo.gov

Project Information	
Total Vendor Staff:	179

Project Objectives:

Provide quality Medicaid Management Information System (MMIS) support and comprehensive Fiscal Agent services, including call centers, document management, and fulfillment services.

Project Description:

This contract signifies the continuation of MMIS implementation and support and Fiscal Agent services Wipro has been providing to the state of Missouri since 1988. This contract facilitates the following project activities:

- Provide and support the provider web portal, including enrollment, re-credentialing, and enhancements to support the elimination of FWA
- Provide and support the eMOMED web portal, which facilitates online provider claims submission, status checks, and remittance advice statement requests
- Provide call center services to program participants, health care service providers, clinical authorizations, and technical help
- Process paper claims and attachments, image provider and participant correspondence, resolution of suspended claims, and data entry into the MMIS
- Provide professional review services for prior authorization and precertification of services
- Maintain and modify the MMIS utilizing the entire range of the system development life cycle
- Provide an avenue for necessary system enhancements or modifications needed to ensure efficient Medicaid program application and to address any regulatory changes

Vendor's Involvement:

Wipro serves as the prime contractor and provides system integration, project management services, and the full scope of the software development life cycle, as well as manages comprehensive Fiscal Agent services for the Missouri Medicaid program.

Project Benefits:

- Provide efficient and accurate provider enrollment processes

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

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

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

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

Reason(s) for difference between Estimated and Actual dates:

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

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

N/A

Table 10: Subcontractor References

Wipro Reference #2

Subcontractor Information		
Vendor Name: Wipro LLC (Wipro)	Contact Name:	Anuj Kumar
	Contact Phone:	573-353-0482
Customer Information		
Customer Organization: Change Healthcare (CHC)	Contact Name:	Abishek Sharma
	Contact Title:	Vice President, IT Research & Development
Customer Address: 3055 Lebanon Pike, Suite 1000, Nashville, TN 37214	Contact Phone:	737-600-7609
	Contact Email:	Abishek.Sharma@changehealthcare.com

Project Information	
Total Vendor Staff:	1,899

Project Objectives:

The goal of this strategic partnership is to establish CHC as a true integrated health care technology enabler, driving organizational capacity and agility as well as delivering enhanced value to customers. Wipro helps enable business and process transformation tools for CHC and their customers through customer engagement platforms that introduce emerging capabilities, including digital, robotic process automation and artificial intelligence, enterprise resource planning (ERP) consolidation, streamlined health care management and customer relationship management systems, and modernization of customized cloud solutions with industry-leading information security frameworks.

Project Description:

CHC engaged Wipro to significantly decrease costs by providing functions using lower priced resources and by transforming processes. CHC seeks a flexible relationship that takes advantage of evolving technologies, including automation, as well as to change platforms or methods of service delivery.

Vendor's Involvement:

The engagement between Wipro and CHC encompasses multiple services lines over the 10-year contractual agreement including infrastructure services, application development, business process services, and joint Wipro/CHC health care technology products.

Project Benefits:

- **Engagement/Project Ramp-up.** Wipro sourced and on-boarded 1,899 dedicated resources across six countries, fulfilling requirements for more than 20 projects
- **Information Security.** To facilitate quick ramp-up, Wipro enabled and equipped 10 PHI-compliant delivery centers across three continents; certifying 1,700+ seats with health care industry-specific information and physical security controls in less than 12 months
- **IT Service Desk.** Migrated global support for all CHC IT Service Desk functions to Wipro centralized operations in offshore markets with premiere technical talent

• **Payer Print Business.** Transitioned print services to Wipro, leveraging backend horsepower for application development to enable CHC's patient billing and payment solution • **Member Engagemen.** Through due diligence and capability showcasing, Wipro earned the trust of CHC's largest payer customer, establishing and providing advocate and coordination services, including member outreach, eligibility and enrollment, and patient scheduling

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

Project Measurements:	
Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A
Reason(s) for change in membership: N/A	

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

Reason(s) for difference between Estimated and Actual dates:

N/A

If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:

Wirpo provides the following activities to CHC:

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

Table 10: Subcontractor References

Wipro Reference #3

Subcontractor Information		
Vendor Name: Wipro LLC (Wipro)	Contact Name:	Bonet Lobo
	Contact Phone:	678-314-2822
Customer Information		
Customer Organization: Best Buy Co., Inc.	Contact Name:	Sherrell Christenson
	Contact Title:	Director, Contact Strategy and Partner Management
Customer Address: 7601 Penn Avenue South, Richfield, MN 55423	Contact Phone:	612-291-1000
	Contact Email:	Sherrell.Christenson@bestbuy.com
Project Information		
Total Vendor Staff:	More than 900	

Project Objectives:

The goal of this strategic partnership is to establish Best Buy as a true integrated technology enabler, driving organizational capacity and agility, as well as delivering enhanced value to Best Buy's customers. Wipro helps enable business and process transformation tools for Best Buy and their customers through customer engagement platforms that introduce emerging capabilities, including digital, robotic process automation and artificial intelligence, enterprise resource planning (ERP) consolidation, streamlined customer relationship management systems, and modernization of customized cloud solutions with industry-leading information security frameworks.

Project Description:

Best Buy contracted Wipro to significantly decrease costs by providing functions using lower priced resources and transforming processes. Best Buy seeks a flexible relationship that takes advantage of evolving technologies, including automation, as well as changing platforms or methods of service delivery.

Vendor's Involvement:

The engagement between Wipro and Best Buy encompasses multiple services lines over the eight-year agreement, including infrastructure services, application development, business process services, and joint Wipro/Best Buy technology products.

Project Benefits:

- Browse & Sell, post-purchase support, billing and renewal, total tech support, and fraud detection management
- Repair, delivery, installation, and post-purchase support for notebooks, desktops, tablets, home theater, mobile, etc.
- Committed transformation benefits through lean and Six SigmaAbo projects

Key Personnel	
Name: Bonet Lobo	Role: Director – Client Partner

Name: Shekar Saraf		Role: Operations Lead		
Project Measurements:				
Projected Membership of Vendor's Contract: N/A		Actual Membership of Vendor's Contract: N/A		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	02/2012	To:	02/2020
Actual Start & Completion Dates:	From:	02/2012	To:	02/2020
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: N/A				

6. FINANCIAL STABILITY

The Vendor should provide the following components for this section:

6.1 Dun & Bradstreet (D&B) Ratings

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

UniCare's ratings report from Dun & Bradstreet (D&B) includes the following information:

- D&B rating of ER7
- D&B viability rating of 6-4-G-Z
  - 6 – Viability Score
  - 4 – Portfolio Comparison
  - G – Data Depth Indicator
  - Z – Company Profile

UniCare also has ratings from two additional entities:

- AM Best rating – A-
- Weiss rating – B+

In addition, UniCare is a wholly owned subsidiary of Anthem, Inc. (Anthem) and is backed by a total of $3.5 billion in senior revolving credit facilities.

6.2 Financial Capacity

The Vendor should supply evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement.

As indicated in Addendum Number 6, Question ID Q120 and Q121, we provide additional information below to document solvency, as well as completing Table 11: Credit References.

UniCare has been financially stable and dependable over the past 16 years and has shown the exceptional capacity for growth necessary to successfully partner with DHHR since we began serving West Virginia Medicaid members in 2003. We have remained well-funded throughout our time serving West Virginia members. We anticipate funding increases in capital requirements through income from operations. We have additional support and backing from our ultimate parent company, Anthem, which puts us in an extremely strong position to support the Specialized Managed Care for Children and Youth Program.

As of December 31, 2018, our statutory net worth exceeds West Virginia Offices of Insurance Commissioner requirements of 200% of the Authorized Control Level (ACL), and demonstrates a strong financial position with a Risk-Based Capital (RBC) ratio of 564%.

Additionally, Anthem provides UniCare with any necessary financial backing through access to capital markets, and we are able to leverage Anthem's financial strength and resources. In 2018, Anthem's combined ACL RBC ratio across its insurance and HMO operating subsidiaries was on average approximately 523%, which is 2.6 times federal and State requirements. As of December 31, 2018, Anthem held $1.9 billion in cash and investments.

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

Credit References

Our ultimate parent company, Anthem, is one of the nation's leading health benefits companies and provides UniCare with the ability to leverage its financial strength and resources through access to its capital markets. In addition to its own available funds and investments, Anthem has senior revolving credit facilities, including a $2.5 billion five-year Facility with a maturity date of June 2024, and a $1 billion 364-day Facility with a maturity date of June 2020 — neither with any outstanding amounts as of June 30, 2019. These credit lines could be used, if necessary, to help provide liquidity to our West Virginia operations.

Additionally, Anthem is a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, and the Federal Home Loan Bank of Atlanta, or collectively, the FHLBs. As a member, Anthem has the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. As of December 31, 2017 and 2018, $825 million and $645 million, respectively, were outstanding under the short-term FHLB borrowings.

We provide the requested credit references in Table 11.

In the following table, please list credit references that can verify the financial standing of your company.

Table 11: Credit References

INSTITUTION	ADDRESS	PHONE NUMBER
Bank of America Merrill Lynch (UniCare bank account)	4361 Irwin Simpson Road Mason, Ohio 45040	888-715-1000
Chase Bank (UniCare bank account)	4 New York Plaza, 13th Floor New York, New York 10004	212-623-9321
Bank of America Merrill Lynch (Anthem line of credit)	100 North Tryon Street Charlotte, North Carolina 28255	980-387-5915

ATTACHMENT C: PROJECT ORGANIZATION AND STAFFING APPROACH

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

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

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

1. Initial Staffing Plan

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

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

- The city and state where each position will be located.
- Whether the Vendor plans to co-locate a liaison within the Department, and if so, which position(s) the Vendor proposes to fulfill this liaison role.
- Identification of Subcontractor staff, if applicable.

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

overall content of reports and the frequency with which they will be provided to the Vendor. Please provide sample reports where available.

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

1. Initial Staffing Plan



UniCare Health Plan of West Virginia, Inc. (UniCare) has created a comprehensive Initial Staffing Plan so that we are ready from day one of the Contract to serve children and youth and their families and caregivers, enrolled in the Specialized Managed Care for Children and Youth Program (the Program). Our staff represent the backbone of our data-informed, comprehensive, integrated care model. From our Fostering Healthy Lives Concierge Representatives (Concierge Representatives) to our Fostering Healthy Lives Care Coordinators (Care Coordinators), our entire staff will collaborate and communicate with system of care stakeholders to deliver needed services and supports to help keep children and youth supported in their homes and communities. Drawing on our local expertise serving West Virginia, as well as the experience of our affiliates who serve 84,000 children and youth in child welfare systems across 13 markets, our Initial Staffing Plan reflects UniCare's Fostering Healthy Lives state-specific model to best serve those involved in the child welfare system.

We built our Initial Staffing Plan on a unique, flexible approach that incorporates traditional and non-traditional roles, a broad array of skill sets, and fully dedicated staff. We know it is critical to recruit, hire, and retain staff who understand the challenges faced by children, youth, and young adults in the child welfare system. We will bring a diverse team that supports the Program goals, is culturally sensitive and responsive, and brings lived experiences, as well as a commitment to improving the lives of children and families.

The following represents our Initial Staffing Plan, including our proposed project team, organizational structure and charts, and a detailed approach to recruiting, hiring, retaining, and adjusting staff across all levels, functions, and departments to successfully implement and operate the Program.

Proposed Project Team

Led by Chief Executive Officer Tadd Haynes, a native West Virginian, who brings more than a decade of leadership experience serving the state, our proposed project team will support better health, permanence, safety, resiliency, and well-being for children and youth while strengthening collaboration across the system of care to prevent duplication and administrative burdens. Mr. Haynes will be supported by our Interim Contract Liaison/Medicaid Administrator, John Marks. Mr. Marks most recently served as Director of Account Partnerships for Beacon Health Options in West Virginia. Like Tadd, John has deep experience in West Virginia Medicaid, positive connections with the provider community, and has been an integral part of the development of the foster care program for the past two years.

As the Interim Contract Liaison/Medicaid Administrator Mr. Marks will be responsible for program implementation, staff recruitment, and provider communications that will ensure a successful implementation ensuring UniCare is able to meet and exceed all state expectations related to standing up the program and ensuring the success of UniCare's model for children and youth in the child welfare system. UniCare is committed to securing a permanent, full-time Contract Liaison/Medicaid Administrator who will be fully dedicated to this program and not shared with the MHT program, exceeding the contractual requirement. In order to ensure a seamless transition Mr. Marks will remain a part of the Fostering Healthy Lives program team supporting ongoing operations.

Our proposed project team reflects the skills, qualifications, and values we believe are paramount to accomplishing the scope of work described in the RFP and in meeting Program goals. Our proposed project team goes beyond making sure we have resources to fulfill the RFP requirements. We are also focused on building a team of employees who not only have experience in child welfare, but also are passionate about serving children and youth who may have experienced traumatic events, including frequent changes in living environments. Across every functional area, our project team will be responsive and accessible, putting the children and families we serve at the center of everything we do. Our team will include:

- Skilled and knowledgeable employees who understand the local system of care, the challenges, resources, and nuances that exist across West Virginia communities, and the unique needs of children and youth in the child welfare system
- Employees who are connected to their local communities and have established, trusted relationships with key organizations and stakeholders
- A strong Fostering Healthy Lives interdisciplinary team with diverse experience and training so that children and families have access to the full gamut of both clinical and non-clinical staff who can link them to resources, supports, and services that will improve their social and health outcomes and support their success
- Individuals who have experience in child welfare from other states and can bring insight and best practices to West Virginia, where appropriate and beneficial

Comprehensive Resources to Fulfill Requirements

UniCare stands ready to recruit, interview, and hire sufficient and qualified candidates within a short period of time to fulfill requirements as specified in the RFP. We have already designated permanent hires for many of our key staff positions, and recruitment efforts are underway for others. As an experienced and trusted partner in West Virginia, UniCare has a comprehensive and mature infrastructure, including an office in Charleston that can easily accommodate the addition of new leadership and support staff to fulfill the Program requirements. Our staffing approach blends our dedicated local staff with the shared supports and experience of our West Virginia Health Bridge and Mountain Health Trust programs (West Virginia Medicaid programs)

and our affiliates serving children and families involved in the child welfare system in other markets.

Our facilities, information technology, and support services are fully developed, integrated, and prepared to meet the goals of the West Virginia Department of Health and Human Resources (DHHR) and support the Program; however, we also understand the Program requires a distinct organizational structure that supports permanence, safety, and improved outcomes. Thus, we have developed innovative roles for staff, including:

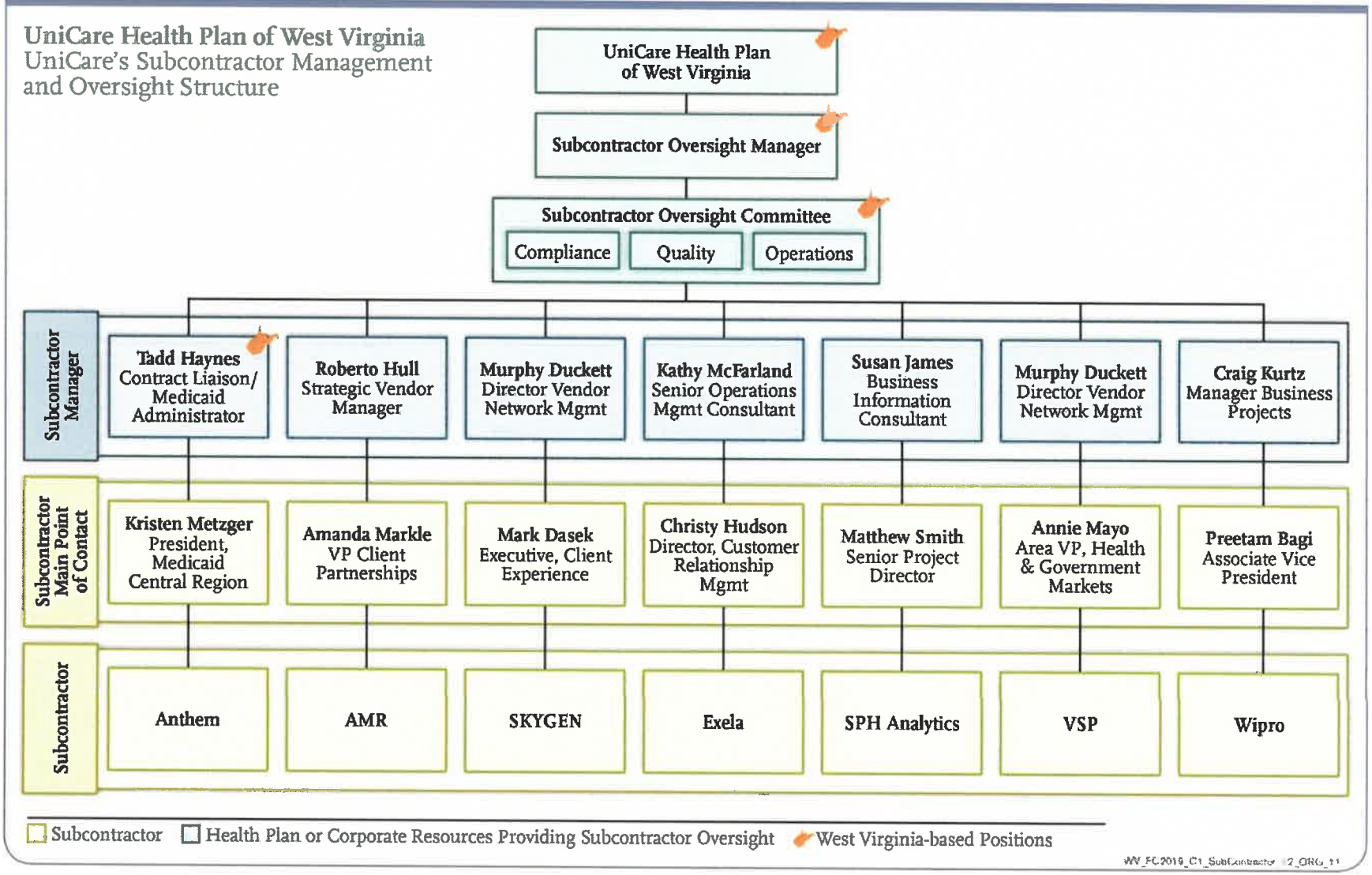
- **Fostering Healthy Lives Care Coordination Team.** The primary responsibility of the regionally assigned Care Coordination team is to connect and develop trusting relationships with members and families to make sure they receive the most appropriate quality of care that is holistic, meaningful, trauma-responsive, and tailored to their individual strengths and needs. The team comprises a combination of clinical and non-clinical staff who have a variety of specialties, including social workers with a background in child welfare and nurses with a range of medical specialty backgrounds. Having direct experience and knowledge of child-placing agencies and their process and structures will also be crucial for this team.
- **Fostering Healthy Lives Concierge Team.** Our dedicated Concierge Representatives will go beyond just answering calls to help build trusting relationships with the individuals we serve. They will carry out initial welcome calls and health screeners, coordinate and schedule assessments, verify and identify accuracy of member contact information, and make sure the care planning process begins with as much information as possible. This team will serve as an easy-to-reach point -of contact, so that members, caseworkers, parents, and caregivers can always reach us to obtain the information, support, and services needed. The Concierge team will work directly with Care Coordinators to streamline processes and assure member information is current.
- **Fostering Independence Coordinators.** Staff will be dedicated to helping transition age youth successfully move into adulthood, teaching self-management skills to achieve independence. They will work with community organizations and State agencies to address issues such as homelessness, mental health, public health, juvenile justice, education, and exploitation. They will work to resolve system challenges and assist youth in achieving their goals.
- **Pharmacist.** Understanding the importance of medication management, especially psychotropic medications, for children and youth within the child welfare system, we will hire a full-time pharmacist (PharmD) to analyze pharmacy data from DHHR; serve as a resource to the clinical team on pharmacy issues that impact members, including the treatment of co-morbid medical and behavioral health conditions; serve as a liaison to the DHHR Pharmacy program, and review medications and counsel physicians about alternative medications when prescribed therapies do not meet national standards.
- **Community Engagement and Training Team.** This team will focus on unifying the local system of care by bringing training, support, and expertise to promote shared understanding of the new single managed care program and the needs of children and families. Our team will be led by a ***Community Engagement Director*** who will oversee a ***Justice/Court Liaison*** and five ***Engagement and Training Representatives*** (geographically dispersed across the State, so that they can identify local training needs and provide it in local forums). We have also added a ***Career Development Specialist*** to this team who will help to ensure youth in foster care are prioritized and have access to resources through new and existing workforce development opportunities, and will help create additional career paths for the youth in foster care.

- **Co-located DHHR Liaison.** To streamline communication and collaboration efforts, we will co-locate a DHHR Liaison who will serve as point-of-contact for operational questions and issues regarding community engagement. This Liaison will represent UniCare at DHHR and other State agency meetings as delegated by or in conjunction with the Contract Administrator.
- **Quality Management (QM) Practice Consultants.** Our field-based Consultants will serve as liaisons between UniCare and our providers, offering support through face-to-face interactions, QM services such as gaps in care and HEDIS® education, review of charts with office staff, and more.

Organizational Structure

UniCare's organizational charts (Figures C.1-1 and C.1-2) illustrate staffing, functions, and lines of reporting, including subcontractors, for the Program.

Figure C.1-2. UniCare's Subcontractor Management and Oversight Structure



Our Initial Staffing Plan includes strategies for recruiting, hiring, and retaining a full roster of dedicated and experienced staff, including all key personnel positions and executive leadership, clinical and care coordination staffing that meets or exceeds required ratios, member and provider support staffs, as well as administrative and operational supports. In addition to our qualified, well-trained staff, we will also bring resources including:

- A statewide network comprising primary care providers (PCPs), specialists, behavioral health (BH), and other non-traditional providers. Our network includes 500 pediatricians and more than 2,200 PCPs, more than 680 BH providers, plus contracts with all 75 Federally Qualified Health Centers and Rural Health Clinics, and 12 comprehensive BH centers.
- Established relationships with DHHR and other agencies and community-based organizations upon which we will continue to build. We have partnered with 1,165 organizations including community, faith-based, government agencies, and schools. Since 2017, we have sponsored 4,269 events, provided $400,000 in funding, and donated nearly $300,000 to benefit our community via the Anthem Foundation.
- Established vision and dental subcontractor relationships so children have ready access to the full array of covered benefits and services.
- A fully functional Management Information System with sophisticated technologies that support information sharing, claims, care coordination, compliance, and reporting.
- A strict program integrity approach with safeguards to prevent fraud, waste, and abuse.
- Comprehensive policies and procedures that define all operational and functional requirements, care coordination processes, and quality improvement.

We have always been able to recruit and retain sufficient numbers of adequately trained employees to meet our Contract obligations. Neither UniCare nor our affiliates have ever had an implementation delay as a result of inability to recruit staff. For example, during our Georgia affiliate's planning and launch as the sole MCO for Georgia Families 360 (child welfare program), the project team assisted in:

- Transitioning more than 27,000 children, youth, and young adults into managed care
- Establishing more than 9,000 care plans in collaboration with parents, guardians, caregivers, and providers in the 60 days before go-live, and linked members and families with care teams within 30 days of launch
- Achieving readiness with systems, staffing, provider network, and infrastructure in place and ready a full three months prior to launch date
- Establishing a dedicated call center available 24 hours a day, 7 days a week

We will leverage the experiences and lessons learned from our affiliates while keeping focus on DHHR's Program goals and the unique West Virginia landscape.

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Many of our key leaders reside in West Virginia and are based in our Charleston office, while additional regionally assigned staff will be placed throughout the state, so we can build strong communities and participate in community-based activities. We designed our leadership team's organizational structure to maximize teamwork and draw on each individual's strengths to achieve DHHR's Program goals. Our organizational chart highlights staff locations. Tadd Haynes, Chief Executive Officer, will lead the Program, with our designated key staff and leadership fully accountable for overseeing all aspects of operations, while leveraging national shared support services and our shared resources for the West Virginia Medicaid programs.

In addition, UniCare plans to co-locate a Liaison to DHHR within DHHR offices. Barbara Wessels will serve as the interim point-of-contact for operational questions and issues regarding community engagement. Ms. Wessels will represent UniCare at DHHR and other State agency meetings as delegated by the Contract Administrator. Table C.1-1 details each of our key leadership positions, designates which have been filled permanently, timelines for the remaining positions, and contact information for each. Our interim key staff all bring the necessary skills and experience to serve West Virginia children and families. Where needed, we have expanded

resources to make sure we have the staff needed until a permanent role is filled. For example, we recognize the importance of having clinical leadership with pediatric experience, so we added an additional Pediatric Medical Director with two decades of experience (Dr. Urmesh Shah) from our affiliate in Texas to work in tandem with our interim Medical Director, Tracey Dlott, MD, who brings a wealth of West Virginia knowledge from her tenure serving West Virginia Medicaid members.

Table C.1-1. UniCare's Designated Full-Time Key Staff, Timelines for Hiring, and Contact Information (MR037)

Names	Key Staff Title	Status/Timeline	Contact Info
Tadd Haynes	Chief Executive Officer	Permanent	Phone: 304-347-2474 Email: tadd.haynes@anthem.com Location: Charleston, WV
John Marks	Contract Liaison/ Medicaid Administrator	Interim (Permanent hire within 30 days of Contract award)	Phone: 304-541-3385 Email: Marksjl1050@gmail.com Location: Charleston, WV
Kevin Dean	Chief Financial Officer	Permanent	Phone: 304-964-7709 Email: kevin.dean@anthem.com Location: Charleston, WV
Tracey Dlott, MD	Medical Director	Interim (Permanent hire within 30 days of Contract award)	Phone: 804-772-0070 Email: tracy.dlott@anthem.com Location: Reston, VA*
Anita Blackburn, RN	Medical Management Director (Medical Management [Utilization Review] Director)	Interim (Permanent hire within 30 days of Contract award)	Phone: 304-539-9947 Email: anita.blackburn@anthem.com Location: Charleston, WV
Vicky Gallaher, RN	Care Management Director	Interim (permanent hire within 30 days of Contract award)	Phone: 304-859-0154 Email: Vicky.gallaher@anthem.com Location: Charleston, WV
Jorge Cortina, MD	Behavioral Health Medical Director	Permanent	Phone: 757-409-0131 Email: Jorge.cortina@anthem.com Location: Virginia Beach, VA
Nancy Graham, LCSW	Social Services Director	Permanent	Phone: 681-209-2996 Email: nancy.graham@anthem.com Location: Charleston, WV
Stephanie Harper	Socially Necessary Services (SNS) Liaison	Permanent	Phone: 304-348-2700 Email:Stephanie.harper@anthem.com Location: Charleston, WV
Victoria Warner, MPH	Quality Director	Permanent	Phone: 304-730-3780 Email: Victoria.warner@anthem.com Location: Charleston, WV
Sylvia Berger	Member Services Director (Enrollee Services Director)	Permanent	Phone: 304-347-2479 Email: Sylvia.Berger@anthem.com Location: Charleston, WV
Chris Kearney	Claims Payment Director	Permanent	Phone: 757-756-2008 Email: Christopher.Kearney@anthem.com Location: Virginia Beach, VA
Carrie Blankenship	Network Development Director	Permanent	Phone: 304-533-4086 Email: Carrie.Blankenship@anthem.com Location: Charleston, WV

Names	Key Staff Title	Status/Timeline	Contact Info
Terri Roush	Provider Relations Director	Interim (permanent hire within 30 days of Contract award)	Phone: 304-989-5471 Email: terri.roush@anthem.com Location: Charleston, WV
Megan Lombard	Program Integrity Lead	Interim (permanent hire within 30 days of Contract award)	Phone: 757-473-2718 Email: Megan.Lombard@anthem.com Location: Virginia Beach, VA*
Leslie Caluya	Information Technology Director	Interim (permanent hire within 30 days of Contract award)	Phone: 805-630-0012 Email: Leslie.Caluya@anthem.com Location: Thousand Oaks, CA*
Natalie Robinson	Community Engagement Director	Interim (permanent hire within 30 days of Contract award)	Phone: 304-539-6928 Email: Natalie.robinson@anthem.com Location: Charleston, WV
Diane Paletta, DDS	Dental Director	Permanent (employee of subcontractor, SKYGEN)	Phone: 304-545-3371 Email: drdee500@aol.com Location: Charleston, WV
Sabrina Payne, BSW, LSW	Medicaid Member Advocate	Permanent	Phone: 304-347-2470 Email: Sabrina.payne@anthem.com Location: Charleston, WV

**Interim staff may be based in in alternate location; however, permanent employee will be based in Charleston, WV*

Key Functional Responsibilities and Reporting

Table C.1-2 provides a brief narrative summary that highlights the key functional responsibilities and reporting requirements of each organizational unit related to our management of the Program.

Table C.1-2. Key Functional Responsibilities and Reporting

Key Functional Responsibilities	Reporting Requirements
Fostering Healthy Lives Model	
Our Fostering Healthy Lives approach incorporates population health management and care coordination interventions to bring a fully integrated approach to meeting the physical health (PH), BH, dental, and social support needs of children and youth in child welfare. As illustrated in our organizational chart, our team includes qualified staff across PH, BH, dental, pharmacy, and social supports to provide the full spectrum of care and services.	Tadd Haynes, our CEO, will maintain ultimate accountability for our model and in overseeing all aspects of the Program.
Care Coordination Team	
Our Fostering Healthy Lives Care Coordination team will focus on the safety, continuity, permanency, and well-being of members. Our Care Coordination department will be organized cross-functionally, integrating PH, BH, dental, and SNS coordination in close collaboration with utilization management (UM), member services, and other supporting staff. Our regionally assigned Care Coordination teams will include licensed BH Clinicians, social workers, and nurses, supported by Concierge Representatives. They are supported by UM Clinicians who work closely with Care Coordinators when evaluating the need for services requiring UniCare authorization. Our Care Coordination team staff must bring experience working with a social work agency, child welfare (including lived) experience, or a combination of relevant experience. They will have a knowledge of local social support services and organizations; and demonstrated understanding and sensitivity of	Our Fostering Healthy Lives Care Coordination team will report to Care Coordination Team Managers. Our Care Management Director, Vicky Gallagher, will oversee the entire clinical team.

Key Functional Responsibilities	Reporting Requirements
child welfare population, including impact of trauma and trauma-based approaches.	
Fostering Healthy Lives Concierge Team	
Our Fostering Healthy Lives Concierge team of dedicated, non-clinical representatives will be specially trained to provide assistance and serve as a central contact point for children, caregivers, providers, Department caseworkers, and court representatives. The Concierge team will conduct an intake process when a new member is identified, including verifying demographic information, outreaching to the Bureau for Children and Families (BCF), obtaining necessary records, completing the HRS, and scheduling and linking to providers to meet HRS requirements. Our team members will have demonstrated experience acting as trusted advisors on health care-related inquiries and coaching members on plan benefits and appropriate programs and offerings. The Concierge team will serve as an easy-to-reach point-of-contact for all questions and concerns from all stakeholders. Members and their families can reach our team to help with scheduling appointments, transportation support, and more. Our Concierge team will also conduct initial and continuing education and awareness to members and caregivers, State partners, providers, and other stakeholders about the role of the Concierge team and Care Coordinators.	Sylvia Berger, Member Services Director, will oversee the Concierge team.
Fostering Independence Coordinators	
Our Fostering Independence Coordinators will be dedicated to helping transition age youth successfully move into adulthood, and teaching self-management skills to achieve independence. They will work with community organizations and State agencies to address issues such as homelessness, mental health, public health, juvenile justice, education, and exploitation, and will also work to resolve system challenges and assist youth in developing and achieving their goals. These Coordinators work in conjunction with the assigned Fostering Healthy Lives Care Coordinator and do not take a primary role in managing a member's care.	These Coordinators also report directly to the Care Coordination Team Managers, who in turn, report to Vicky Gallagher, the Care Management Director.
Provider Relations	
Our Provider Relations team aligns the various activities that support providers, including network development, contracting, payment strategies, provider collaboration, demographics and directories, and provider communications to execute our Provider Pledge and deliver a seamless experience. The team works directly with the providers in the very communities they live and offers them technical assistance, training, support, resources, and tools they need to focus on member care. Our collaborative approach facilitates identification of opportunities to improve the effectiveness and efficiency of their practices through education and practice tools. Our knowledgeable, locally based provider network staff has more than 80 years of combined experience in recruitment and provider service in West Virginia Medicaid.	Our Provider Relations Director, Terri Roush, will oversee the team.
Quality Management	
The Quality Management (QM) team provides effective monitoring, reporting, and analysis so that we can act on opportunities to improve clinical care and services. The team plays a critical role in helping us achieve high scores on quality measures, which means our members are receiving effective care. They also provide health education to children and families, providers, and community partners, forming lasting relationships across communities. The team works to close crucial gaps and conducts clinical quality interventions for both providers and members. They also are	Victoria Warner, our Quality Director, will oversee our QM program's daily activities and verify goals remain on target.

Key Functional Responsibilities	Reporting Requirements
responsible for overseeing compliance with NCQA and other accreditation standards, as well as grievances and appeals. The team reports up through the Quality Improvement Committee, which oversees all our quality management/quality improvement (QM/QI) and Quality Assurance and Performance Improvement (QAPI) programs.	
Community Training and Engagement Team	
Our Community Training and Education team will be led by an experienced and dedicated Specialist who will oversee development of the Program's education, training, and outreach strategy, including development and delivery of expert, customized training to various audiences and in different formats. These Representatives will be strategically positioned throughout West Virginia to identify local training needs, collaborate with local subject matter experts, and provide trainings in local forums. We have also added a Career Development Specialist to this team who will help to assure foster youth have access to resources through new and existing workforce development opportunities, and will help create additional career paths for transition age foster youth.	Community Engagement Director Natalie Robinson will oversee the Training and Engagement Team, including development, evaluation, and continuous improvement of the Program's education, training, and outreach strategy.
Technology Services and Claims	
Our Technology Services area represents a multifaceted team of professionals with the primary goal of maintaining and advancing an information security program that protects our technology resources, infrastructure, data, and information assets against unauthorized use, disclosure, modifications, damage, and loss. Our Claims operations are responsible for processing claims, adjustments, correspondence, and payment disputes; drives improvements with claim automation, productivity, and quality; supports growth, migrations, regulatory requirements, audits, and various other change related initiatives. Our team will leverage industry, national, and health plan knowledge to collaboratively work with DHHR in developing new system interfaces or resolving operational or system issues.	IT and Claims report to our Program Integrity Lead Megan Lombard.
Finance	
The Finance team is responsible for delivering all financial and actuarial services to our program. The team provides budgeting and forecasting support, cost-of-care trend analysis, rating system and product pricing support, and industry competitive analysis. Our team provides strategic analysis to impact our leadership's decision making, improve efficiency, and drive innovation.	This team reports directly to our CFO, Kevin Dean.

Screening Tools and Processes to Fill Positions

Our multi-channel recruitment approach includes traditional advertising media, social media marketing strategies, association outreach, job fairs, word-of-mouth, and staff and community referrals. Our existing staff are well connected to the local communities, organizations, and individuals who currently serve children, youth, and families; and we will leverage these informal networks to identify potential staff. We have attracted high caliber employees by setting high standards for ourselves, which draws people with those same high standards eager to put their skills to use in a meaningful way. This helps us further our policy and practice of hiring our employees from the communities where they know and understand the populations they serve.

UniCare was one of eleven West Virginia companies named a "Five-Diamond Employer" in 2019 by the State's Chamber of Commerce. This designation recognizes outstanding companies for their employee policies, continuing educational opportunities, community service participation, and empowerment of employees. All West Virginia Chamber member companies doing business in the Mountain State were eligible for the award.

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In addition, we partner with external organizations, colleges and universities, and our nine employee resource groups to recruit, retain, and develop a workforce that reflects the communities we serve, and implement best practices to offer an inclusive environment for all. Our formal recruitment screening and process (Figure C.1-3) begins with determining the skills and qualifications a position requires and how it factors into our overall Initial Staffing Plan. We use a centralized recruiting system to post job openings internally and externally. The Talent Acquisition department includes recruiters, sourcing specialists, and administrators who support all of our affiliates in locating top-level talent. We also use succession planning strategies to recruit from within and to conduct behavioral interviewing techniques to screen internal and external candidates.

Figure C.1-3. UniCare's Recruitment Cycle Helps Locate and Hire the Right People



Replacing Key Staff (MR039)

Through our Initial Staffing Plan, we focus on retaining key personnel by making sure they have the resources they need to succeed. The success of our operations depends on qualified key personnel and stable staffing across all levels of our organization, as well as flexible policies and processes to facilitate contingency plans for filling key positions.

When a key staff member departs, our current leadership team is qualified to easily step in on an interim basis to prevent disruption to our operations. We will meet DHHR's requirements and replace any key staff position within 30 days after a position is vacant, using the following strategies:

- Identifying at least one backup for each key personnel position (as an established and trusted partner for 16 years, we know West Virginia and can readily deploy additional resources and provide any needed training while we work to acquire a permanent replacement)
- Re-allocating work assignments and mobilizing backups quickly to deliver needed services
- Identifying employees at our parent company and affiliates who can provide backup temporarily, while we work to fill the vacant position

We maintain a list of eligible and highly qualified individuals we can expeditiously recruit for any of the key positions. This list includes individuals we have interviewed, local experts in specific areas, qualified employees of UniCare interested in taking on new responsibilities, and individuals referred to us by our State representatives, providers, and other stakeholders.

Succession Planning: Key to Staffing Success

With succession management, we have created a pipeline of leadership talent to execute our business strategies, minimize disruption when replacing personnel becomes necessary, and invest proactively in our leadership so we have readily available talent to fulfill vacant roles. To facilitate this, we use an online tool for directors, executives, and key leadership in our organization to describe job preferences that best align with their experience and aspirations. In addition, leaders complete a career summary where they may outline their experience, education, achievements, and competencies. We use this information to complete a succession plan for leadership positions within our organization. Having a strong pipeline of talent helps us fill critical leadership positions with individuals who have the necessary skills to take our company into the future.

Hiring Plan for Administration of the Contract

Our comprehensive Hiring Plan represents an extension of our Initial Staffing Plan, and will include our activities following Contract award. Given that the most intensive hiring phase occurs at the beginning of a new program, our Initial Staffing Plan reflects extensive planning to identify the type and number of employees needed across all areas of the organization. Our Hiring Plan represents the ongoing plan and strategies we will use to recruit and retain qualified, well-trained employees to help make sure children and families receive the services they need, and that we meet all DHHR requirements outlined in the Service Provider Agreement and RFP requirements.

Staffing Numbers to Serve the Foster Care Program

As indicated earlier, we anticipate our local West Virginia team will include 152 full-time employees, with over 85% located throughout West Virginia. We fill positions based on where each employee can serve most effectively, which means our member- and provider-facing employees and our leadership will remain local in West Virginia. We locate our administrative support functions at offices that maximize operational consistency and efficiency through cross-training, shared technology, and shared management services.

Through our Initial Staffing Plan, we have the ability to flex the projected headcount as staffing assumptions change. We will adjust staffing levels based on changes in volume and service delivery. We begin the process by staffing based on whether each position is fixed, variable, or semi-variable in relation to the projected membership. Fixed positions, such as that of Contract Administrator/Medicaid Liaison, do not vary by membership or specific workloads but support fixed deliverables, compliance, and management. We will augment staffing based on increases in membership, the makeup of members, and their specific level of care needs, as well as other volume-dependent activities.

We have built all these factors into our staffing model, and we will continually review our staffing levels and quality of service standards to determine whether we need additional employees to adequately support members, providers, and DHHR. Each manager and department will routinely review their specific responsibilities and determine their current capacity by monitoring any changes in volume, membership, program updates, and service delivery to adjust staffing levels to meet our members' needs.

We recognize that only a locally-developed West Virginia staff will best serve this population; however, our management will work closely with their counterparts in our affiliate health plans to share best practices, review new processes and programs, and determine whether global or systemic changes may offer opportunities to enhance service delivery locally. We will use lessons learned from our affiliates to determine whether best practices within a specific service will require additional staff. Based on that information, managers will refine existing staffing plans, identify additional resources that can be rapidly mobilized, continue to provide required training, and work with other departments to identify operational efficiencies.

Plan for Hiring Care Coordination Staff

We anticipate hiring at least 59 Care Coordinators of varying backgrounds for specialized care across the State, ideally at least three months prior to Contract implementation to provide sufficient time for extensive training. We recommend a case-mix methodology that uses a weighting system to assist in determining average Care Coordinator-to-member ratios, and look forward to working with DHHR to develop these upon award. Based on this methodology, our suggested ratio for our members in our highest level of care coordination, the complex level, is one Care Coordinator per 50 members (1:50). Our proposed maximum caseload is 350, assuming we will have a high volume of members who are stable and will be in our Connected level of care coordination. Our maximum caseload includes the expected levels of member engagement based on our experience in West Virginia and our affiliate experience serving members engaged with the child welfare system. For additional detail regarding our hiring plan for Care Coordination staff please see our response in CM046 and CM047.

Additional Program-specific Training



Our Initial Staffing Plan emphasizes ensuring our employees have the resources, tools, training, and assistance they need to successfully fulfill their roles. Ongoing training across the organization is integral to UniCare's success and for improving outcomes for the children, youth, and families we serve.

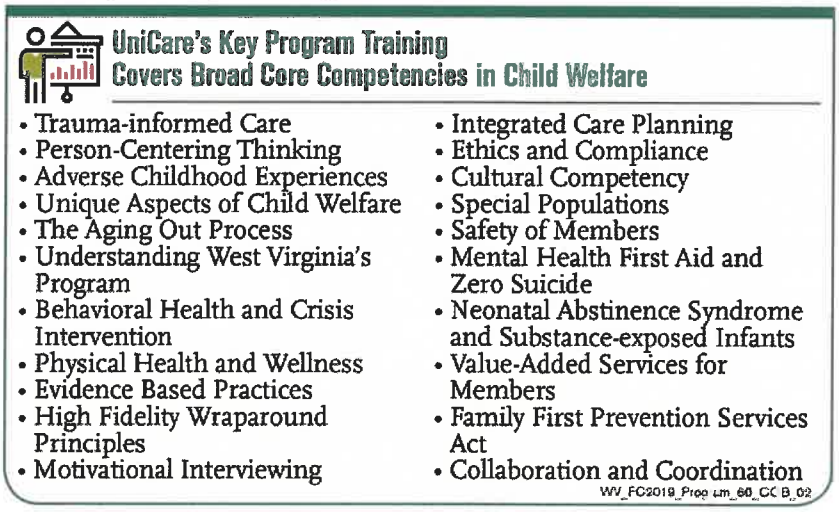
Our UniCare Training Academy will support all initial and ongoing training for staff, acting as a vehicle to facilitate a robust, consistent, compliant, and comprehensive approach. It streamlines the development, delivery, and reporting of training into one easy-to-use, scalable system; and it incorporates multi-modal training and mechanisms for tracking, monitoring, and alerting, as well as reporting compliance and training completion. Through its comprehensive features, it will include required, regionally identified, culturally competent, and program-specific training, and will be updated regularly to remain relevant and topical.

Our training includes a comprehensive, tailored curriculum to assure all our employees across all operational areas receive the appropriate information and education to fulfill their responsibilities and duties, as outlined in the RFP. Further, we recognize and support DHHR's requirement for additional training, particularly for the Contract Liaison/Medicaid Administrator beyond the topics of health care in general, serving Medicaid populations, and cultural sensitivity, for example. We know that children and youth who will be served through the Program have unique needs, and our training program will reflect this.

Our training plan will be developed by UniCare staff with extensive West Virginia experience, and will leverage subject matter experts who have child welfare experience and expertise in such areas as trauma-informed care, Adverse Childhood Experiences (ACEs), and evidence-based practices. Employees will receive both classroom training and job shadowing and mentorship to foster opportunities for discussion and questions.

Specialized Content for Our Clinical Staff

Our clinical team will receive a 90-day orientation and training period during which they learn the basic functions of their job and the policies and procedures that will govern our Fostering Healthy Lives model operations. We make sure they are well versed in Contract requirements and fully understand their roles and responsibilities.



At the center of our comprehensive curriculum is the system of care approach based upon the High Fidelity Wraparound model — full integration of physical, behavioral, functional, and social health. All our clinical employees must master the requisite skills to oversee and coordinate care for members with co-occurring disorders. Training supports the intake, stratification, and care coordination team in the multidisciplinary development of a Fostering Healthy Lives Care Plan (Care Plan) for the individual. It is the foundation for effective communication across the member's system of care. This initial training includes skills practice sessions throughout to reinforce the information taught. For additional information on our specialized training content for clinical staff please see our response in CM047.

Approach to Subcontracting Services

UniCare views subcontractors as valued partners in delivering the highest quality services to members, providers, and DHHR. As an incumbent health plan serving Medicaid-eligible West Virginians since 2003, we have established a proven approach to working with subcontractors to coordinate seamless delivery of services. Our approach centers on identifying areas where DHHR, our members, and providers can be best served through subcontractors with specialized capabilities and whose core business represents a capability required by the State's Contract.

UniCare retains sole responsibility for fulfilling West Virginia Contract requirements. We are fully accountable for our subcontractors' performance through processes implemented to monitor, supervise, and enforce Contract compliance. Additionally, we promote frequent, open, and effective communication that emphasizes delivery of quality services to members. These well-defined processes have proven successful throughout our tenure in West Virginia and across our affiliate health plans in 22 other markets.

Activities and Tools to Monitor Each Subcontractor

We are proposing seven subcontractors to provide services as listed in Table C.1-3.

Table C.1-3. Seven Subcontractors Will Provide Specialized Services Required by the Contract

Subcontractor Name	Services Provided by Subcontractor
Anthem, Inc. (Anthem)	Administrative services
Advanced Medical Reviewers, LLC (AMR)	Utilization management, clinical chart reviews
Exela Technologies, Inc. (Exela)	Paper claims keying, provider correspondence, claims data capture services
SKYGEN USA, LLC (SKYGEN)	Dental Benefits Manager
Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Access and availability provider surveys
Vision Service Plan Insurance Company (VSP)	Vision Benefits Manager
Wipro Limited (Wipro)	Claims adjudication, claims processing

Health Plan Level Oversight

UniCare benefits from a multi-level approach to subcontractor management that is overseen at the health plan level, but supported by national departments focused on subcontractor management. At the local health plan level, UniCare's Subcontractor Oversight Committee regularly meets with subcontractor representatives and our national Subcontractor Managers who are their day-to-day liaisons to review reports that enable us to monitor performance and confer with subcontractor representatives. The Subcontractor Oversight Committee comprises representatives from UniCare, Compliance, Quality, and Operations. ***Additionally, UniCare will hire a West Virginia-based Subcontractor Oversight Manager who will lead the Subcontractor Oversight Committee and expand its scope under the Program.***

Subcontractor Managers assigned to each subcontractor are responsible for focused day-to-day management, oversight, and ongoing communication with that subcontractor. Managers are assigned to subcontractors based on area of expertise, thereby maximizing their level of collaboration and effectiveness in monitoring performance. Subcontractor Managers keep the Subcontractor Oversight Committee apprised of concerns with, or significant changes at, the subcontractor. This approach places a subject matter expert as the first line of oversight while giving UniCare overall responsibility for overseeing subcontractor performance.

National Oversight Committees

National oversight committees provide an additional level of support to our program. Regular communication between these committees and our West Virginia Oversight Team maintains focus on delivering high-quality services to our members. National oversight functions include:

- The **National Quality Improvement Committee,** which meets quarterly and reports any quality or compliance issues to local committees, including those related to subcontractors.
- The **Delegate/Vendor Oversight and Management Committee (DVOMC)** which oversees subcontractors serving multiple health plans. It is responsible for compliance with state, federal, NCQA, CMS, and individual program requirements and standards, as well as other regulatory or accreditation standards. It reports to the National Quality Improvement Committee quarterly.
- The **Delegation Operations Committee (DOC),** which includes representatives from account management, quality, legal, compliance, and other areas as needed. Reporting to the DVOMC monthly, the DOC assesses oversight and compliance, monitors corrective action plans (CAPs) (including recommending escalation), evaluates subcontractor performance through reports analysis, and makes recommendations to DVOMC on findings as well as the use of audit tools.
- **Joint Operations Committee (JOC)** Meetings, which are held quarterly to assure appropriate oversight and communication occurs between the national teams, health plans, and Plan Compliance Officers. Meeting agendas can include national and health plan

updates, delegate updates, delegated function report overview, market-specific issues and collaborative project reports, and many other items. The Subcontractor Managers report meeting minutes, including significant deficiencies identified and reported to the DVOMC, are made available for the annual State audit or internal audits.

Subcontractor Selection and Oversight Program Activities

Our Subcontractor Oversight Program begins with a thorough, rigorous evaluation process to confirm subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical standards. We use our internal regulatory guidelines, policies, and procedures to vet and evaluate new subcontractors, including our Subcontractor Management Due Diligence Policy, Medicaid Disclosure of Ownership Policy, and Medicaid Offshore Governance Policy.

During our pre-delegation audit, we examine items such as the organization's HIPAA privacy and security compliance, grievance and appeals history, operating procedures, staffing ratios, and financial viability. We audit our subcontractors for their comprehension of these items and their ability to train providers on such items. We offer guidance and instruction for our subcontractors on topics such as UniCare policies and procedures; HIPAA compliance; fraud, waste, and abuse avoidance and prevention; and cultural competency. When possible, we also check credible references in the industry on subcontractor service delivery.

Our program enables us to monitor subcontractor performance and financial stability. In collaboration with our QM department, we also monitor subcontractor over- and under-utilization and adherence to complaint and grievance policies and procedures. We tailor our program, including scope and frequency of oversight, to functions and services each subcontractor provides. We outline our ongoing oversight activities in Table C.1-4.

Table C.1-4. Our Oversight Program Monitors Subcontractors Throughout the Life Cycle

Timing	Oversight Activities
Daily	• Subcontractor Managers and Subject Matter Experts work with subcontractors as necessary to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns
Monthly	• Complete Performance Indicator dashboard on each subcontractor • Review performance against standards, including trends, and report submissions • Review performance with subcontractor, Subcontractor Managers, and WV Oversight Team • DVOMC meeting to discuss approval of delegation, performance monitoring, CAPs, and terminations
Quarterly	• JOC Meetings with UniCare leadership to review performance metrics, HEDIS and health plan-specific initiatives, and CAPs • Meet with subcontractors to discuss performance across markets and present issues, gaps, and concerns to the DVOMC or health plan • DVOMC reports to the National Quality Improvement Committee to discuss any quality issues with subcontractor performance • Report additions, terminations, CAPs, and risk to West Virginia Compliance Committee
Annually	• Perform audit or annual review to confirm that subcontractor meets operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements • Present audit findings to the DVOMC and the West Virginia Oversight Team

We customize each Performance Indicator Report for each subcontractor, representing a key component of our Subcontractor Oversight Committee. On a scheduled basis, the Subcontractor Manager and assigned subcontractor meet with the West Virginia Oversight Team to review performance against standards. The meetings provide a forum to discuss issues and brainstorm potential solutions. Our experience shows that transparency and open, constructive dialogue is critical to maintaining a collaborative partnership and seamless service delivery to members.

UniCare performs annual formal reviews of our subcontractor performance. To assure an unbiased review of performance, our subcontractors are also reviewed by our National Oversight Support Services. We utilize standardized audit tools to evaluate subcontractors prior to delegation and annually thereafter. The audit tools are functional area- and product-specific, and based on contractual, federal, and State regulatory and accreditation standards. If a CAP is required, the Audit CAP Notification letter will outline deficiencies and be sent to the Subcontractor Manager via email. The subcontractor will submit a CAP with all action items completed within 30 calendar days of the electronic receipt of their CAP Notification letter. For non-compliant CAPs or if a CAP is not received within a specified time frame, the issue will be escalated for resolution.

Improving Subcontractor Performance and Results

UniCare always strives to improve the level of service we deliver, and we expect our subcontractors to do the same. During subcontractor oversight and monitoring, we not only review areas with substandard performance, but also seek out opportunities to "raise the bar" and deliver better service. For example, we use our Performance Indicator Report to monitor performance, track actions taken to improve performance, set new targets, and drive positive results from our subcontractors (included as Supplemental Document C.1-2).Clearly defined expectations and consistent performance monitoring is a key piece of our Subcontractor Oversight Program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we will take action and work closely with the subcontractor toward a resolution and return to complete and ongoing compliance. If we identify a performance or operational problem with a subcontractor, we immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions. UniCare views interventions not as a punitive action, but rather a documented process to improve performance and more closely collaborate with our subcontractors. The type of intervention depends on a combination of factors, including the severity of the issue and historical performance. We track and monitor all interventions. If interventions are unsuccessful in generating a sustained performance improvement, we consider termination and promptly notify DHHR.

Sample Subcontractor Agreements

See Supplemental Document C.1-1 for a sample of a general Master Services Agreement.

Benefit Manager and UniCare Functions

In Table C.1-5, we identify the functions our benefit manager subcontractors perform, and we identify which of these functions UniCare performs as the Vendor.

Table C.1-5. Benefit Manager Subcontractor Functions and Vendor Functions

Function	Performed by SKYGEN (Benefit Manager)	Performed by VSP (Benefit Manager)	Performed by UniCare (Vendor)
Member/Provider - Grievances and Appeals			Yes
Provider Recruitment	Yes	Yes	Yes
Member and Provider Calls	Yes	Yes	Yes
Utilization Management	Yes		Yes
Provider Education	Yes	Yes	Yes
Fraud, Waste, and Abuse			Yes

Subcontractor Reports and Data to Help UniCare Manage Benefits

UniCare monitors all subcontractors with which we have contractual and other performance requirements. We require subcontractors to submit two primary report types: data we need to fulfill regulatory reporting requirements and operational information to monitor their performance against standards. Subcontractor Managers maintain a schedule of due dates for both types of reports and collaborate with subcontractors if they are late or submit incomplete or inaccurate data. During implementation, we will review DHHR reporting requirements and identify the subcontractor data we need (including format and due date) to present a collaborative and complete picture of our West Virginia Foster Care Contract activities. For all reports, we identify an internal due date prior to DHHR deadline to provide time for a thorough quality review. For sample reports, please refer to Supplemental Document C.1-2 where, for review, we provide samples of a Performance Indicator Report and GeoAccess® Map for both SKYGEN and VSP.

SKYGEN provides UniCare with more than 20 reports to help us manage benefits. The subset of reports shown in Table C.1-6 includes those used to **assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care** (QU050, QU051, QU052).

Table C.1-6. SKYGEN Routinely Provides UniCare with More than 20 Different Reports, Including the Five Listed

SKYGEN Report	Frequency	How we use report data to assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care	Does this report help us manage the medical, social, or any other benefit?
Appeal and Denial Letters	Quarterly	Used to monitor state and contract metrics and provide oversight of performance	Yes
Authorization Denial Report	Monthly	Used to monitor state and contract metrics and provide oversight of performance	Yes
Medicaid GeoAccess®	Quarterly	Used to monitor member access to providers	Yes
Performance Indicator Report	Monthly	Used to monitor state and contract metrics and provide oversight of performance	Yes
Provider Satisfaction Survey	Annually	Used to monitor member access and satisfaction	Yes

Similarly, VSP provides UniCare various reports to help us manage benefits. We have included two sample reports as Supplemental Document C.1-2 and listed in Table C.1-7.

Table C.1-7. VSP Routinely Provides UniCare Reports to Help Manage Benefits

VSP Report	Frequency	How we use report data to assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care	Does this report help us manage the medical, social, or any other benefit?
Medicaid GeoAccess	Quarterly	Used to monitor member access to providers	Yes
Performance Indicator Report	Monthly	Used to monitor state and contract metrics and provide oversight of performance	Yes

Leveraging Reports and Data to Increase Member Access, Satisfaction, and Continuity of Care

UniCare uses reports to identify and address performance issues, such as a subcontractor falling short of a required service level agreement. In addition, we use data provided by benefit management subcontractors to enhance member care. For instance, in 2018, we sent more than 80,000 reminders to members to make dental appointments. We also use subcontractor

supplied dental claims to monitor member adherence to annual dental visits. In 2018, UniCare representatives placed 270 reminder calls to members who had missed an annual dental visit. This outreach has resulted in gains in the Annual Dental Visits HEDIS measures as given in Table C.1-8. We will continue to utilize claims and other dental subcontractor supplied data to drive member satisfaction and continuity of dental care.

Table C.1-8. HEDIS Score Improvements from 2018 to 2019

Measure	HEDIS 2018 (MY 2017)	HEDIS 2019 (MY 2018)
Annual Dental Visits for 2-3-year-olds	39.87	41.17
Dental Sealants for 6-9-year-olds	25.02	51.32

Exchanging Information and Data

UniCare will require our subcontractors to send and receive data files and other information on a specified schedule. We will use secure transmission methods to exchange all information and data with our subcontractors. Data files will typically be exchanged using secure file transfer protocol or other secure communication protocol. Reports and other information will typically be exchanged through encrypted email or other secure methods.

We will document not only the schedule (frequency, day, and time), but also the format and secure transmission method. If we do not receive a file on its due date, an email alert will notify the Subcontractor Manager to ascertain the status and reason for the delay.

Adhering to Complaint and Grievance Policies/Procedures

UniCare records and resolves all member complaints and grievances, including those for subcontractor services. ***We do not subcontract the processing and resolution of member complaints and grievances.*** Our West Virginia-based team oversees the entire process (intake, investigation, and resolution), working closely and collaborating with our subcontractors. We instruct subcontractors to forward member complaints and grievances to UniCare.

Subcontractors are responsible for addressing provider complaints and grievances per their agreements with their providers. Review of subcontractors' Performance Indicator dashboards verifies their adherence to provider complaint and grievance requirements, standards, policies, and procedures. We know prompt attention and resolution of complaints and grievances is an important component of provider satisfaction and our members' ability to receive services. The Subcontractor Manager and West Virginia UniCare Oversight Team promptly and thoroughly address any performance variances with our subcontractors.

Identifying Frequency of Calls with Each Subcontractor

We understand the importance of frequent, ongoing contact and collaboration with our subcontractors, particularly those that provide benefits to our members — both upon go-live and ongoing thereafter. Two of our subcontractors — SKYGEN and VSP — are Benefits Providers, while the remaining five are Administrative Services Providers. Because our ***Benefits Manager Subcontractors are client-facing and our ultimate goal is to work to make sure members have no disruption in service, our frequency of calls with these subcontractors includes weekly implementation meetings, and daily post go-live calls that eventually change to monthly post go-live calls, when the contact frequency reverts to the regular schedule, which includes:***

- **A Monthly Operations Call.** A touch base and review of monthly report summaries to make sure that SLAs and contract requirements are being met
- **A Quarterly JOC Meeting.** Review performance metrics and CAPs
- **Ad hoc Meetings as needed.** Review detailed performance, monitor operational activities, and address broad scale issues

Our contact with Administrative Services Provider subcontractors tends to be less frequent as these subcontractors are not client-facing and their services are based on tested, successful processes. We are always available to both our Benefits and Administrative Services providers and immediately reach out to them as needed.

Addressing Subcontractors Unable to Fulfill Contract Obligations

If we identify a performance or operational problem with a subcontractor, we immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions. If we determine that a CAP is needed, the Subcontractor Manager, West Virginia UniCare Oversight Team, and operational areas, as appropriate, work with the subcontractor to identify the root cause, initiate corrective actions, and develop the CAP, which will include: a timeline for correcting the deficiency; dashboards to review ongoing metrics; and regularly scheduled meetings to review progress. The corrective action monitoring process ends when the subcontractor demonstrates ongoing compliance, typically for at least 90 days. Our approach to identifying and addressing subcontractor deficiencies centers on establishing and maintaining a collaborative partnership with each subcontractor and regular, consistent monitoring. The Subcontractor Manager works daily to identify and discuss resolution of performance issues early — before they become a problem. We supplement our proactive account management structure with robust monitoring, including monthly performance reporting, quarterly reviews, and annual audits. If, following an annual audit, we continue delegation of a subcontractor with a CAP, the subcontractor will submit a CAP for all noted deficiencies, which will include the time frames for completion (CAP due dates may be more immediate, if necessary, depending on the severity of the deficiency), follow-up evaluations, and deficiency resolutions of the issue(s). The subcontractor must submit the remediated CAP within the time frame specified. Follow-up assessments will be performed as needed, depending upon the nature and scope of the deficiencies. Such assessments are in addition to the annual assessment. The subcontractor must agree to implement the CAP and resolve the issue(s) within the determined time frame(s). The CAP response will be evaluated for acceptable resolution. The ongoing monitoring of the CAP and its status will be reported to the Committee monthly until all findings are resolved. A subcontractor that receives a score of Non-Compliance may be subject to escalation.

Improving Subcontractor Performance and Results

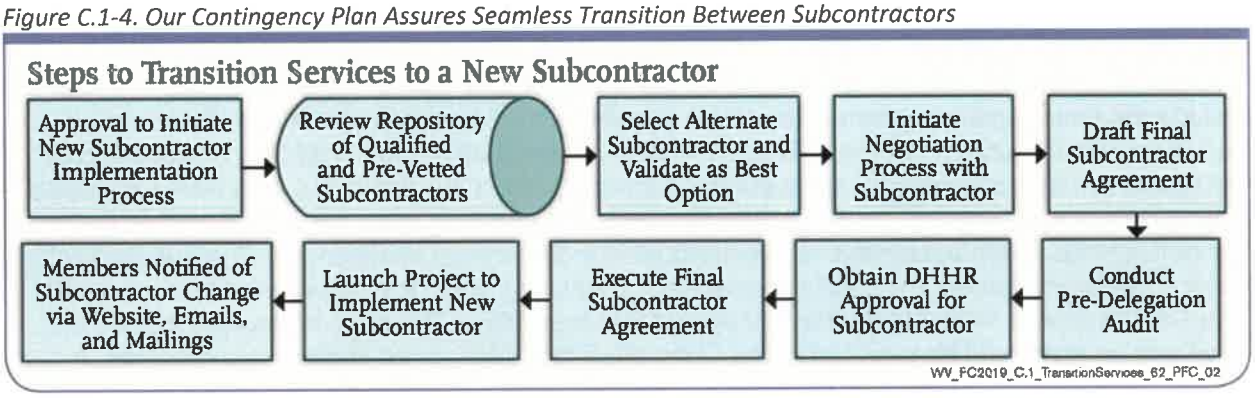
We use our Performance Indicator Report to monitor performance, track actions taken to improve performance, and drive positive results from our subcontractors. Clearly defined expectations and consistent performance monitoring is a key piece of our Subcontractor Oversight Program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we take action and work closely with the subcontractor toward a resolution and return to complete and ongoing compliance. Our subcontractor agreements outline specific SLAs, metrics, and key performance indicators that align with DHHR requirements for each function we delegate. If DHHR modifies a standard, we amend the subcontractor agreement to reflect the change. Where applicable, a program-specific addendum is part of all subcontractor agreements outlining critical components of the state contract.

Contingency Plan if Contract Is Terminated

UniCare knows a comprehensive and detailed contingency plan is critical to any change in subcontractors. Above all, we focus on making sure members have uninterrupted access to medically necessary services and continue to receive the care they need. In developing our contingency plan, we combine our planned transition workflow, lessons learned, and overall

focus on reducing risk. When a subcontractor contract is terminated, we can quickly ramp up with another subcontractor from our repository, chosen based on multiple factors, including their being licensed in West Virginia and their ability to provide continual service to members, helping us to assure no disruption in service. These subcontractors who reside in our repository are pre-vetted to make sure they are qualified to perform all work, including storage of all information, within the United States. When a subcontractor is terminated, we will provide DHHR written notice no later than five business days after receiving notice or giving notice of the intent to terminate a subcontractor for any reason. Following this submission, we will also work with the State to assure continuity of care by giving members the ability to receive services from their current provider for up to 90 days while the new subcontractor builds out their network as needed. At least 90 calendar days prior to the effective date of a new subcontract, we will submit utilization review and claims processing subcontracts to the State for approval. Lastly, we will issue a subcontractor agreement that clearly details all the performance and compliance requirements the subcontractor needs to follow, including responsibilities, reporting, and data requirements to which they must adhere. Our contingency plan includes a comprehensive set of tasks, customized for each type of subcontractor, so that necessary functions continue seamlessly. Figure C.1-4 illustrates our subcontractor contract termination contingency plan and seamless transition from one subcontractor to another.

Figure C.1-4. Our Contingency Plan Assures Seamless Transition Between Subcontractors



Subcontractor Status as Affiliate or Unrelated Third Party

Six of our seven subcontractors are unrelated third parties. Only Anthem, Inc. is an affiliate of UniCare.

MASTER SERVICES AGREEMENT

This Master Services Agreement, by and between Anthem, Inc., an Indiana corporation ("Anthem"), and _____, a _____ corporation ("Supplier"), is entered into as of _____ (the "Effective Date").

In consideration of the covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the terms and conditions contained in this Agreement.

1. **DEFINITIONS; INTERPRETATION**.

Definitions. Capitalized terms used herein shall have the meanings ascribed to them in the body of this Agreement and/or in the Exhibits and other documents attached hereto, or as defined below. Terms other than those defined herein shall be given their plain English meaning-and terms of art having specialized meanings in Supplier's industry shall be construed in accordance with industry standards. Unless the context otherwise requires, words importing the singular include the plural and vice-versa.

1.1. "Affiliate" means any entity controlling or controlled by or under common control with a Party, at the time of execution of the Agreement and any time thereafter, where "control" is defined as (a) the ownership of at least fifty percent (50%) of the equity or beneficial interest of such entity, or (b) any other entity with respect to which such Party has significant management or operational responsibility (even though such Party may own less than fifty percent (50%) of the equity of such entity).

1.2. "Agreement" means (a) the body of this Agreement, (b) any other Anthem policies and procedures, as may be modified from time to time, as set forth in Section 2, (c) any applicable Exhibits, and (d) any SOW that is entered into and signed by both Parties pursuant to this Agreement, as well as any SOW entered into subsequent to the Effective Date of the Agreement.

1.3. "Anthem Data" means, in or on any media or form of any kind: (i) all data or summarized data related to Anthem or its Affiliates, and all data indexing such data (regardless of whether or not owned by Anthem, generated or compiled by Anthem, or provided by Anthem's customers), including data that is in Anthem's or its Affiliates' databases or otherwise in Anthem's or its Affiliates' possession on the Effective Date or at any time from such date through the last day of the Term, all tapes of recorded conversations with Anthem's or its Affiliates' customers and all other information recorded by Supplier concerning Anthem's or its Affiliates' customers or the provision of the Services or Deliverables; and (ii) all other Anthem or its Affiliates' records, data, files, input materials, processed data, reports and forms that may be received, computed, developed, used, or stored by Supplier, or by any of Supplier's subcontractors, for Anthem or its Affiliates in the performance of Supplier's duties under the Agreement, but excluding in any event any internal data and information of Supplier and its subcontractors.

1.4. "Anthem IP" means (i) any IP made, conceived, developed, purchased, or licensed by Anthem or its Affiliates, or by third parties under contract to Anthem or its Affiliates, prior to the Effective Date of the applicable Statement of Work or PCWA, (ii) any IP provided by Anthem or its Affiliates or their respective agents to Supplier for incorporation into the Deliverables or use in connection with the Services (including any Anthem Data, images, programming, computer code, photographs, illustrations, graphics, audio clips, video clips and text), and (iii) any modifications or enhancements to the foregoing.

1.5. "Applicable Laws" shall mean all international, federal, state and local laws, statutes, ordinances, codes, rules, regulations, standards, orders (which are applicable to Anthem or Supplier),

licenses, or permits of any governmental entity or other authority that reasonably relate to performance under this Agreement in any applicable jurisdiction (whether within the United States or in any other country).

1.6. "BCP" has the meaning ascribed in Section 4.9.1.

1.7. "Confidential Information" has the meaning ascribed in Section 10.2.

1.8. "Custom IP" means IP made, conceived, or developed by Supplier or any subcontractor for Anthem or its Affiliates in creating the Deliverables or performing the Services. Except for the licenses granted herein, Custom IP does not include Supplier IP or Third-Party IP.

1.9. "Deliverable" or "Deliverables" means the tangible or intangible items produced by Supplier for Anthem or its Affiliates pursuant to a Statement of Work. Deliverables are a subset of Services and any reference to "Services" hereunder shall be deemed to include any Deliverables to be provided under an applicable Statement of Work. "Documentation," is a subset of Deliverables and any reference to Deliverables shall be deemed to include reference to any related Documentation.

1.10. "Documentation" shall mean all manuals, descriptions, instructions or other materials, that are in existence or may come into existence during the period Supplier is providing Deliverables, Supplier-Provided Materials and/or Services hereunder and which describe the operation, maintenance, functionality and use of such Deliverables, Supplier-Provided Materials and/or Services, as applicable.

1.11. "Exhibit" or "Exhibits" shall include, when applicable, Exhibit A (Business Associate Agreement), Exhibit B (Medicare Advantage and Medicare Part D Regulatory Exhibit), Exhibit C (Federal Program Commercial Item Addendum), Exhibit D (Diversity Supplier Compliance Exhibit), Exhibit E (State Medicaid Attachments), Exhibit F (Required Information Security Controls), Exhibit G (Qualified Health Plan Regulatory Exhibit), or any other Exhibits attached hereto.

1.12. "Expenses" has the meaning ascribed in Section 3.1.

1.13. "Fees" has the meaning ascribed in Section 3.1.

1.14. "Force Majeure Event" has the meaning ascribed in Section 17.7.

1.15. "IP" means all concepts, inventions (whether or not protected under patent laws), works of authorship, information fixed in any tangible medium of expression (whether or not protected under copyright laws), moral rights, mask works, trademarks, trade names, trade dress, trade secrets, publicity rights, names, likenesses, know-how, ideas (whether or not protected under trade secret laws) and all other subject matter protected under patent (or which is not patented, but is subject matter that is protected under patent law), copyright, mask work, trademark, trade secret, or other laws, whether existing now or in the future, whether statutory or common law, in any jurisdiction in the world, for all media now known or later developed, including all new or useful art, combinations, discoveries, formulae, algorithms, specifications, manufacturing techniques, technical developments, systems, computer architecture, artwork, software, programming, applets, scripts, designs, processes and methods of doing business.

1.16. "Nonpublic Personal Financial Information" or "NPFI" shall have the same meaning as "Nonpublic Personal Information" in 15 USC, Subchapter I, Sec. 6801-6809, of the Gramm-Leach-Bliley Act. NPFI may also be referred to herein as "Personally Identifiable Information."

1.17. "Party" means Anthem or Supplier; "Parties" means Anthem and Supplier.

1.18. "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. § 160.103, limited to the information created or received by Supplier from or on behalf of Anthem.

1.19. "Service Credits" has the meaning ascribed in Section 4.4.4.

1.20. "Service Levels" has the meaning ascribed in Section 4.4.1.

1.21. "Services" shall mean all services performed under the Agreement pursuant to a properly authorized and executed Statement of Work, together with any or all of the acts, services, tasks, subtasks, work, and/or Deliverables reasonably required to provide Anthem with such services in accordance with this Agreement, whether or not such inherent or implicit acts, services, tasks, subtasks, work and/or Deliverables are expressly identified in the Statement of Work (other than such acts, services, tasks and materials that Anthem or its representatives are responsible for providing as expressly listed in the applicable Statement of Work).

1.22. "Statement of Work" or "SOW" means the document, in the form provided by Anthem, describing the services, functions, responsibilities and projects to be performed thereunder, in accordance with this Agreement, and signed by authorized representatives of both Parties.

1.23. "Supplier IP" means IP made, conceived, developed, purchased, or licensed by Supplier or its Affiliates, or by third parties under contract to Supplier or its Affiliates, (i) prior to the effective date of the applicable Statement of Work or PCWA or (ii) independent of the Services, that, in case of both (i) and (ii) above: neither contains Anthem IP or any derivative works thereof; nor uses, includes or refers to Confidential Information of Anthem. For the avoidance of doubt, Supplier IP does not include Custom IP or any other Anthem IP.

1.24. "Supplier-Provided Materials" shall mean all materials, systems, goods, processes, and/or any other item, as applicable, provided by Supplier and delivered or made accessible to Anthem for Anthem's use or benefit as identified in an Exhibit or SOW.

1.25. "Term" has the meaning ascribed in Section 7.1.

1.26. "Third-Party IP" means IP licensed, made, conceived, or developed by a third-party and used by Supplier in creating the Deliverables or performing the Services.

1.27. "Transferred Entity" has the meaning ascribed in Section 1.34.

1.28. Applicability of Definitions. The definitions contained in this Agreement shall apply to each SOW.

1.29. Requirement of a SOW; Order of Precedence. For each engagement under this Agreement, the Services to be performed by Supplier at Anthem's request will be described in an SOW. Each SOW and each amendment thereto must be signed by both Parties and must state that it is made pursuant to this Agreement. Each SOW shall constitute a separate agreement which incorporates the terms and provisions of this Agreement. The provisions of this Agreement shall control over any conflicting provisions in an SOW or Exhibit, except to the extent the SOW or Exhibit indicates the clear intent of the parties that such conflicting term prevail over a term or condition of this Agreement. Notwithstanding the foregoing or any other provision of this Agreement to the contrary, in the event of any inconsistency or conflict between the terms and conditions of this Agreement and the terms and conditions of any of the

following Exhibits, if such Exhibits are attached to this Agreement, then the terms and conditions of the following specified Exhibits shall prevail over the terms and conditions of the main body of this Agreement or any SOW: Exhibit A (Business Associate Agreement), Exhibit B (Medicare Advantage and Medicare Part D Regulatory Exhibit), Exhibit C (Federal Program Commercial Item Addendum), Exhibit E (State Medicaid Attachments), Exhibit F (Required Information Security Controls), Exhibit G (Qualified Health Plan Regulatory Exhibit). An SOW or Exhibit may contain additional terms, provided that the terms do not conflict with the provisions of this Agreement.

1.30. Interpretation. The use of the terms "including," "include" or "includes" shall in all cases herein mean "including without limitation," "include without limitation" or "includes without limitation," respectively.

1.31. Number and Gender. Words importing the singular include the plural and words importing the masculine include the feminine and vice versa where the context so requires.

1.32. No Primary Drafter. The Parties acknowledge and agree that they have mutually negotiated the terms and conditions of this Agreement and that any provision contained herein with respect to which an issue of interpretation or construction arises shall not be construed to the detriment of the drafter on the basis that such Party or its professional advisor was the drafter, but shall be construed according to the intent of the Parties as evidenced by the entire Agreement.

1.33. Anthem Affiliates. Supplier acknowledges and agrees that Anthem and all of its Affiliates (as they may exist during the term hereof) may all engage Supplier to perform Services and deliver Deliverables under this Agreement. In addition, Anthem Affiliates shall be entitled to receive the benefits of the Services and Deliverables under this Agreement; provided that they shall be deemed to be bound by the terms and conditions contained herein. In no event shall Anthem, Inc. be deemed or understood to administer or insure health care plans and/or health care delivery services.

1.34. Transferred Entities. In addition to Section 1.33 above, if any time during the Term Anthem sells or otherwise transfers ownership of a business unit or Affiliate (a "***Transferred Entity***") using any Services or Supplier-Provided Materials or entitled to purchase Services or Supplier-Provided Materials hereunder, at Anthem's option the Transferred Entity may continue to use or maintain the right to purchase such Supplier-Provided Materials and/or Services for a period not to exceed six (6) months, under the terms and conditions of this Agreement, provided such Transferred Entity signs an agreement with Supplier agreeing to be bound by the terms and conditions of this Agreement and Supplier shall cooperate with Anthem, the Transferred Entity and any new supplier in a transition to a new supplier's products and/or services.

2. ANTHEM POLICIES AND PROCEDURES.

2.1 Sources. In addition to all other obligations contained herein, Supplier and its sub-contractors shall adhere to the then-current and applicable Anthem policies and procedures described in this Section and this Agreement. The policies and procedures are expressly referenced and incorporated into this Agreement and are either attached as exhibits to this Agreement and/or provided to Supplier via the web site addresses listed below (or any successor site or communication designated by Anthem).

Supplier Relations Webpage: https://www.antheminc.com/Suppliers/index.htm

(a) Supplier Code of Conduct

(b) Supplier Reimbursable Expense Guidelines
(c) Procurement Process Technology and Electronic Signatures

(d) Requirements for Onsite Personnel

(e) Exhibit A: Business Associate Agreement ("BAA")

(f) Exhibit B: Medicare Advantage and Medicare Part D Regulatory Exhibit

(g) Exhibit C: Federal Government Services Addendum for Commercial Items

(h) Exhibit D: Diversity Supplier Compliance Exhibit

(i) Exhibit E: State Medicaid Attachments

(j) Exhibit F: Required Information Security Controls

(k) Exhibit G: Qualified Health Plan Regulatory Exhibit

3. **INVOICING AND PAYMENT; AUDIT**.

3.1 Payment of Fees and Expenses. Supplier shall invoice Anthem for the fees as set forth in each SOW, as applicable ("***Fees***"). Except for (i) the Fees and (ii) expenses agreed to in an applicable SOW and incurred in accordance with this Agreement ("***Expenses***"), no other amounts shall be charged by Supplier or payable by Anthem. Anthem shall have the right of offset against amounts owed to it by Supplier. If a SOW specifies that Anthem is to pay Supplier's Expenses for travel, meals and lodging, Anthem shall reimburse Supplier for actual, necessary and reasonable Expenses for: (a) travel by non-local Supplier personnel to a site specified by Anthem to perform services under a SOW; and (b) meals and lodging for such non-local personnel while performing such services. Such Expenses shall not under any circumstances include airfare other than coach. Anthem shall not be billed for travel time.

3.2 Anthem Invoice Requirements.

3.2.1 General. Supplier shall invoice Anthem for all Fees and, if applicable, Expenses via the Anthem Invoice online tool in accordance with the then current requirements at Anthem, Inc. Policies and Procedures (https://www.antheminc.com/wellpoint/groups/wellpoint/@wp_suppliers/documents/wlp_assets/pw_e226861.pdf) and as stated in the Procurement Process Technology and Electronic Signatures provisions therein. Supplier shall not charge Anthem for researching, reporting or correcting errors related to invoices. The invoice date shall not be earlier than the date on which Supplier is entitled to payment under the applicable SOW, or if not specified in the SOW, invoices may be issued monthly in arrears. Unless otherwise specified in a SOW, rates under a SOW or rate card Exhibit attached to this Agreement shall be fixed for the greater of (i) the initial term or (ii) five (5) years. Thereafter such rates shall not increase more often than annually and such increases shall not exceed the lesser of (i) the Consumer Price Index for All Urban Consumers (CPI-U): U. S. city average or (ii) three percent (3%) above the immediate prior rate. Supplier shall give Anthem at least ninety (90) days prior written notice of any increase in rate. Anthem shall not be responsible for any Fees or Expenses invoiced more than four (4) months after the close of the month to which such fees or expenses relate. Each such invoice shall contain sufficient detail to allow Anthem to identify all Services rendered.

3.2.2 Procurement Process Technology Fees. Supplier will be solely responsible for all expenses associated with transmitting and receiving documents via Anthem's Procurement Process Technology.

3.3 Payment by Anthem. Upon Acceptance of the Services, Deliverables and/or Supplier-Provided Materials in accordance with any acceptance criteria provided in this Agreement and in each applicable SOW and receipt of a correct and undisputed invoice, Anthem shall

(i) at its option either (a) pay Fees net fifteen (15) days; less a two percent (2%) discount on the invoiced amount or (b) pay Fees net ninety (90) days with no discount;

(ii) if applicable, pay Expenses net ninety (90) days with no discount; and

(iii) pay the amounts in accordance with Anthem's then-current payment policies (e.g. payment via ACH electronic payment to Supplier's financial institution per instructions in Anthem's ACH electronic payment form).

3.4 If Anthem disputes any invoiced amount, Anthem may withhold the disputed amount and will notify Supplier in detail as to the nature of the disputed charges and the reason for Anthem's disagreement. Supplier shall respond by providing documentation in reasonable detail for the disputed charges. The Parties shall make all reasonable attempts to resolve the dispute as amicably as possible within thirty (30) days. Invoices which are not sent via the Anthem Invoice online tool shall automatically be deemed to be in dispute until the invoice is resubmitted via such online tool.

3.5 Record Retention; Audits.

3.5.1 Billing Audits. Supplier shall maintain complete, accurate and detailed records regarding all amounts charged to Anthem under this Agreement. Supplier shall retain such records for no less than three (3) years from date of the invoice for such amount charged. Supplier shall allow Anthem and/or its authorized representatives to inspect and conduct audits on such records during normal business hours upon five (5) business days written notice. Supplier shall also impose a like requirement on any subcontractor who performs Services, directly or indirectly, to Anthem hereunder at a value of $100,000 or more in any twelve (12) month period. If discrepancies or questions arise with respect to such records, Supplier shall preserve such records until an agreement is reached with Anthem regarding their disposition. Each Party shall bear its own expenses in conducting the audit and responding to information requests and Supplier shall not pass on such costs (including employee time, overhead, research, copying charges, professional fees, etc.) to Anthem. If an audit reveals that Supplier overcharged Anthem for any Fees, expenses or any other charges under this Agreement for any logically or readily identifiable component of a Service or chargeable material (as examples for illustrative purposes only: such as a greater than an agreed upon hourly rate for one or more personnel providing services, billing in excess of actual hours worked, miscalculation of actual amount of chargeable of supplies consumed, etc.), Supplier shall promptly reimburse Anthem in full for such overcharge(s). If such overcharges exceed five percent (5%) of the Fees, expenses or any other charges under this Agreement, Supplier shall also promptly reimburse Anthem for all reasonable internal and external audit expenses incurred by Anthem, including the reimbursement for any contingency fees paid by Anthem.

3.5.2 Performance Audits. Supplier agrees to make available (including providing copies of documents requested by Anthem auditors at no additional expense to Anthem) Supplier personnel and any and all books, records or other documents in its possession pertaining to the performance of its duties under this Agreement or applicable state and federal regulating authorities with jurisdiction over Anthem. The foregoing audit rights shall include when applicable, audits of (i) practices and procedures, (ii) security practices and procedures, (iii) disaster recovery and backup procedures, and (iv) other areas necessary to enable Anthem to meet Applicable Laws applicable to the Services. Such audits and inspections may address Supplier's performance of the Services and compliance with the provisions of this Agreement The auditors and other representatives of Anthem will be bound by

confidentiality obligations related to Supplier Confidential Information no less restrictive than the confidentiality terms hereof.

3.5.3 SOC 1 and SOC 2 Audit Reports Supplier shall, at Supplier's expense, provide Anthem with a general (i.e., not Anthem-specific) Service Organization Control ("SOC") 2, Type II, AT section 101, report of Supplier annually. At a minimum, the SOC 2 report shall include a review of controls relevant to the Security Trust Service Principle, with additional Trust Service Principles potentially required based on the nature of the Services. To the extent that Supplier and Anthem agree that it is not feasible for Supplier to produce a SOC 2 report within the time period of the contract, Supplier agrees to develop a plan to obtain HiTRUST certification in accordance with Exhibit F – Required Information Security Controls. Additionally, if the nature of the Services includes transaction-processing, then Supplier shall also provide Anthem with a general (i.e., not Anthem-specific) SOC 1, Type II, Statement on Standards for Attestation Engagements, report of Supplier annually. Both the SOC 1 and SOC 2 report(s) of the third-party auditors will be solely for the use of Supplier and Anthem, its regulators and its independent accountants and will not be distributed or used by any other parties unless approved by Supplier, such approval not to be unreasonably withheld. If such report(s) include(s) any findings that Supplier fails to comply with the SOC 2 or SOC1/SSAE 16 requirements, or audit tests result in exceptions, Supplier agrees to remedy such noncompliance. Bridge letters covering the period from the end of the SOC 1 audit period through the end of Anthem's financial reporting period will also be provided by Supplier upon request by and without cost to Anthem. Supplier will comply with future guidance relating to SOC 2 (AT section 101) and SOC 1/SSAE 16 as issued by the AICPA, the Securities and Exchange Commission or the Public Company Accounting Oversight Board. Both Parties recognize that the report(s) of the third-party auditor do not constitute a certification or an attestation by Supplier under the Sarbanes-Oxley Act of 2002 or otherwise, but Supplier acknowledges that such report(s) may be relied upon by Anthem and Anthem's auditors as they deem appropriate. Supplier agrees to work collaboratively with Anthem to support alignment of Supplier's SOC 1 report with Anthem's financial reporting requirements.

3.5.4 Taxes. Anthem shall pay to Supplier all applicable sales or use taxes assessed by a government authority with respect to the Services and/or Supplier-Provided Materials provided by Supplier under this Agreement, provided that Supplier shall separately itemize such taxes on its invoice(s) to Anthem and that, upon request of Anthem, Supplier shall provide substantiation to Anthem confirming Supplier's reporting and remittance of such taxes to the appropriate government entity. To the extent Anthem has timely paid Supplier for any sales or use type tax, Supplier shall indemnify, defend, and hold Anthem harmless for any such tax, and any related penalties and interest arising from any failure of Supplier to timely report and remit such tax. Anthem shall not be liable for the payment of taxes imposed upon Supplier or upon Supplier's personnel resources, including state and federal income taxes, franchise taxes, Social Security taxes, welfare taxes, unemployment contributions, disability insurance, training taxes and any prepayments, estimated payments, reports, or withholdings required for such taxes. Any payment by Anthem of a Supplier tax obligation shall in no way affect or abrogate Supplier's obligations under this Agreement and shall not be construed as acceptance by Anthem of any Service or Supplier-Provided Materials or as a waiver of any of Anthem's rights.

4. SERVICES - GENERAL TERMS.

4.1 Services. During the Term of this Agreement, Supplier shall perform the Services, produce and deliver the Deliverables, as applicable, pursuant to this Agreement and written SOWs upon written request by Anthem or its Affiliates for such Services and Deliverables. Unless otherwise agreed to in advance by Anthem in a properly executed Statement of Work, Supplier shall perform all Services in the United States and at no other location. Although the Parties have attempted in this Agreement (and the Parties agree to attempt in any Statement of Work) to delineate the specific services and functions to be provided by Supplier to Anthem and its Affiliates hereunder, the Parties acknowledge and agree that

no such delineation could possibly be entirely exhaustive or complete and that some intended items may not be specifically identified. Accordingly, and notwithstanding anything to the contrary elsewhere in this Agreement or in any Statement of Work, Supplier's obligations hereunder shall include the performance of not only all of the Services and functions, and delivery of not only all of the Deliverables, that have been specifically delineated in this Agreement and in any Statements of Work, but also all of the incidental or related services and deliverables that are consistent with, and reasonably necessary to, the performance of any of the Services and functions, and delivery of the Deliverables, so delineated, except (i) services or functions for which Anthem expressly retains responsibility hereunder or (ii) services or functions expressly excluded from the Services, or subject to express qualifications or limitations of a Statement of Work.

4.2 No Minimum Commitment. Supplier understands Anthem makes no promises or representations whatsoever as to the amount of Services and/or Supplier-Provided Materials it will request during the term of this Agreement.

4.3 Non-Exclusivity. This Agreement is nonexclusive and does not grant Supplier an exclusive right to provide Anthem or its Affiliates with any kind of services, deliverables or products and Anthem and its Affiliates may use its own employees or other contractors to perform the same or similar Services or provide the same or similar Supplier-Provided Materials as are to be performed and/or provided by Supplier hereunder.

4.4 Performance Standards.

4.4.1 Supplier will perform the Services in accordance with the qualitative and quantitative standards set forth in the service level section of the applicable Statement of Work (the "Service Levels") if applicable. The Service Levels shall be applied as expressly provided in the applicable SOW.

4.4.2 Supplier will track, monitor, measure and report on its performance as against the Service Levels on a daily basis or as otherwise agreed between the parties in writing. Unless the applicable Statement of Work provides that Anthem will implement specific measurement and monitoring tools, Supplier shall implement the necessary measurement and monitoring tools and procedures required to accurately and timely monitor and report on Supplier's performance of the Services against the applicable Service Levels. Supplier shall maintain such measurement and monitoring tools and procedures throughout the Term.

4.4.3 Unless otherwise provided in the applicable Statement of Work, if during the course of any month (e.g., by reviewing daily performance data), Anthem becomes aware of adverse performance trends (e.g., trends indicating the Supplier may not meet the Service Level for the month), at Anthem's request Supplier will promptly prepare corrective action plans and with Anthem's approval, promptly implement such plans, even though the measurement period has not been completed and, accordingly, there has not yet been a Service Level default.

4.4.4 Supplier will provide Anthem credits against Supplier's charges if it fails to meet a Service Levels as provided in the Statement of Work ("***Service Credits***"). The specifics of the Service Levels and any possible related Service Credits will be listed in the applicable Statement of Work.

4.4.5 If Supplier fails to meet a Service Level, or if Anthem otherwise requests during a month due to adverse performance trends, Supplier will perform a root cause analysis to determine the cause of the failure, take such steps as are necessary to recover from such failure, develop for Anthem

review and approval a plan outlining the steps Supplier will take to minimize to the extent possible the risk that such failure will reoccur and, with Anthem approval, implement such plan. In addition, Supplier will report to Anthem in writing regarding the cause of the failure and the steps taken by Supplier.

4.4.6 Where Supplier can establish to the reasonable satisfaction of Anthem that: (a) the root cause of its failure to achieve a Service Level was a factor outside of the reasonable control of Supplier, (b) Supplier is without fault in causing such factor, (c) Supplier would have achieved such Service Level but for such factor, and (d) Supplier used commercially reasonable efforts to (1) foresee and prevent the occurrence of such factor, and (2) perform and achieve that Service Level notwithstanding the presence and impact of such factor, then no Service Level Credit shall be assessed against Supplier for any resulting Service Level Default and Supplier shall otherwise be excused from achieving such Service Level for as long as the circumstances relating to such factor and preventing achievement of such Service Level prevail and Supplier continues to use its commercially reasonable efforts to prevent, overcome and mitigate the adverse effects of such factor to the extent required to achieve the applicable Service Level. For purposes of this provision, a failure of a subcontractor or Affiliate of Supplier shall not be treated as outside the control of Supplier except to the extent Supplier establishes to Anthem's reasonable satisfaction that the failure is the result of factors outside the control of both Supplier and the subcontractor or Affiliate. Notwithstanding the forgoing, the presence of such factor(s) determined by Anthem to be outside of the control of Supplier and/or its subcontractors or Affiliates shall not relieve Supplier of its business continuity and disaster recovery obligations set forth in Section 4.9.

4.5 Unauthorized Deliverable; Pre-Contract Work Authorization. Anthem will not be required to compensate Supplier for any work not described in a SOW, order form, or other appropriate writing signed by an authorized representative of Anthem, either as originally agreed to or as changed pursuant to the change control procedures set forth in Article 6 herein. An exception to the requirement of an executed SOW may be made if Anthem determines there is an urgent requirement to commence work and authorizes commencement of work before the finalization of a written SOW by way of a Pre-Contract Work Authorization ("***PCWA***") duly signed by Anthem; provided, however, that Anthem can terminate the PCWA at anytime if not satisfied with the progress being made toward finalization of a written SOW.

4.6 Cooperation with and Access by Third Parties. Anthem may from time to time hire outsourcers, subcontractors, consultants, or other third Parties ("Anthem Third-Party Contractors") to perform services or provide products relating to Anthem's business or the business of an Anthem Affiliate, and which may be integrated with the Services or Supplier-Provided Materials provided by Supplier hereunder (an "Integrated Project"). Supplier shall cooperate with and work in good faith with any Anthem Third-Party Contractor(s) as requested by Anthem. Such cooperation may include knowledge sharing of standards, policies, quality assurance and testing processes, as applicable, to ensure smooth deployment of Integrated Projects and/or the smooth and efficient transition of any Services (or component of Services) to, from, or among Anthem, Supplier and any Anthem Third Party Contractor. Moreover, nothing in the Agreement shall restrict access by such persons to the Services, Supplier-Provided Materials, and/or Deliverables, as applicable, as reasonably required for such Anthem Third Party Contractors to perform functions for and on behalf of Anthem or any Anthem Affiliate; and provided that such Anthem Third Party Contractors shall use or access the Supplier-Provided Materials and/or Services solely for Anthem's benefit and shall have agreed to confidentiality provisions no less restrictive than those contained in this Agreement, and Anthem shall remain responsible for such Anthem Third Party Contractor's use or access to the Supplier-Provided Materials and/or Services in accordance with the terms of this Agreement.

4.7 Third-Party Software.

4.7.1 Clearance for Certain Anthem Provided Software. If Anthem will provide any software or access to software to Supplier, then before commencement of Supplier's Services (if specified on the applicable SOW) or before such software is accessed or used by Supplier (if the software is not specified on the applicable SOW), Anthem shall have the opportunity to ascertain whether it has the license rights to permit Supplier to access and use the third-party software needed for such Project. Anthem may cancel or postpone any specific work with Supplier (without any financial penalty and without such cancellation constituting a breach of contract by Anthem) if Anthem determines that it does not possess the needed license for Supplier to perform the Services for which such third-party software is needed. Unless explicitly provided for in a SOW, Supplier is responsible for any software, equipment, supplies, materials or other provisions it may need in performing Services or providing Deliverables.

4.7.2 Use of Anthem Provided Software. For each item of third-party software to which Anthem provides Supplier access or use of pursuant to a SOW, Supplier must de-install and return all such software to Anthem upon the expiration or termination of a SOW or at Anthem's request (and, at Anthem's request, provide an officer's written certification it has done so). Supplier may use or have access to such software only for the purpose of performing the applicable SOW and any other use is strictly prohibited. Supplier shall adhere to any third-party software license limitations when informed of, or provided with, those limitations, and shall indemnify, protect and defend Anthem for any misuse by Supplier or its personnel.

4.8 Disaster Avoidance. Upon the Effective Date, Supplier will create and maintain disaster avoidance procedures (e.g. fire detection, sprinkler systems, physical security) designed to safeguard Anthem's Data and the business continuity of the processes for which Supplier is responsible throughout the Term. These procedures will be subject to Anthem's review and approval as part of the agreed upon BCP. Supplier will be required to revise and maintain these procedures so that they are reasonably acceptable to Anthem throughout the Term.

4.9 Business Continuity Plans.

4.9.1 General. Supplier shall, at no additional cost, (i) within sixty(60) days of the Effective Date of this Agreement, develop a business continuity plan designed to safeguard the business continuity of Supplier's Services generally (the "General BCP"); (ii) within sixty(60) days of the Effective Date of an SOW under which Services will be provided, develop a business continuity plan designed to safeguard the business continuity of Supplier's Services under such SOW (an "SOW BCP"); and (iii) thereafter, maintain the General BCP and any applicable SOW BCP. The General BCP and any SOW BCP shall be referred to hereunder as a ***"BCP"***. Each such BCP shall be designed, utilizing Anthem's "Critical Path Curriculum" Methodology, to comply with the minimum requirements set forth herein and the Anthem Policies, including governance and oversight processes and procedures, in effect at the time the BCP is being submitted to Anthem. The BCP shall be subject to Anthem's review and approval. Such Supplier BCPs shall be implemented and resourced within ninety (90) days of approval of the BCP by Anthem. If the Parties have not mutually agreed on an SOW BCP within ninety (90) days of the SOW Effective Date, Anthem may terminate the applicable SOW upon written notice to Supplier without cause and Anthem shall not be responsible for any transition or wind down costs. Supplier shall revise each BCP as may be reasonably requested by Anthem from time to time throughout the Term. In the event of implementation of a BCP disruption response and recovery, Supplier shall not increase any costs or charges or charge Anthem or any Anthem Affiliate any fees in addition.

4.9.2 Business Continuity Plan Validation. After delivery of the BCP, the Parties shall conduct an initial exercise to validate that the applicable BCP will be able to meet the operational requirements of the business continuity strategy (including capacities and service quality) that will provide for the response to and recovery from the disruption event and the restoration of Services in

accordance with the agreed upon recovery time objectives ("***RTOs***") contained in the applicable BCP. Supplier will provide an exercise test plan and schedule to Anthem prior to the initial exercise and on completion of the exercise a summary of the results. Supplier will deliver an action plan to correct any material deficiencies found in its BCP within thirty (30) days of the completion of an exercise. Such action plan shall be designed to provide for mitigation of all material deficiencies within ninety (90) days of the completion of the exercise. Anthem reserves the right to observe or participate in any BCP exercise covering Services provided to Anthem on (i) Anthem's internal environment, or (ii) Supplier environments solely dedicated to the performance of Services for Anthem. Anthem reserves the right to require full documentation for any BCP that covers the continuity of Services. Anthem reserves the right to require any changes to any BCP that covers the continuity of Services that, in Anthem's commercially reasonable judgment, are necessary to comply with Anthem's and its affiliates' business continuity, risk and governance program requirements, regulatory requirements and accreditation requirements.

4.9.3 Business Impact Analysis. If requested by Anthem, Supplier will carry out a business impact analysis along with the Anthem BCP and business teams, utilizing Anthem's "Critical Path Curriculum" Methodology. The objective would be to:

A. Validate any existing assumptions on Services (take down to task and activity level, assess for regulatory, compliance, financial or customer impact) to understand the journey from now until solution identification
B. Validate RTOs for the Services.
C. Prioritize processes for recovery and required functional knowledge at an alternate site, taking into account the RTOs and then the importance of the applicable Service and its use to end users.

4.9.4 Restoration of Services. Supplier will provide business continuity, disaster recovery, and backup capabilities and facilities, through which Supplier will be able to perform its obligations hereunder (including service level agreements) with minimal disruptions or delays in accordance with the BCP. Supplier represents and warrants that it will comply with, provide, and fund the BCP. To the extent Services are impaired or disrupted due to an incident, Supplier agrees to execute recovery of the Services, in accordance with the applicable BCP. In the event Supplier does not restore the Services within such RTOs, Anthem may, at its option: (i) exercise any rights it may have to terminate under the Agreement; or (ii) either in-source or resource the Services that are disrupted ("step in rights") and, in doing so, may take other action as is reasonably necessary to restore such disrupted Services. In the event that such failure to restore the Services gives Anthem the right to terminate for cause under the Agreement, Supplier shall have no further right to cure. In the event that such failure to restore the Services does not give Anthem the right to terminate for cause, Anthem may still terminate the SOW, without cause and Anthem shall not be responsible for transition or wind-down costs. Notwithstanding the foregoing, in the event Supplier does not restore the Services within thirty (30) days, Anthem may still exercise step-in rights at any time during the period that the Supplier fails to restore services in accordance with the applicable and approved BCP and included RTO(s) and, in doing so, may take other action as is reasonably necessary to restore such disrupted Services. Supplier shall cooperate fully with Anthem and its agents in the exercise of such step-in rights and provide reasonable assistance at no charge to Anthem to promptly restore such disrupted Services. Supplier shall not be entitled to receive any charges to the extent they relate to Services performed by Anthem and all costs associated with the exercise of such step-in rights. Such step-in rights shall continue until Supplier demonstrates to Anthem's reasonable satisfaction that Supplier is able to resume performance of the Services with appropriate mitigation in place designed to prevent further BCP failures for the Services. Such exercise of step-in rights shall not constitute a waiver by Anthem of any termination rights or rights to pursue a claim for damages arising out of the failure that led to the step-in rights being exercised. The foregoing does not limit Supplier's liability with respect to any default or non-performance by Supplier under the Agreement.

4.9.5 Without limiting the foregoing, Supplier covenants and agrees that it will restore Services to meet Service Levels in accordance with the BCP to support restoration of Service Levels within the RTOs set forth in applicable BCPs, but in no event shall a disruption of such services exceed thirty (30) days. Supplier agrees to cooperate with Anthem Third Party Contractors to restore Services, if and when appropriate.

4.9.6 If a business disruption will impact Services provided to Anthem, Supplier shall provide Anthem with timely notification and updates of the disruption, expected impact, expected duration, action plan and status. Supplier will ensure all Anthem Data in the possession or under the control of Supplier is backed up in accordance with agreed upon Service Levels, but in no event shall the off-site backup cycle of Anthem Data residing on Supplier's network exceed twenty-four hours.

4.9.7 Supplier shall consider and incorporate, where applicable and not limited to, the following areas when creating the BCP to be submitted for Anthem's review and approval:

- Scope and Severity of Disaster
- Disaster Response Team (DRT) roles and responsibilities
- Communications with media
- Identification of emergency services in each city
- Description of facilities at all locations
- DRT team members for each facility
- Alternate locations for each facility for the different disaster levels
- Plan review and update parameters
- Plan testing parameters
- Contact information
- Risk Mitigation for base infrastructure for various scenarios
- Diesel generator in data center
- UPS for critical equipment
- Fire detection and protection system
- Computer room
- Voice communication
- Transportation arrangement to and from the facility for employees
- Transportation arrangement between facilities in a city
- High uptime contracts for critical equipment
- All projects shall employ a system whereby backups are completed, at a minimum, every two (2) weeks, including both full and incremental backups and a validation that such backups of data were successfully made.
- Offsite storage of full backup is required. Supplier shall notify Anthem of the location of such offsite storage. Additional project-specific tape storage requirements may be addressed in the applicable Statement of Work.
- Document the decision tree for invocation, including basis points 1 to 4 above. This will include coordination with Anthem business continuity personnel as well as joint disaster recovery plans, as required to support the delivery continuity of the Services in accordance with this Agreement, including RTOs.
- Annually, as part of the test of the BCP, all processes are validated.

4.9.8 Supplier will meet with Anthem representatives to review said BCP. Supplier will make reasonable changes to said BCP as requested by Anthem. Supplier will maintain and test the BCP at regular intervals (no less frequently than annually), and will provide Anthem with documented

results of the BCP tests that relate to the Services provided hereunder. In addition, Supplier will provide Anthem with sufficient notice to allow Anthem to participate in and/or monitor Supplier's BCP exercises for the Services. Supplier will promptly revise its BCP to conform to new governmental regulations, except that Supplier shall not increase any costs or charges without Anthem approval. If Supplier becomes aware that it is not in compliance with its BCP, Supplier will (a) notify Anthem in writing promptly, and (b) cure any such non-compliance within ten (10) calendar days thereafter. If the non-compliance cannot reasonably be cured within such period, Supplier will use commercially reasonable efforts to cure the non-compliance as soon as practicable. If such non-compliance results in risks unacceptable to Anthem, Anthem may: (i) terminate the applicable Statements of Work, without cause, upon written notice to Supplier, in accordance with the terms of the Agreement. and Anthem shall not be responsible for transition or wind-down costs; or (ii) at Anthem's option, exercise step-in rights for the Services that are disrupted and, in doing so, may take other action as is reasonably necessary to restore such disrupted Services.

4.9.9 Disaster Recovery Sites. Unless otherwise specified by Anthem, Supplier shall provide at least two (2) geographically diverse facilities from which Services may be performed so that, if a location from which Services are provided becomes unavailable (and subject to the applicable business continuity and disaster recovery provisions of this Agreement) and an alternate location is required in order to provide the Services, Supplier shall restore the Services at the secondary or backup sites, including staffing, at no additional charge to Anthem.

4.9.10 Training. Each Party shall train and have sole responsibility for training its own personnel on the Party's respective roles and responsibilities under the BCP. Supplier shall provide Anthem with a training status report and roles and responsibilities roster at least once every six (6) months or whenever there is a material change in key roles and responsibilities/staffing or skills readiness status. Key roles shall be identified in the BCP.

4.10 Acceptance and Training. Acceptance with respect to Services shall be as addressed in Section 4.10.1 and with respect to Deliverables shall be as set forth in Section 4.10.2.

4.10.1 Acceptance of Services. To the extent a SOW provides for Services:

(a) Preliminary Acceptance. Unless otherwise specified in a SOW, Anthem shall have ten (10) business days from the completion of each phase or milestone to test the Services relating thereto in order to determine whether such Services meet the standards and/or accomplish the objectives or other criteria for such Services as established in the applicable SOW ("Services Preliminary Acceptance Period"). In the event a SOW does not provide acceptance criteria, then the acceptance criteria shall be Anthem's reasonable satisfaction. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have five (5) calendar days to re-perform the deficient Services at no cost to Anthem, until the applicable standards, objectives, milestones and/or other criteria are met to Anthem's reasonable satisfaction; and (iii) a ten (10) calendar day re-testing preliminary acceptance period shall begin.

(b) Final Acceptance: Multi-Phase Projects. Upon completion of all related Services for a particular project, (including upon completion of an intermediate phase of a project or entire project, as specified in a SOW), Anthem shall have fifteen (15) business days after completed performance of the final phase of Services to test whether they meet the specifications set forth in the SOW ("Specifications"), in all material respects, (the "Services Final Acceptance Period"), unless a different time frame is specified in a SOW. The SOW shall identify any applicable preliminary and final acceptance milestones, deadlines or other criteria. The Services Final Acceptance Period shall not begin until any related Documentation, if any, has been delivered to Anthem. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail;

(ii) Supplier shall have fourteen (14) calendar days to re-perform the deficient Services at no cost to Anthem until the applicable standards, objectives, milestones and/or other criteria are met to Anthem's reasonable satisfaction; and (iii) the Services Final Acceptance Period shall begin again. In the event Supplier fails to re-perform a rejected Service to conform to the Specifications, as determined in Anthem's reasonable discretion, Anthem may terminate the applicable SOW immediately and receive from Supplier a refund of: (i) the fees previously paid to Supplier for the rejected Services; and (ii) the fees previously paid for all other Services which are materially affected by such non-conformity. If Services are deemed unacceptable despite efforts to correct deficiencies pursuant to the foregoing procedures, and the Parties fail to resolve the matter to their reasonable satisfaction, then either Party may submit the matter for dispute resolution pursuant to the procedures provided for in Article 16, Dispute Resolution. For Services and/or Deliverables performed and provided in multiple phases under a SOW, they shall be subject to final Acceptance testing under this paragraph, because such interim phases culminate in an integrated deployment or other solution, notwithstanding any preliminary acceptance that may have been determined during an intermediate phase of the project. To the extent a project involves Deliverables integrated with Services, then the foregoing testing, rejection and refund procedures and remedies shall include all related Deliverables.

4.10.2 Acceptance of Deliverables. To the extent a SOW provides for Deliverables, the SOW shall identify whether the Deliverable will be subject to Anthem review (a "Review Deliverable") or will be subject to Anthem testing (a "Test Deliverable"). Any reference to a "Deliverable" herein shall include reference to a Test Deliverable or a Review Deliverable, as the context requires.

(a) Preliminary Acceptance. Unless otherwise specified in the applicable SOW, Anthem shall have ten (10) calendar days after receipt to review each Review Deliverable or twenty (20) calendar days to test each Test Deliverable (or portions thereof if such Deliverable is to be delivered in portions as set forth in the applicable SOW) to determine whether it meets the Specifications (the "Preliminary Acceptance Period"). This Preliminary Acceptance Period shall not begin until the Documentation has been delivered to Anthem and the Deliverables are fully installed and operational as determined by the Parties. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have five (5) calendar days to correct the Deliverable at no cost to Anthem; and (iii) the Preliminary Acceptance Period shall begin again.

(b) Final Acceptance: Multi-Phase Projects. Upon final delivery of all related Deliverables, (including upon completion of an intermediate phase of a project or entire project, as specified in a SOW), Anthem shall have ten (10) calendar days after receipt to review the Review Deliverables or thirty (30) calendar days to test the Test Deliverables to determine whether they meet the Specifications (the "***Deliverables Final Acceptance Period***"), unless a different time frame is specified in a SOW. This Deliverables Final Acceptance Period shall not begin until the Documentation has been delivered to Anthem and the Deliverables are fully installed and operational as determined by the Parties. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have fourteen (14) calendar days to correct the Deliverables at no cost to Anthem; and (iii) the Deliverables Final Acceptance Period shall begin again. In the event Supplier fails to modify a rejected Deliverable to conform to the Specifications contained in the applicable SOW, as determined in Anthem's reasonable discretion, Anthem may terminate the applicable SOW immediately and receive from Supplier a refund of: (i) the fees previously paid to Supplier for the rejected Deliverable; and (ii) the fees previously paid for all other Deliverables which are materially affected by such non-conformity. If Deliverables are deemed unacceptable and the Parties fail to resolve the matter to their reasonable satisfaction, then either Party may submit the matter for dispute resolution pursuant to the procedures provided for in Article 16 (Dispute Resolution). If the Parties intend that all Services and/or Deliverables performed and provided in multiple phases under a SOW are to be subject to final Acceptance testing under this paragraph, because such interim phases culminate in

an integrated deployment or other solution, notwithstanding any preliminary acceptance that may have been determined during an intermediate phase of the project, then the Parties shall so explicitly provide in the SOW. To the extent a project involves Deliverables integrated with Services, then the foregoing testing, rejection and refund procedures and remedies shall include all related Services.

4.10.3 Deemed Acceptance; Further Notice. If Anthem does not furnish a written notice of acceptance or non-acceptance to Supplier as contemplated in this Section 4.10, prior to the end of the applicable acceptance period, then Supplier will give Anthem's Account Manager written notice (which may be by e-mail) of Anthem's failure to provide notice of acceptance or non-acceptance. In the event that Supplier has not received written notice of acceptance or non-acceptance of the applicable Services and/or Deliverables within ten (10) business days after Anthem's receipt of such notice, then and only then will Anthem be deemed to have accepted such Services and/or Deliverable or other items as applicable.

4.10.4 Training. Upon Anthem's request, and promptly following the delivery or installation of any Deliverable(s), Supplier shall provide Anthem with training on the use and operation of the Deliverable(s) as is necessary for Anthem to operate and maintain such Deliverable(s). Anthem shall pay Supplier the fee as set forth in the applicable SOW for such training. Unless otherwise specified in the SOW, the training shall be conducted by Supplier at Anthem's facilities for at least four (4) Anthem employees.

4.11 Transition Assistance. At Anthem's request, commencing upon the termination of this Agreement or any SOW hereunder, or other discontinuation of a component of the Services, for any reason, Supplier shall provide up to one-hundred eighty (180) days of assistance to Anthem for transition of the Services to Anthem or a third-party designee of Anthem. Such transition assistance shall be rendered at the lower of (a) the time-and-materials rate set forth in the SOW for the relevant Services, or (b) Supplier's lowest published time-and-materials rate. Within ten (10) calendar days of Anthem's request for transition assistance, the Parties shall meet to develop a transition plan. Such transition plan and transition assistance may include, by way of example: detail of Supplier's then-current responsibilities and resource commitments; knowledge transfer sufficient to assure a smooth transition and to enable Anthem or its designee to assume responsibility for continued performance of the Services with minimal disruption to Anthem's business and operations; Supplier information concerning personnel, software, skill sets and other resources used by Supplier to provide the Services (including third party services required to provide the Services); explanation of security and problem management processes and standards; provision of all documentation, logs, and applicable records to Anthem; return of any Anthem assets, information, data, and Confidential Information; anything else reasonably related to the transition of affected Services. The Parties may provide for different transition assistance responsibilities, timing and payment schedules in a SOW.

4.12 Supplier Resources and Materials. Except as expressly provided otherwise in this Agreement or in a Statement of Work, Supplier shall (at its own risk and expense) provide all of the materials and resources necessary for delivering the Services, providing the Deliverables and otherwise meeting Supplier's obligations under this Agreement. Any project-specific resources (and the financial and operational responsibility therefore) shall be detailed in each applicable Statement of Work. If an applicable SOW provides that Anthem will be paying for any such materials, all such costs shall be set forth in detail in the applicable SOW; any such third party charges shall be passed through to Anthem at Supplier's actual cost, with no mark-up.

4.13 Anthem Property. Any tangible property furnished to Supplier by Anthem or its Affiliates in connection with this Agreement shall be deemed bailed to Supplier for the mutual benefit of the Parties and title thereto shall at all times remain in Anthem or its Affiliate, as the case may be; in no event may Supplier transfer any such Anthem tangible property outside the continental United States without

Anthem's prior written consent, which may be given or withheld in Anthem's reasonable discretion. Supplier assumes all risk of loss of any such property while in Supplier's constructive possession or control, and Supplier shall promptly pay Anthem for all such tangible property that is damaged or destroyed during any such time or that Supplier otherwise fails to return to Anthem. Supplier shall maintain at all times, and shall submit to Anthem upon written request from time to time, an accurate, detailed and current written list of any property of Anthem or its Affiliates (including designs, reports, manuals, documents, specifications, hardware, software and equipment) received or obtained by Supplier pursuant to this Agreement. No property of Anthem or its Affiliates shall be removed from Anthem's or its Affiliates' premises without the prior written consent of Anthem. Any property of Anthem or its Affiliates' shall be promptly returned upon the earlier of: (i) Anthem's request for the return thereof; or (ii) completion or termination of the applicable Statement of Work to which such property pertains. Supplier shall, at its risk and expense, while any property of Anthem or its Affiliates is in Supplier's custody or control: (a) maintain such materials in good condition; and (b) insure such materials in an amount equal to the replacement cost thereof with loss payable to Anthem.

4.14 Use of Anthem Facilities. If Anthem requires Supplier to provide Services at an Anthem facility, Anthem shall provide Supplier with adequate space in such Anthem facility necessary for Supplier to perform the Services (as such space is identified in the relevant Statement of Work). Supplier shall use the Anthem facilities for the sole and exclusive purpose of providing the Services and delivering the Deliverables. Access to Anthem facilities shall be restricted to normal Anthem business hours, or the normal business hours of the particular Anthem facility or Service Location, as applicable. Access to Anthem facilities outside of normal business hours will be based on demonstrable project or other support effort needed and must be approved in advance by Anthem's Project Manager or his/her designee. Supplier shall repair, or cause to be repaired, at Supplier's sole cost and expense, any and all damage caused by negligent or willful misconduct of Supplier personnel to Anthem facilities or other Anthem facilities, including Anthem's buildings, grounds, equipment and furniture, caused by the negligence or willful misconduct of Supplier or any of its personnel or subcontractors, or any other person performing Services on Supplier's behalf under this Agreement or any Statement of Work. Supplier shall immediately notify Anthem of any and all such damages. All costs incurred by Anthem, as reasonably determined by Anthem, for such repairs shall be repaid by Supplier by cash payment upon demand and without limitation of Anthem's other rights and remedies provided by law, in equity, or otherwise under this Agreement. Anthem may deduct any such costs from any amounts due to Supplier from Anthem under this Agreement.

5. RELATIONSHIP MANAGEMENT.

5.1 Progress Reports. At the frequency specified in each applicable SOW and at other times as requested by Anthem, Anthem and Supplier shall meet to review Supplier's performance and discuss issues related to the provision of Services and Supplier-Provided Materials, including Supplier's compliance with the performance standards in the applicable SOW.

5.2 Account Relationship Manager. At Anthem's request, Supplier shall designate an Account Manager who shall act as liaison with Anthem on behalf of Supplier with respect to the relationship and responsibilities of the Parties. Such Account Manager shall be responsible for coordinating and managing delivery of all Services and/or Supplier-Provided Materials, and also for coordinating, cooperating and resolving any concerns, service problems or other matters relating to the overall relationship between the Parties. Anthem shall designate a corresponding Account Manager to act as liaison on behalf of Anthem.

5.3 Supplier Financial Information. Upon Anthem's request, Supplier will provide Anthem with complete and accurate annual financial statements so long as this Agreement is in effect. Publicly traded companies will supply their Forms 10Qs and 10K filed with the Securities and Exchange

Commission. Privately held companies will provide balance sheet and income statement with footnotes. Supplier shall provide Anthem with such statements within ninety (90) days after the end its annual accounting period. Supplier may use the automated Securities Exchange Commission Filing email distribution process to provide financial statements to Anthem. Any information disclosed hereunder shall be Confidential Information (as defined in Section 10 (Confidentiality)).

5.4 Continuous Improvement. Supplier shall work with Anthem to drive continuous improvements in effectiveness, cost efficiency and best practices. Supplier shall monitor improvements and the Supplier Account Manager shall report progress to Anthem as requested by Anthem on an annual basis.

6. CHANGE CONTROL.

6.1 Requests by Anthem. Anthem may request changes or modifications to any Statement of Work issued hereunder by delivering to Supplier a written change order, describing the requested changes in such reasonable detail as to enable Supplier to evaluate them ("Request"). Changes, modifications or enhancements to the Services or Deliverables being provided pursuant to a Statement of Work that are not material shall be deemed to be part of the Services or Deliverables, as the case may be, and shall not be subject to this Section or any other change control provision. Changes, modifications or enhancements to the Services being provided pursuant to a Statement of Work that are material (a "Change") shall be subject to this Section. If the Parties are unable to agree whether a Change, modification or enhancement to the Services are material, the disagreement shall be subject to the dispute resolution procedures set forth in the Agreement.

6.2 Process. Within ten (10) business days after delivery of such a Request or as otherwise agreed by the parties, Supplier shall deliver to Anthem a proposed plan that: (i) assesses any impact of the Request on any Services or Deliverables already to be provided under such Statement of Work; (ii) describes the Request and any new or additional Services or Deliverables to be provided pursuant to it; (iii) sets forth cost estimates, specifications, implementation plans and time schedules with milestone and completion dates; (iv) contains completion and acceptance criteria; and (v) sets forth any other necessary and appropriate information ("***Change Order***"). Supplier may also request changes or modifications to any Statement of Work from time to time by preparing and delivering to Anthem a proposed SOW Amendment that describes the proposed changes. Notwithstanding the foregoing, Anthem may, in its sole discretion, with a Change Order, extend any scheduled completion date under any Statement of Work upon providing written notice thereof to Supplier, provided however that Anthem shall be liable for any efforts, Services or other pre-approved expenses due to Supplier caused by such extension, but only to the extent Supplier is unable, after diligent efforts, to redistribute personnel or other assets during the remaining duration of the extension period either to other Anthem or Anthem Affiliate Services or Deliverables or services provided by Supplier to third party customers of Supplier.

6.3 Acceptance or Rejection. If within seven (7) calendar days after receipt of a proposed Change Order Anthem notifies Supplier in writing that it does not accept the Change Order, or fails to notify Supplier with respect to such Change Order, then such Change Order shall be deemed rejected, and Supplier shall take no further action with respect to it. If Anthem accepts Supplier's Change Order within such timeframe by the express written approval and authorized signature of Anthem on such Change Order and the delivery of such Change Order back to Supplier before its revocation or by issuance of a purchase order by Anthem through Anthem's Procurement Process Technology, then this Agreement and the applicable Statement of Work shall thereby be amended in accordance with such Change Order, and such Change Order shall be deemed adopted and incorporated therein.

6.4 No Changes by Supplier. Except as may be necessary on an emergency basis, as determined by Anthem, no changes, modifications or enhancements in Services shall be made without Anthem's prior written consent, which shall be provided at its sole discretion, unless such change, modification or enhancement: (a) has no impact on the Services being provided by Supplier; (b) has no impact on the security of Anthem Data and Anthem's systems; and (c) causes no increase in fees or other costs chargeable to Anthem hereunder. If an emergency arises which requires Supplier to make a change, modification or enhancement to the Services, Supplier shall notify Anthem thereof as soon as practicable.

7. **TERM; TERMINATION**.

7.1 Agreement. The term of this Agreement shall begin on the Effective Date and shall end _____ (___) years thereafter unless earlier terminated in accordance with this Agreement; provided however, that upon expiration, any SOW(s) then in effect (and no additional SOWS) that have specified a term longer than the Term stated above shall continue to be subject to the terms and conditions contained in this Agreement. Notwithstanding the foregoing, Anthem shall have the right, but not the obligation, to extend the Term on the then existing terms and conditions (including price) for up to twelve (12) months on thirty (30) days notice. Anthem will have four (4) such rights. The initial term and any renewal term shall be referred to herein as the "***Term***."

7.2 SOWs. Each SOW is an independent obligation of the Parties, and each SOW, if not entered into as of the Effective Date, shall commence as of the commencement date set forth in (or if not specified, as of the date last set forth in the signature area of) the relevant SOW.

7.3 Termination for Supplier's Breach. Anthem, in its sole discretion, may terminate the entire Agreement or any and all Statements of Work (i) immediately if Supplier is in breach of Sections 9 (Security), 10 (Confidentiality), 12.1 (General Warranties) or 12.2 (Supplier's Representations, Warranties, and Covenants); or (ii) upon thirty (30) days written notice and opportunity to cure in the event of a material breach by Supplier if Supplier has not remedied such breach within thirty (30) days of its receipt of written Notice from Anthem of such breach. Should Supplier again materially breach the Agreement in substantially the same manner as a prior material breach by Supplier within one (1) year of such prior material breach, Anthem may terminate any or all Statements of Work or this entire Agreement upon no less than ten (10) business days written notice. Notwithstanding the foregoing, Anthem, in its sole discretion, may immediately cease receiving Supplier-Provided Materials or Services from Supplier and cease providing Supplier with access to Anthem's computer systems, facilities, personnel or information.

7.4 Termination for Anthem's Breach. Subject to the following sentence, Supplier may terminate a SOW upon written notice in the event of a material breach of such SOW by Anthem if Anthem has not remedied such breach within thirty (30) days of its receipt of written notice from Supplier of such breach. Prior to issuing any notice of termination, Supplier shall escalate the matter to Anthem executives pursuant to the informal dispute resolution procedures set forth in Section 16, Dispute Resolution herein. If Supplier effectuates termination of an Exhibit or SOW hereunder, Supplier shall, at Anthem's option, provide necessary transition assistance to Anthem after such termination notice is given. Transition Services are further covered in Section 4.11.

7.5 Termination for Convenience. Anthem may terminate this Agreement, or any SOW issued hereunder, in whole or in part, for any or no reason upon not less than thirty (30) days prior written notice of termination to Supplier.

7.6 Termination Due to Insolvency. Either Party may terminate this Agreement or any SOW immediately upon the occurrence of any of the following events with respect to the other Party: (a) the other Party becomes insolvent, generally unable to pay its debts as they become due, or makes an assignment for the benefit of its creditors or seeks relief under any bankruptcy, insolvency or debtor's relief law; (b) if proceedings are commenced against the other Party under any bankruptcy, insolvency or debtor's relief law, and such proceedings have not been vacated or set aside within sixty (60) days from the date of commencement thereof; (c) a receiver is appointed for the other Party or its material assets; or (d) if the other Party is liquidated, dissolved or ceases operations.

7.7 Termination Upon Change of Control of Supplier. If a change in Control of Supplier occurs, Anthem may at its option, terminate this Agreement or any SOW, in whole or in part, by giving Supplier at least thirty (30) days' prior written notice and designating a date upon which such termination will be effective. Any such notice must be given with six (6) months following the later of Supplier's provision of written notice to Anthem of, or, if Supplier fails to give such notice, the date on which Anthem learns of such change in Control. For this purpose, "Control" and its derivatives means the legal, beneficial or equitable ownership, directly or indirectly, of at least fifty percent (50%) of the aggregate of all voting equity interests in an entity or equity interests having the right to at least fifty percent (50%) of the profits of Supplier or, in the event of dissolution, to at least fifty percent (50%) of the assets of an entity and, if Supplier is a partnership, also includes the holding by an entity of the position of sole general partner in Supplier.

7.8 Effect of Termination or Expiration. In the event that a SOW expires or in the event that Anthem terminates a SOW pursuant to the terms contained in such SOW, Anthem may, in its sole discretion, simultaneously terminate other Statements of Work materially and adversely affected by such termination or expiration. Notwithstanding the foregoing, the termination of a particular SOW, or portion of a SOW, shall not result in the termination of the Agreement unless such termination explicitly provides for termination of the entire Agreement between the Parties. However, termination of the Agreement shall serve to terminate all Statements of Work unless such notice of termination specifies otherwise. All sections identified as surviving the termination of a SOW, as well as Sections 3.5 (Record Retention), 4 (Services), 8 (Intellectual Property Ownership), 9 (Security), 10 (Confidentiality), 13 (Indemnification), 14 (Limitation of Liability) and 16 (Dispute Resolution) inclusive, shall survive the expiration or termination of the Agreement. In the event of termination for any or no reason of any SOW, Anthem shall pay Supplier any undisputed Fees and/or expenses owed in accordance with such SOW up to the effective date of termination. If the Agreement includes Deliverables, Supplier shall promptly deliver such Deliverables, in whatever stage of completion, to Anthem. The return or destruction of Confidential Information upon termination is addressed in Section 10.5 below.

8. INTELLECTUAL PROPERTY OWNERSHIP.

8.1 Custom IP. Supplier acknowledges and agrees that Anthem shall be the sole and exclusive owner of all rights in the Custom IP. Supplier hereby unconditionally and irrevocably conveys, transfers, delivers and assigns and agrees to unconditionally and irrevocably convey, transfer, deliver and assign to Anthem, and Anthem accepts and agrees to accept, Supplier's entire right, title and interest worldwide in and to such works, free from any liens and encumbrances, including all patents, copyrights, trade secrets and other proprietary rights therein, effective immediately upon the authorship, conception, creation, discovery, or development thereof, together with all federal, state and provincial registrations, applications for registration and all renewals and extensions thereof (including any continuations, continuations-in-part, divisionals, reissues, substitutions and reexaminations), all goodwill associated therewith, and all benefits, privileges, causes of action and remedies relating to any of the foregoing,

whether before or hereafter accrued (including the exclusive rights to apply for and maintain all such registrations, renewals and extensions, to sue for all past, present and future infringements or other violations of any rights relating thereto, and to settle and retain proceeds from any such actions).

8.2 Confirmation of Anthem's Ownership of Custom IP. Supplier further agrees, at no additional cost, to execute, or cause to be executed by its employees, agents, or subcontractors, standard assignments of IP rights and ancillary and confirmatory documents that may be required or appropriate so that title to any Custom IP shall be clearly and exclusively held by Anthem or any nominee thereof. Supplier shall deliver to Anthem any Source Code incorporated in each Deliverable at the time of completion of such Deliverable. In the event Anthem is unable for any reason to secure Supplier's signature to any document Anthem requests Supplier to execute under this Section, Supplier hereby irrevocably designates and appoints Anthem and Anthem's duly designated authorized officers and agents as Supplier's agents and attorneys-in-fact to act for and in Supplier's behalf and instead of Supplier to execute such document and to file such application and to do all other lawfully permitted acts with the same legal force and effect as if executed by Supplier.

8.3 License; Waiver of Rights. To the extent, if any, that any Custom IP or IP rights therein are not assignable or that, notwithstanding Section 8.2 (Confirmation of Anthem's Ownership of Custom IP), Supplier for any reason retains any right, title, or interest in and to any Custom IP or any IP rights therein, Supplier (i) unconditionally and irrevocably waives the enforcement of such rights, and all claims and causes of action of any kind against Anthem or its Affiliates with respect to such rights, (ii) agrees, at Anthem's request and expense, to consent to and join in any action to enforce such rights, and (iii) hereby grants to Anthem and its Affiliates a perpetual, irrevocable, fully paid-up, royalty-free, transferable, sublicensable (through multiple levels of sublicensees), exclusive, worldwide right and license under its IP rights to use, reproduce, distribute, display and perform (whether publicly or otherwise), prepare derivative works of and otherwise modify, make, sell, offer to sell, import and otherwise use and exploit (and have others exercise such rights on behalf of Anthem or its Affiliates) all or any portion of such Custom IP. The license granted herein shall commence on the Effective Date, and notwithstanding anything to the contrary contained in this Agreement, shall continue in perpetuity and without regard to the Term of this Agreement. Supplier hereby waives and quitclaims to Anthem and its Affiliates any and all claims, of any nature whatsoever, which Supplier now or may hereafter have for infringement of any Custom IP or IP rights therein assigned hereunder to Anthem.

8.4 Supplier IP. Supplier shall identify all Supplier IP to be incorporated into the Services or Deliverables, if any, in each applicable Statement of Work. Supplier hereby grants to Anthem and its Affiliates a perpetual, irrevocable, fully paid-up, royalty free, transferable, sublicensable (through multiple levels of sublicensees), worldwide, non-exclusive right and license under its IP rights, to use, reproduce, distribute, display and perform (whether publicly or otherwise), prepare derivative works of and otherwise modify, make, import and otherwise use and exploit (and have others exercise such rights on behalf of Anthem or its Affiliates) all or any portion of the Supplier IP incorporated into the Deliverables or Services, for use in connection with Anthem's business or the business of any Anthem Affiliate (including its distribution of products or provision of services to third-parties). The license granted herein shall commence on the Effective Date and, notwithstanding anything to the contrary contained in this Agreement, shall continue in perpetuity and without regard to the Term of this Agreement.

8.5 Anthem IP. Except as may otherwise be provided in a Statement of Work, Supplier shall only use the Anthem IP in the form provided by Anthem and solely in connection with this Agreement. Subject to Section 17.2 below, Anthem hereby grants to Supplier, solely for the performance of the

Services and creation of the Deliverables a non-exclusive, non-transferable, non-sublicensable right to access, operate and use the Anthem IP. Upon expiration or termination of this Agreement for any reason, (i) the rights granted to Supplier, its agents and subcontractors, in this Section shall immediately revert to Anthem, and (ii) Supplier shall (a) deliver to Anthem, at no cost to Anthem, a current copy of all of the Anthem IP in the form in use as of the date of such expiration or termination, and (b) immediately cease use of, and completely destroy or erase all other copies of the Anthem IP in Supplier's or its agents' or subcontractors' possession in any form, including electronic, hard copy, or other memory device, and at Anthem's request, have its officers certify in writing that it has so ceased use of, destroyed or erased all copies of the Anthem IP and that it shall not make any further use of the Anthem IP.

8.6 Third-Party IP. Supplier shall not incorporate Third-Party IP in any Service or Deliverable without obtaining Anthem's prior written consent. To the extent any Third-Party IP is required to be so incorporated, Supplier shall identify all Third-Party IP embedded in Services or Deliverables, if any, in each applicable Statement of Work. Such identification shall include, at a minimum, the following information: (i) the nature of the Third-Party IP; (ii) the owner of the Third-Party IP; (iii) Supplier's authority to include the Third-Party IP in the Deliverables or Services; and (iv) any restrictions or royalty terms applicable to the incorporation of the Third-Party IP in the Deliverables or Services. Supplier represents and warrants that the Deliverables, including the Third-Party IP, do not include any embedded software or open source software of any kind or any IP that is subject to licensing terms requiring disclosure of source code under any circumstances. All software a Party licenses from a third-party vendor will be and remain the property of such third-party or such third-party's licensors. If Anthem provides Supplier with access to or use of Third-Party IP licensed by Anthem from third-parties, Supplier shall be responsible for (a) complying with all applicable obligations under any third-party license agreements, (b) indemnifying, defending and holding Anthem harmless from and against any breach by Supplier of such license agreements as set forth in Section 13 below, and (c) treating all such Third-Party IP as Confidential Information of Anthem. Unless provided otherwise in a Statement of Work, Supplier shall obtain, at Supplier's sole cost and expense, an irrevocable, fully paid-up, royalty-free, perpetual, worldwide, non-exclusive license for Anthem and Anthem's agents and assigns, to use the Third-Party IP incorporated into the Deliverables and Services. Supplier will not incorporate, integrate or bundle Open Source software in or with any Deliverable, without Anthem's prior written consent, and to the extent that Supplier uses Open Source software in the performance of Services, it shall ensure that such use does not grant, or purport to grant, to any third-party any IP rights in the Deliverables, and does not cause a Deliverable, or any part thereof to become subject to the terms of such Open Source software license.

8.7 Reservation of Rights. Except as provided herein, each Party (and each Anthem Affiliate) reserves all rights in its IP and nothing contained herein shall be construed as granting the other Party any ownership interest in its IP. Each Party shall include, maintain, reproduce and perpetuate all notices or markings on all copies of all tangible media comprising each Party's IP or Confidential Information in the manner in which such notices or markings appear on such tangible media or in the manner in which either Party may reasonably request. Nothing in this Agreement waives or limits extra-contractual rights or remedies available to Anthem or its Affiliates to protect IP rights afforded Anthem under the law of any jurisdiction, including trademarks and service marks.

8.8 Waiver of Moral Rights. Supplier hereby forever waives and agrees never to assert against Anthem, its Affiliates, their successors, or licensees any and all moral rights Supplier may have in the Custom IP, and any elements thereof, and any results or proceeds therefrom, even after expiration or termination of this Agreement, to the extent permitted by applicable law. However, this Section 8.8 shall not be interpreted as a waiver of moral rights as to Supplier IP, except as may be embedded in the Custom

IP.

9. **SECURITY**.

9.1 Limited Access. To the extent made accessible to Supplier, Supplier shall, at all times, limit access to Anthem Confidential Information to those employees or subcontractors that have an actual need to access such data for purposes of providing the Services. Prior to gaining access to Anthem Confidential Information, Supplier shall require all employees or subcontractors to comply with confidentiality, security and IP provisions no less stringent than the provisions set forth in this Agreement and, at Anthem's request, have an Officer certify in writing it has done so.

9.2 Notification of Security Breaches. Supplier shall immediately notify Anthem should it discover any breach of the security provisions set forth in this Agreement and will immediately coordinate with Anthem to investigate and remedy such breach(es) in a diligent and timely manner. Except as may be strictly required by Applicable Law, Supplier agrees that it will not inform any third-party of any such security breach, without Anthem's prior written consent; however, if such disclosure is required by Applicable Law, Supplier agrees to work with Anthem, at no additional cost to Anthem, regarding the content of such disclosure so as to minimize any potential adverse impact upon Anthem and its members.

9.3 Access to Anthem Systems. If Supplier is given access, whether on-site or through remote facilities, to any Anthem computer or electronic data storage system, in order for Supplier to perform any of its obligations hereunder, Supplier shall limit such access and use solely to perform such Services or other obligations and will not attempt to access any computer system, electronic file, software or other electronic services other than those specifically required to perform the Services or other obligations. Supplier shall limit such access to those of its personnel with an express requirement to have such access in connection with this Agreement or the applicable SOW, shall advise Anthem in writing of the name of each such personnel who will be granted such access (and identifying whether each is an employee or subcontractor of Supplier), and shall comply with any security policies Anthem may promulgate from time to time relating to use of Anthem electronic resources and systems. All user identification numbers and passwords disclosed to Supplier and any information obtained by Supplier as a result of Supplier's access to, and use of, Anthem computer and electronic storage systems shall be deemed to be, and shall be treated as, Anthem Confidential Information (as defined in Section 10.2 Confidential Information) under applicable provisions of this Agreement. Supplier shall cooperate with Anthem in the investigation of any apparent unauthorized access by Supplier to Anthem computer or electronic data storage systems or unauthorized release of Anthem Confidential Information by Supplier. Supplier's access shall be subject to such other business control and information protection policies, standards, and guidelines as may be provided to Supplier by Anthem from time to time and in Exhibit F (Required Information Security Controls) if made part of this Agreement. Any other use by Supplier of any other Anthem assets or property or systems is strictly prohibited. Supplier warrants and agrees that its personnel will not remotely access Anthem's system from a networked computer unless the network is protected from all third party networks by a firewall that is maintained with all patches up to date by a 7x24 administrative staff. Said firewall must be certified by the International Computer Security Association (ICSA) (or an equivalent certification as determined by Anthem) if the connection to Anthem's network is an ongoing connection such as frame relay or T1 line.

10. **CONFIDENTIALITY**.

10.1 HIPAA, Medicare, FEP, Medicaid. The provisions set forth in this Section 10 are in addition to and not in lieu of any confidentiality, privacy, security and other requirements imposed on Supplier in the Exhibits that form part of this Agreement. Notwithstanding anything to the contrary, in the event a BAA is not included with this Agreement or otherwise in place between the Parties, and

Supplier is engaged for services that include the potential for access to PHI, Supplier must enter into a BAA acceptable to Anthem prior to performing such services. In the event the BAA is not signed by Supplier, Anthem may withhold payment for such services and/or suspend or terminate such services without penalty or termination fees.

10.2 Confidential Information.

10.2.1 During the Term, a Party (the "Receiving Party") may be exposed to or acquire information regarding the business, projects, operations, finances, activities, affairs, research, development, products, technology, technology architecture, business models, business plans, business processes, marketing and sales plans, customers, finances, personnel data, health plan rating and reimbursement formulas, computer hardware and software, computer systems and programs, processing techniques and generated outputs, intellectual property, procurement processes or strategies or suppliers of the other Party or their respective directors, officers, employees, agents or clients (collectively, the "Disclosing Party"), including, without limitation, any idea, proposal, plan, procedure, technique, formula, technology, or method of operation (collectively, "***Confidential Information***"). With respect to Anthem only, Confidential Information shall include all Anthem Data and all Confidential Information of Anthem Affiliates.

10.2.2 Confidential Information shall not include any information that a Party can demonstrate: (i) was in the public domain at the time of disclosure to such Party; (ii) was published or otherwise became part of the public domain after disclosure to such Party through no fault of such Party; (iii) was previously disclosed to such Party without a breach of duty owed to the other Party by a third-party who had a lawful right to such information; or (iv) was independently developed by such Party without reference to Confidential Information of the other Party.

10.2.3 In addition, either Party may disclose Confidential Information to the extent disclosure is based on the good faith opinion of such Party's legal counsel that disclosure is required by law or by order of a court or governmental agency; provided that, the Party that is the recipient of such Confidential Information shall give prompt notice to the Disclosing Party, use all commercially reasonable efforts to maintain the confidentiality of the Confidential Information, and cooperate with the owner of such Confidential Information, in efforts to protect the confidentiality of such Confidential Information by an appropriate protective order. The owner of such Confidential Information reserves the right to obtain a protective order or otherwise protect the confidentiality of such Confidential Information. Each Party shall be responsible for its own costs with respect to the performance of its obligations under this Section. Either Party may disclose the existence of this Agreement and the terms of this Agreement to the extent required to enforce its terms or the rights of such Party hereunder or to comply with its legal obligations (but in the event either Party files this Agreement or portions thereof with any public agency it shall redact sensitive portions hereof, to the mutual written agreement of the other Party, which agreement shall not be unreasonably withheld or delayed).

10.2.4 Anthem Non-Disclosable Information. With respect to Anthem only, Confidential Information shall also include the following: (i) PHI and NPFI; (ii) other medical information and personal information regarding Anthem's or its Affiliates' health plan members, employees, or medical or hospital service providers; (iii) other information that Anthem or its Affiliates are required by law, regulation or company policy to maintain as confidential; (iv) other financial information concerning Anthem's or its Affiliates' health plan members, employer groups and other health plan groups or medical or hospital service providers that is disseminated by Anthem or its Affiliates internally for staff use; (v) personnel and payroll records, patient accounting and billing records, and information contained in those records; (vi) Anthem's or its Affiliates' trade secrets; and (vii) information that could aid others to commit fraud, sabotage or otherwise misuse Anthem's or its Affiliates' products or services or damage their business, including without limitation Exhibit F attached hereto and other Anthem security policies

(collectively, the "Anthem Non-Disclosable Information"). Due to the sensitive nature of the Anthem Non-Disclosable Information and due to Anthem's obligations to maintain the privacy of its customers and providers, Supplier acknowledges and agrees that Anthem Non-Disclosable Information shall at all times remain confidential and shall not be subject to exceptions, except as set forth in Exhibit A, BAA.

10.3 General Obligations. Each Party agrees to hold the Confidential Information of the other Party in strict confidence, to use such information solely in the course of performing its obligations hereunder, and to make no disclosure of such information except as authorized in accordance with the terms of this Agreement. To the extent a Party may be exposed to the Confidential Information of a third party (for example, because Supplier may be maintaining Anthem systems on which third party software is loaded, the Parties agree to accord such third party Confidential Information the same protections accorded a Party's Confidential Information hereunder. A Party may disclose Confidential Information to its personnel and the personnel of its subcontractors who have an absolute need to know such Confidential Information in order to fulfill its obligations hereunder and who have previously executed a written confidentiality agreement imposing confidentiality obligations no less restrictive than those applicable hereunder. In addition, either Party may disclose Confidential Information of the other Party to third party professional advisors (including accountants, auditors, attorneys, financial or other advisors) which are acting solely for the Party's benefit and on such Party's behalf, provided: (i) such professional advisors have previously executed a written confidentiality agreement imposing confidentiality obligations no less restrictive than those applicable hereunder; (ii) such professional advisors have a need to know such information in order to provide advice or services to the disclosing Party and agree to use the disclosing Party's Confidential Information solely for the purpose of providing such advice or services; (iii) such professional advisors agree not to disclose the Confidential Information to any other Party without the disclosing Party's prior written consent; and (iv) notwithstanding anything to the contrary, no Anthem Non-Disclosable Information is disclosed by the other Party to its professional advisors. Each Party shall be primarily responsible and liable for any confidentiality breaches by its personnel and the personnel of its subcontractors. Each Party shall immediately advise the other Party of any actual or potential violation of the terms of this Section 10, and shall reasonably cooperate with the Disclosing Party in relation thereto.

10.4 Continuing Obligations. A Party's obligation to maintain the confidentiality of Confidential Information shall remain in force until information falls within one of the exceptions noted in Section 10.2.2. Supplier's obligation to maintain the confidentiality of Anthem Non-Disclosable Information shall neither terminate nor expire.

10.5 Return of Confidential Information. Promptly upon expiration or termination of the entire Agreement or of a SOW (with regard to the Confidential Information disclosed under the Agreement or through such Agreement or SOW, as the case may be) or, in the case of Non-Disclosable Information at any time upon Anthem's request, the Receiving Party shall promptly, at the Disclosing Party's option, either return or destroy all (or, if the Disclosing Party so requests, any part) of the Confidential Information, and all copies, summaries and redactions thereof and other materials containing such Confidential Information, including deletion from such Party's files and systems and the Receiving Party shall certify in writing its compliance with the foregoing. Notwithstanding the foregoing, except for PHI or NPFI (which shall be promptly returned or destroyed), each Party may, subject to the obligations of confidentiality as described in this Section 10, retain (i) one (1) copy of the other Party's Confidential Information for archival purposes only, but such retained Confidential Information shall only be accessed by the retaining Party on a limited need basis to, for example, defend a claim by the other Party or for auditing purposes and (ii) reasonable archival records of payments, invoices and similar information for tax compliance, regulatory compliance, accounting, audit or similar purposes but only for the period of time required by this Agreement or Applicable Law; in each instance, all such retained Confidential Information shall remain the Confidential Information of the Disclosing Party and shall be subject to all of the restrictions contained in this Agreement.

10.6 Injunctive Relief. Each Party acknowledges that in the event of a breach of this Section 10 damages may not be an adequate remedy and the Disclosing Party may be entitled to seek, in addition to any other rights and remedies available under the Agreement or at law or in equity, injunctive relief to restrain any such breach, threatened or actual, without proof of irreparable injury and without the necessity of posting bond even if otherwise normally required.

11. **INSURANCE**.

11.1 Minimum Requirements. The Supplier shall, at all times during the term of this Agreement keep in force with insurers with an A.M. Best rating of A- or better:

i. Commercial General Liability insurance with a limit of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate naming Anthem as an additional insured and containing a waiver of subrogation;

ii. Automobile Liability insurance with a minimum $1,000,000 per occurrence combined single limit for owned, non-owned and hired automobiles;

iii. Workers' Compensation coverage with statutory limits and employers liability insurance, containing a waiver of subrogation with respect to Anthem for workers' compensation when applicable and permitted by law; unless, if Supplier is a sole proprietor, and is not, pursuant to applicable laws, statutes, rules or regulations required to required workers' compensation;

iv. Professional Liability insurance, applicable to the industry or specialty with a minimum $1,000,000 limit for each wrongful act and aggregate of not less than $3,000,000 if professional services are being rendered. In the event of cancellation of the professional liability insurance policy, an extended reporting period endorsement ("tail policy") is required for the term of at least one year in the amount of not less than the same limits above;

v. Commercial Crime/Employee Dishonesty with a limit of not less than $500,000. When applicable, Supplier will name Anthem as Loss Payee to the extent their interests may appear;

vi. Cyber, Network Security and Privacy liability) coverage with a minimum of not less than $1,000,000 per claim;

vii. Technology Professional Liability insurance, including Network Security and Privacy liability with a minimum $5,000,000 limit for each wrongful act and aggregate of not less than $5,000,000 if professional services are being rendered. In the event of cancellation of the professional liability insurance policy, an extended reporting period endorsement ("tail policy") is required for the term of at least one year in the amount of not less than the same limits above, and

viii. Umbrella Liability Coverage with a minimum of not less than $2,000,000.

The forgoing coverage amounts, with the exception of the Umbrella Liability coverage, may be met in part by an appropriate umbrella or excess liability policy.

11.2 Any materials or equipment brought on jobsite shall be insured under an all risk property insurance policy and shall be the sole responsibility of Supplier.

11.3 Supplier agrees that any subcontractors coming on the jobsite shall maintain workers' compensation insurance coverage. Supplier is solely responsible and liable for its subcontractors and any actions or inactions, damages or injuries by or to its subcontractors.

11.4 Proof of Insurance; Notice of Cancellation. Promptly upon Anthem's written request for same, Supplier shall cause its insurers or insurance brokers to issue certificates of insurance evidencing that the coverages required under this Agreement are maintained and in force. In addition, Supplier will use reasonable efforts to give thirty (30) days prior written notice to Anthem prior to cancellation or non-renewal of any of the policies providing such coverage; provided, however that Supplier shall not be obligated to provide such notice if, concurrently with such cancellation or non-renewal, Supplier provides self-insurance coverage as described below or obtains coverage from another insurer meeting the requirements described above. The furnishing of acceptable evidence of insurance does not relieve Supplier from any liability or obligation for which it is otherwise responsible to Anthem. The limits of insurance or applicable deductibles will not limit the liability of Supplier nor relieve Supplier of any liability or financial responsibility. Failure to maintain the required insurance coverage shall be deemed a material breach of the Agreement by Supplier. The failure of Supplier to purchase or maintain such insurance coverages, or the failure of Supplier to provide, or of Anthem to request, a copy of the certificates evidencing such coverages will not be considered or construed as a waiver by Anthem of the requirement that Supplier maintains such coverages, which such requirement will be continuing, and Supplier remains liable for all injuries and/or damages in accordance with the terms of this Agreement.

11.5 Supplier Right to Self-insure Coverage. Notwithstanding the foregoing, Supplier reserves the right to self-insure coverage, in whole or in part, in the amounts and categories designated above, in lieu of Supplier's obligations to maintain insurance as set forth above, at any time. Promptly upon Anthem's written request for same, Supplier shall provide evidence of all self-insured coverages required under this Agreement.

12. REPRESENTATIONS, WARRANTIES, AND COVENANTS.

12.1 General Warranties of Both Parties

12.1.1 Compliance with Laws. Each Party shall at all times comply with all Applicable Laws and regulations in the performance of this Agreement

12.1.2 Existence. Each Party is duly organized and existing and is in good standing and is qualified to do business under the laws of any jurisdiction where the ownership of assets or conduct of its business require it to be so qualified, and each Party possesses any and all licenses and/or governmental approvals required to perform the Services and/or to provide the Supplier-Provided Materials contemplated by this Agreement, and is qualified to perform such Services and/or provide such Supplier-Provided Materials.

12.1.3 Duly Authorized. Each Party's execution, delivery and performance of this Agreement has been duly authorized by all appropriate corporate action and this Agreement constitutes a valid, binding and enforceable obligation.

12.2 Supplier's Representations, Warranties, and Covenants. Supplier hereby represents, warrants and covenants:

12.2.1 No Conflict. Neither the execution, delivery, nor performance of this Agreement will conflict with or violate any other agreement, license, contract, instrument or other commitment or arrangement to which either Party is bound.

12.2.2 No litigation. There is no litigation and Supplier knows of no material threat of litigation that will affect the performance of its obligations hereunder.

12.2.3 Performance. At all times during the Term, each of Supplier's personnel assigned to perform Services or any other obligations under the Agreement shall have the proper skill, training and background so as to be able to perform the Services required to be performed by it hereunder and will perform such Services in a timely, good, workmanlike manner in accordance with high industry standards for such Services. At a minimum, Supplier will maintain staffing levels and continuity of personnel consistent with its obligations to perform Services hereunder and in the event of a delay or other problem, Supplier will train and staff additional personnel as needed.

12.2.4 Supplier's Employees. Supplier shall perform all obligations of an employer with respect to all personnel hired by Supplier in connection with any Services to be performed, including, but not limited to the withholding and reporting of contributions, insurance deductions and applicable taxes (including payroll and unemployment insurance taxes) required by Applicable Law.

12.2.5 Continuity of Key Personnel. Key personnel, if so specified in a SOW, shall be assigned pursuant to such SOW and should any such key personnel be unable to perform his or her obligations for any reason, Supplier shall replace such personnel as quickly as possible with personnel approved by Anthem in its sole discretion.

12.2.6 No Material Defects; Conformity with and Completeness of Documentation. Any Services and/or Supplier-Provided Materials to be provided, as applicable, shall be free from material errors or other defects; shall function properly; and shall substantially conform to all written specifications applicable thereto for a period of one (1) year after conclusion of any Final Acceptance Period The Documentation and other materials describing the Services and/or Supplier-Provided Materials hereunder completely and accurately reflect their operation and functionality. If the Services and/or Supplier-Provided Materials include a service or product from a third party and that third party provides a warranty, Supplier shall assign all rights under the third party warranty to Anthem.

12.2.7 All Rights; No infringement. Supplier has all rights and authorizations necessary to perform any Services and/or use or provide any Supplier-Provided Materials for Anthem's use and enjoyment as contemplated herein; and that unless otherwise specified in a SOW or attachment thereto, Supplier shall deliver all Deliverables and/or other Supplier-Provided Materials to Anthem free and clear of any liens, claims, charges or encumbrances; and that Supplier has proper title in all Deliverables and/or other Supplier-Provided Materials for which ownership is to be transferred to Anthem Further, if applicable, Supplier shall pass through to Anthem any product and third party end-user warranties and indemnities relating to the Deliverables. To the extent Supplier is not permitted to so pass-through, Supplier agrees to enforce such warranties and indemnities on behalf of Anthem. All Supplier-Provided Materials, and all elements thereof to be provided by Supplier, if any, unless provided by Anthem, and any Services performed by Supplier, will not violate, misappropriate or infringe upon any patent, copyright, trademark, trade secret, or other intellectual, contractual, proprietary, employment, or confidentiality right of a third party; there are no claims of any third party against Supplier relating to any IP that is the subject of, to be provided under, or to be used directly or indirectly pursuant to this Agreement.

12.2.8 No Disabling Devices. All Supplier-Provided Materials and/or Services provided by Supplier do not, and will not when delivered or provided, contain any computer code (i) designed to disrupt, disable, harm, or otherwise impede in any manner the operation thereof, or any other associated software, firmware, hardware, computer system or network (sometimes referred to as "viruses" or "worms") and Supplier has taken reasonable steps to test for, and has found no such, viruses or worms Supplier shall not allow unauthorized traffic to pass into Anthem's networks. Supplier agrees that in the event of any dispute with Anthem regarding an alleged breach of this Agreement or for any other reason, Supplier will not use any type of electronic means to prevent or interfere with Anthem's use of any system or Deliverable created for Anthem under this Agreement or any SOW without first obtaining a valid court order authorizing same. Anthem shall be given proper notice and an opportunity to be heard in connection with any request for such a court order. Supplier understands that a breach of this provision could foreseeably cause substantial harm to Anthem and to numerous third parties having business relationships with Anthem. No limitation of liability shall apply to a breach of this paragraph.

12.2.9 Deliverable Functionality. Each Deliverable will accept input, perform processes, and provide output in a manner that (i) is consistent with its intended use and all applicable specifications; (ii) prevents ambiguous or erroneous results; and (iii) will not result in any adverse effect on functionality or performance of any Deliverable.

12.2.10 Alpha/Beta Site. Supplier shall not use Anthem as an alpha or beta site for any Supplier-Provided Materials or Services to be provided, if any, without the prior written consent of Anthem.

12.2.11 Government Programs; Ineligible Persons. Supplier represents and warrants that neither Supplier nor its employees, subcontractors or agents providing Services or Supplier-Provided Materials under this Agreement has been, nor shall be during the term of this Agreement (i) excluded from participation in the Medicare, Medicaid and/or any state health care program; (ii) listed on any General Services Administration List of parties Excluded from Federal Procurement and Non-procurement Programs; (iii) sanctioned by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, or any other federal agency; and (iv) under a corporate integrity agreement with the United States Department of Health and Human Services, Office of Inspector General, or any other federal agency; in the event Supplier or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Supplier has an obligation to (i) immediately notify Anthem of Supplier's status as an ineligible person and (ii) within ten (10) days of Supplier receiving such notice, Supplier will remove such individual from responsibility for, or involvement with, Supplier's business operations related to the federal government healthcare contracts. Anthem shall have the right to immediately terminate this Agreement or applicable SOW in the event it receives notification of the Supplier's ineligible person status. Supplier also covenants and represents that it complies with the rules set forth by the Office of Foreign Assets Control of the United States Department of Treasury.

12.2.12 Criminal Convictions. Neither Supplier nor its employees, subcontractors or agents has been, nor shall be during the Term, convicted of a criminal offense related to the delivery of an item or service under Medicare, Medicaid and/or under any state health care program.

12.2.13 Embedded Software. All Open Source Software (as defined herein) and non-Open Source third-party software components provided by Supplier to Anthem shall be considered "Embedded Software" and subject to all warranties, indemnities and other requirements of this Agreement, including scope of license, maintenance and support. "Open Source Software" means any software, programming or other IP that (a) contains or is derived in any manner (in whole or in part) from any software that is distributed as free software, open source software, shareware or similar licensing or

distribution models; and (b) is subject to any agreement with terms requiring that such IP be (i) disclosed or distributed in source code or object code form; (ii) licensed for the purpose of making derivative works; and/or (iii) freely redistributable by end users to third parties without payment of compensation. Open Source includes but is not limited to software licensed or distributed under any of the following licenses or distribution models: the GNU General Public License, GHN Library General Public License, Artistic License, BSD license, Mozilla Public License, or any similar license, including those licenses listed at www.opensource.org/licenses. Supplier has identified each item of Embedded Software in an attachment to this Agreement or in the Order Schedule, and has provided Anthem with copies of all relevant license agreements relating to such Open Source Software, and has sufficient rights to provide all Embedded Software to Anthem for use as permitted hereunder.

12.2.14 Compliance with Applicable Laws. Supplier shall perform its obligations hereunder in accordance with all Applicable Law, and shall be responsible for obtaining all licenses, authorizations, permits and the like required by Applicable Laws and regulations, and any fees, costs or expenses incurred by Supplier shall be borne solely by Supplier. Supplier shall be solely responsible for any fines and penalties imposed on Supplier or Anthem resulting from Supplier's failure to comply with any such Applicable Laws and regulations and Supplier shall indemnify, protect and defend Anthem therefrom.

12.2.15 Location of Work. Supplier warrants that all Services shall be performed in locations approved in writing by Anthem in advance. All such locations shall be in the United States and at no other location, and any Services governed by Exhibit E shall be provided in the applicable State unless otherwise agreed in writing by Anthem.

12.2.16 Compliance with Foreign Corrupt Practices Act.

12.2.16.1 Acknowledgement. The FCPA makes it unlawful for a U.S. Company, U.S. citizens, or anyone acting on a U.S. company's behalf (including certain foreign subsidiaries of U.S, companies) to offer, pay, promise or authorize to pay any money, gift or any other items of value directly or indirectly to any Foreign Official with the intent of causing the Foreign Official to misuse such official's position to obtain or retain business for the U.S. company or one of its subsidiaries or affiliates. Under the FCPA, the term Foreign Official is broadly defined to include not only traditional government officials and those employed by government agencies, departments, or ministries, but also employees of companies which are owned or controlled by the state. To obtain or retain business has also been construed broadly to mean other discretionary decisions of government officials, even if they do not relate directly to purchasing decisions. Supplier acknowledges and confirms its understanding of the FCPA, and its receipt of a copy of the FCPA, and agrees to comply with those provisions and not to take or fail to take any action that might in any way cause Supplier or the Company to be in violation of the FCPA, or any other applicable anti-bribery laws (including the U.S. Travel Act).

12.2.16.2 Representations, Warranties and Covenants of Supplier. Supplier makes the following representations and warranties to Anthem, and covenants and agrees as follows:

12.2.16.2.1 Public and Commercial Bribery Representations, Warranties and Covenants of Supplier. Supplier hereby represents, warrants and covenants to Anthem that it has not, and covenants and agrees that it will not, in connection with the transactions contemplated by the Agreement or in connection with any other business transactions involving Anthem, make or promise to make any payment or transfer of any item of value, directly or indirectly to any Foreign Official with the intent of causing the Foreign Official to misuse such official's position to obtain or retain business for Anthem or one of its subsidiaries or affiliates. In addition, Supplier will not provide any gifts or business entertainment to a Foreign Official on behalf of the Company, or in connection to any business transactions involving the Company, without the written pre-approval by the Company's Chief

Compliance Officer and Chief Accounting Officer (or their designees). It is the intent of the parties that no payments or transfers of value shall be made which have the purpose or effect of public or commercial bribery, acceptance of or acquiescence in extortion, kickbacks or other unlawful or improper means of obtaining business.

12.2.16.2.2 No Governmental Ownership of Supplier. Supplier hereby represents and warrants to Anthem that no ownership interest, direct or indirect, in Supplier or in the contractual relationship established by the Agreement, is held or controlled by any Foreign Official, governmental body, political party, or a family member (or friend) of a Foreign Official through whom the Foreign Official will indirectly benefit from the Agreement.

12.2.16.2.3 Supplier Compliance Procedures Acknowledgement. Supplier agrees (i) any payments to Supplier by Anthem under the Agreement shall be made by check or wire transfer only, directly to Supplier or to a bank account in Supplier's name, and no requests for cash payments or other payments in non-bearer form shall be accepted; (ii) any payments to Supplier by Anthem shall be made in the country where Supplier is to perform its duties under the Agreement or in the United States; (iii) Supplier agrees that its books and records showing expenses incurred pursuant to this Agreement shall reflect the purpose for which each expenditure was made and for whose benefit the expenditure was made and that there will be written records of each and every service that Supplier performs for Anthem or on Anthem's behalf; (iv) Supplier shall retain accurate, detailed records of, and permit Anthem to review upon written request, any expenses or costs of Supplier which Anthem is required to reimburse under the Agreement, including any training-related expenses; and (v) the terms of the Agreement may be disclosed to government agencies and other persons with a legitimate need for such information, including, but not limited to, the U.S. Department of Justice.

12.2.16.3 Anthem's Rights upon an FCPA Default. In the event that Anthem believes in good faith, and whether or not it has conducted an investigation, that Supplier has acted in any way that may subject Anthem or any of its affiliates to liability under the FCPA, Anthem shall have the unilateral right, exercisable immediately upon written notice to Supplier, to terminate the Agreement, subject to the provisions of **Section 7** of the Agreement

12.2.17 Affordable Care Act Compliance

12.2.17.1 For purposes of Section 4980H of the Internal Revenue Code of 1986, as amended ("Code"), Supplier agrees and confirms that Supplier, and not Anthem, is the common-law employer of each Supplier personnel. Accordingly, the Supplier is responsible for complying with the requirements of Section 4980H of the Code, and the regulations promulgated thereunder with respect to each Supplier personnel, including, without limitation, the obligation to offer "Compliant Coverage" (as hereafter defined) on behalf of Anthem in accordance with Treas. Reg. § 54.4980H-4(b)(2). As such, the Parties acknowledge and agree that the fee paid by Anthem to Supplier is higher than the fee that Anthem would otherwise pay the Supplier if the Supplier personnel did not enroll in such Compliant Coverage. For purposes of this Agreement, "Compliant Coverage" means coverage under an "eligible employer-sponsored plan" under Code Section 5000A(f)(2) and applicable regulations and guidance thereunder sponsored by Supplier which, with respect to the individual covered by such coverage, as applicable, (i) provides "minimum essential coverage" as defined in Code Section 5000A(f)(1); and (ii) satisfies the terms of Code Section 36B(c)(2)(C)(i) (coverage must be affordable) and Code Section 36B(c)(2)(C)(ii) (coverage must provide minimum value).

12.2.17.2 For each calendar month covered by this Agreement, Supplier shall provide each Supplier personnel who is a "full-time employee," as defined in Code Section 4980H(c)(4), the opportunity to enroll himself/herself, and his/her "Dependent(s)" (as defined under

applicable regulations and guidance under Code Section 4980H) in Compliant Coverage. Supplier, and not Anthem, shall be responsible for determining whether any Supplier personnel is a full-time employee under Code Section 4980H(c)(4), which determination shall be made in accordance with a method for determining whether an employee is a full-time employee described in applicable regulations or guidance issued under Code Section 4980H. The obligation to provide Compliant Coverage under this subsection applies even to those employees who Supplier determines are not full-time employees, but who are later determined by the Internal Revenue Service, a court or other governmental authority to be full-time employees under Code Section 4980H(c)(4).

12.2.17.3 Supplier's obligations under Section 12.2.17.2 above are absolute and are not dependent on whether Supplier would be subject to a "Penalty" (as hereafter defined) if Supplier personnel enrolled in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the Supplier personnel. By way of illustration and not limitation, Supplier shall, for example, be obligated under Section 12.2.17.2 to offer any Supplier personnel the opportunity to enroll in Compliant Coverage regardless of whether Supplier is, in fact, an "applicable large employer" with respect to such Supplier personnel or whether Supplier has determined that, if Supplier failed to offer Compliant Coverage to an Supplier personnel for any reason, such as offering Compliant Coverage to at least 95% of its other full-time employees, Supplier would not be subject to a Penalty. For purposes of this Agreement, "Penalty" means an assessable payment described in Code Section 4980H(a) or Code Section 4980H(b).

12.2.17.4 At least annually, or with such other frequency as reasonably requested by Anthem, Supplier shall certify to Anthem its compliance with the terms of this Section 12.2.17.

12.2.18 Outbound Telecommunications Requirements

12.2.18.1 Supplier shall comply with all applicable telecommunication laws and regulations including, without limitation, the Telephone Consumer Protection Act (47 USC 227), and the rules, and regulations and guidance promulgated thereunder issued by the Federal Communications Commission (47 CFR Parts 64 and 68); the Telemarketing and Consumer Fraud and Abuse Prevention Act (15 USC 6101-8) as implemented by the Telemarketing Sales Rule issued by the Federal Trade Commission (16 CFR Part 310); and all state laws, rules, regulations and (for Medicaid) state contract provisions that apply to outbound health related telephone contact, including text or SMS messages sent to wireless numbers, and outbound telemarketing telephone contact, including text or SMS messages sent to landline or wireless numbers with Covered Individuals, potential members, and providers.

12.2.18.2 Further, Supplier is subject to Anthem's VENDOR GUIDELINES FOR TCPA (the "Guidelines"), which Anthem shall communicate to Supplier in writing (email is acceptable). The Guidelines are designed to ensure that Anthem's outbound telephone contacts with Covered Individuals or potential members, including text or SMS messages, comply with the law and also meet Anthem's quality standards. To the extent the Guidelines conflicts with terms of this agreement, the Guidelines shall govern.

12.2.18.3 In accordance with Anthem's record retention obligations, Supplier is responsible for retaining records, including but not limited to call logs and recordings, in accordance with Anthem's requirements and must retain records for at least four years from the last phone call or text message. Supplier shall inform Anthem, in writing, at least five business days prior to the

disposal of any such records. This writing shall be sent to TCPAComplianceHelpDesk@Anthem.com and copied to your Anthem contact.

12.2.18.4 Supplier shall comply with the Guidelines existing as of the Effective Date and shall take all necessary steps to remain compliant with the Guidelines as they are amended and revised from time to time

12.2.18.5 Supplier is responsible for compliance with the obligations stated above and will indemnify Anthem, including reimbursement of attorney's fees and costs associated with litigation, and accept Anthem's tender of defense should there be a lawsuit or third-party claim against Anthem relating to Supplier's alleged violation of the above-mentioned laws, including the TCPA.

12.2.19 Website Accessibility Standards. To that extent that Supplier is providing development, design and/or maintenance of any electronic and information technology, including, without limitation, any consumer facing web and mobile experiences, Supplier shall ensure that all such electronic and information technology meets, to the extent possible, the accessibility requirements set forth in Section 508 of the Rehabilitation Act (29 USC 794(d)), the related Technical Standards issued by the Architectural and Transportation Barriers Compliance Board (aka the "Access Board"), success level AA or higher of the most current Web Content Accessibility Guidelines issued by the Worldwide Web Consortium, and any other federal or state law which requires specific design elements to accommodate disabled individuals.

12.2.20 Certain Employment Obligations. When Supplier provides services or goods to Anthem relating to one of its federal contracts, Supplier agrees to comply with the following federal regulations, as applicable: **Supplier shall abide by the requirements of 41 CFR §§ 60-1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, national origin, protected veteran status or disability.**

12.2.21 Certification of Compliance. Upon request by Anthem, Supplier shall provide Anthem with reasonable assurances of Supplier's compliance with the terms of this Agreement and any Exhibit(s). Reasonable assurances may include, but are not limited to, Supplier's signed certification of such compliance, as it applies to certain requirements, and/or the Agreement or Exhibit(s) generally.

12.3 Certain Warranty Remedies. Should Anthem be prevented from using any Supplier-Provided Materials or receiving any Service due to a breach of the aforementioned warranties, and in addition to all other obligations and remedies herein, Supplier shall at its expense but at Anthem's discretion, and in addition to any other rights or remedies available to Anthem under the Agreement, at law or in equity, (i) modify the Supplier-Provided Materials without impairing in any material respect its functionality or performance, so that it complies with all warranties, (ii) in the case of an infringement of third-party rights, procure for Anthem the right to continue to use the Supplier-Provided Materials or affected Service, or (iii) replace the affected Supplier-Provided Materials with equally suitable and functionally equivalent, non-infringing software, materials, equipment, processes, items, and/or documentation, as applicable, or, as to Services, secure equally suitable alternatives.

12.4 Refund for Certain Service Failures. To the extent Services are to be performed by Supplier and Supplier fails to provide Services in accordance with this Agreement, Supplier shall at its expense but at Anthem's discretion, and in addition to any other rights or remedies available to Anthem under the Agreement, at law or in equity, refund to Anthem all amounts paid for the failed Services and all other Services materially or adversely affected.

12.5 Anthem's Representations and Warranties. Anthem hereby represents and warrants that the materials provided to Supplier by Anthem, and elements thereof, shall not, to the best of Anthem's knowledge, violate or infringe upon any IP or confidentiality right of a third party.

13. INDEMNIFICATION.

13.1 Supplier's Indemnities. Supplier shall indemnify, defend and hold harmless Anthem and its Affiliates, and their respective successors and assigns (and its and their respective officers, directors, employees, sublicensees, customers and agents) from and against any third party claims and damages based upon (i) any allegation that any portion of the Supplier-Provided Materials and/or Services, as applicable, provided by Supplier to Anthem pursuant to this Agreement, infringes, misappropriates or violates any IP right of any person or entity; (ii) a breach of Supplier's representations and warranties; (iii) the failure by Supplier to comply with applicable governmental laws or regulations; (iv) a breach of Supplier's obligations with regard to PHI and NPFI as set forth in Section 10 and Exhibit A (BAA); (v) a breach of Supplier's obligations under Exhibits B, C, E and/or G, (vi) a breach of Supplier's security or confidentiality obligations as set forth in Sections 9 (Security) (including Exhibit G referenced therein) and 10 (Confidentiality), respectively; (vii) any claim relating to any act, omission, negligence or willful misconduct on the part of Supplier, its personnel, subcontractors, and/or agents, resulting in personal injury, death, or damage to property; (viii) any claim of a Supplier subcontractor against Anthem; and (ix) any act or conduct by a subcontractor based on a claim falling within the foregoing categories (i) through (viii), inclusive. In addition to the indemnification obligations set forth in this Agreement, in the event of a disclosure of Protected Health Information or Nonpublic Personal Financial Information by Supplier, Supplier shall indemnify Anthem for all costs related to the investigation as well as, at Anthem's election, furnishing notice to affected Anthem participants and/or the offer of ongoing credit monitoring services to such affected individuals. This indemnification by Supplier shall survive the termination of this Agreement.

13.2 Anthem's Indemnities. Anthem shall indemnify, defend and hold harmless Supplier from and against any third party claims and damages based upon (i) any allegation that the Confidential Information provided by Anthem to Supplier pursuant to this Agreement infringes, misappropriates or violates any IP right of any person or entity; (ii) any claim relating to any act, omission, negligence or willful misconduct on the part of Anthem or its personnel resulting in personal injury, death, or damage to property; (iii) breach of Anthem's representations and warranties; and (iv) breach of Anthem's confidentiality obligations as set forth in Section 10.

13.3 Notice and Participation. The indemnified Party may, at its own expense, assist in the defense of any indemnifiable claim described in this Section 13 if it so chooses, provided that, as long as indemnifying Party can demonstrate sufficient financial and legal resources, indemnifying Party shall control such defense and all negotiations relative to the settlement of any such claim, and further provided that any settlement intended to bind the indemnified Party or which may adversely affect the indemnified Party shall not be final without such indemnified Party's prior written consent, not to be unreasonably withheld or delayed. Notwithstanding the foregoing, if the claim relates to a violation of governmental law or regulation as set forth in Section 13.1 (iii) or to a breach of Supplier's obligations relating to PHI

and NPFI as set forth in Section 13.1 (iv), and Anthem determines in its own discretion it has a compelling interest in conducting its own defense, then Supplier shall indemnify Anthem for Anthem's reasonable costs of defense (including attorneys' fees) and for all related damages, assessment of fines, penalties or other regulatory assessment, and/or settlement or compromise (and provided Anthem gives Supplier an opportunity to comment on any proposed settlement or compromise). The indemnified Party shall provide the indemnifying Party with reasonable written notice of any claim that such indemnified Party believes falls within the scope of this Section 13.3. Each Party shall use reasonable efforts to mitigate any potential damages or other adverse consequences arising from or related to the Services and/or Supplier-Provided Materials.

14. LIMITATION OF LIABILITY.

14.1 No Consequential Damages. Except as set forth in Section 14.3 below, neither Party or its Affiliates shall be liable for any indirect, incidental, special, consequential, exemplary or punitive damages (including, without limitation, loss of profits) arising out of or relating to this Agreement, even if such Party or its Affiliate has been advised of the possibility of such damages.

14.2 Limit on Direct Damages. Except as set forth in section 14.3 below, neither Party's nor its Affiliates' aggregate liability arising out of or relating to this Agreement shall exceed the greater of (a) the amount paid or payable by Anthem to Supplier, pursuant to this Agreement, in the thirty-six (36) months preceding the month in which the event occurred or dispute arose giving rise to the claim for damages or (b) two (2) times the total fees payable by Anthem to Supplier, or in the event the Services are provided pursuant to a credit from Supplier, then two (2) times the value of the credit pursuant to this Agreement. Any amount owed by Supplier to Anthem or its Affiliates in the way of Service credits and a failed service level agreement as set forth in a SOW, if applicable, shall not count toward any calculation of damages under this section.

14.3 Exceptions to Limitation of Liability. The limitations of liability in Sections 14.1 and 14.2 shall not apply to (i) a Party's indemnification obligations under the Agreement, (ii) a breach by a Party of its confidentiality or security obligations under the Agreement, (iii) claims relating to willful misconduct, gross negligence, personal injury or damage to property, (iv) abandonment by Supplier of the Agreement, a breach by Supplier of the paragraph entitled "Electronic Self-Help", or (v) any fines or penalties arising from Supplier's acts or omissions in performing Services (unless such acts or omissions were undertaken at Anthem's instruction).

15. SUBCONTRACTORS.

15.1 Supplier shall not subcontract any of its obligations without (i) notifying in writing Anthem of the scope of the proposed subcontract, the identity and qualifications of the proposed subcontractor and the reasons for subcontracting the work in question (and allowing Anthem a reasonable period of time for evaluation of Supplier's request), (ii) causing the proposed subcontractor to agree in writing to perform and be subject to all of Supplier's obligations under this Agreement, and (iii) obtaining Anthem's prior written approval of that subcontractor. Neither Supplier nor any authorized subcontractor may subcontract its performance of any obligation under any Agreement without the prior written consent of Anthem in each instance. Supplier shall also include language in its subcontract prohibiting further subcontracting without Anthem's prior written approval.

15.2 Notwithstanding Anthem's approval of a subcontract arrangement, Supplier shall remain primarily liable for the performance of all subcontracted obligations and Supplier shall promptly pay for all Services, materials, equipment and labor used by Supplier. Regardless of any subcontract, Supplier

shall remain Anthem's sole point of contact under this Agreement. At Anthem's reasonable request, Supplier shall promptly remove and/or replace any subcontractor.

16. **DISPUTE RESOLUTION**.

16.1 Informal Dispute Resolution.

16.1.1 Good Faith Efforts. The Parties agree that they will make a good faith attempt to resolve any dispute arising under this Agreement before instituting legal action. Such good faith attempt shall include, but not be limited to, elevating the issue to management personnel of each Party who have the power to settle the dispute on behalf of that Party and, failing that, to a vice president level executive for each Party, as noted in 16.1.2 below.

16.1.2 Escalation to Executives. To the extent any disagreements arising under this Agreement are not resolved by the management personnel of each Party within a reasonable time after the occurrence of the disagreement, either Party may give to the other notice in writing (the "Notice") that a dispute has arisen. The Notice shall contain (i) a detailed description of the dispute and all relevant underlying facts, and (ii) a detailed description of the amount(s) in dispute and how they have been calculated. Within fourteen (14) days after the date of the Notice, such dispute shall be referred to a vice president level executive for each Party.

16.1.3 Failure of Informal Efforts. If such executive officers of both Parties are unable to resolve the dispute within fourteen (14) days of the referral to them, either Party shall be free to pursue any claim in accordance with this Section 16.

16.2 Binding Arbitration.

16.2.1 Except as otherwise provided below in this paragraph, all disputes that arise from or relate to this Agreement shall be decided exclusively by binding, non-appealable arbitration in Marion County, Indiana under the JAMS Comprehensive Arbitration Rules (the "Rules"), provided, however, the Parties may agree in writing to further modify the Rules. The dispute shall be decided by a sole arbitrator, who shall be a retired or former judge, or an attorney with at least ten (10) years of experience, and be mutually acceptable to the Parties. If the amount in controversy exceeds two million dollars ($2,000,000.00), then a three person panel of arbitrators with similar qualifications shall preside rather than a sole arbitrator, unless the Parties agree in writing that the dispute shall be decided by a sole arbitrator. The sole arbitrator (or panel) shall be selected by mutual agreement of the Parties, or, if the Parties cannot agree upon an arbitrator within ten (10) days, then each Party shall select an arbitrator who shall confer and select a third arbitrator to serve. If a three person panel is required, each Party shall select an arbitrator and the two arbitrators shall together designate a third to serve with them on such panel. The arbitrator shall issue a short written statement (not to exceed 15 pages, excluding exhibits) setting forth its decision and reasons therefore. The Parties agree that the arbitrator's award shall be final, and may be filed with and enforced as a final judgment by any court of competent jurisdiction.

16.2.2 Costs and Fees. Each Party will bear its own attorneys' fees and its own costs and expenses (including filing fees), and will also bear one half of the total arbitrator's and other administrative fees of arbitration

16.2.3 No Power to Alter Agreement. The arbitrator shall have no power to (i) award damages in excess of the amount or other than the types allowed by Section 14 (Limitation of

Liability); or (ii) alter any of the provisions of this Agreement. Either Party may seek interim measures of protection concerning any subject matter of the dispute subject to arbitration, including but not limited to interim injunctive relief, in a court of competent jurisdiction located in Marion County, Indiana.

16.2.4 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, the Parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

16.3 Disputes Involving Confidential Information or Intellectual Property. Notwithstanding the foregoing, in any dispute concerning Anthem Confidential Information and intellectual property, Anthem may elect to have the dispute resolved by a court of competent jurisdiction located in the Marion County, Indiana and upon Anthem's commencement of any such action, any arbitration then pending shall be stayed, insofar as it concerns Anthem Confidential Information or intellectual property. Without limiting the generality of the foregoing, Supplier acknowledges that irreparable injury may result to Anthem in the event that Supplier fails to perform its obligations under this Agreement with respect to Anthem Confidential Information or IP and agrees that, in such event, Anthem shall be entitled, in addition to any other remedies and damages available to it, to seek interim injunctive relief to restrain the breach or compel the performance of this Agreement.

16.4 Consent to Jurisdictions. The Parties consent and agree to the exclusive jurisdiction of the tribunals mentioned in this Section 16, and waive any and all objections to such forums, including but not limited to objections based on improper venue or inconvenient forum.

16.5 Waiver of Jury Trial. Each of the parties hereby unconditionally waives any right to a jury trial with respect to and in any action, proceeding, claim, counterclaim, demand, dispute or other matter whatsoever arising out of this agreement.

16.6 Continued Services; Enforcement. In all circumstances other than Anthem's failure to pay undisputed amounts as set forth herein, Supplier shall continue timely performance of any Services it provides or its other obligations under this Agreement and, if it discontinues or does not timely perform such Services or other obligations, Anthem may seek a temporary and/or permanent injunction or similar order in any state or federal court within the State of Indiana for the sole purpose of compelling continued and timely performance of Supplier's obligations hereunder. The provisions of this Section may be enforced by any court of competent jurisdiction, and the prevailing Party in any such action shall be entitled to an award of all costs, fees and expenses, including attorneys' fees.

16.7 Statute of Limitations. The statute of limitations with respect to any claim or matter submitted to arbitration shall be suspended as of the date of a demand for arbitration hereunder (or, if not determinable, as of the date of receipt of such request), and shall be tolled until the date of any formal settlement agreement entered into by the Parties or the date of any final determination issued by an arbitrator, as the case may be, but in any event not longer than six (6) months from the date such statute of limitations was suspended, unless the Parties specifically agree in writing to a different tolling period.

16.8 Electronic Self-Help. Supplier agrees that in the event of any dispute with Anthem regarding an alleged breach of this Agreement or for any other reason, Supplier will not use any type of electronic means to prevent or interfere with Anthem's use of any system or Deliverable created for

Anthem under this Agreement or any SOW without first obtaining a valid court order authorizing same. Anthem shall be given proper notice and an opportunity to be heard in connection with any request for such a court order. Supplier understands that a breach of this provision could foreseeably cause substantial harm to Anthem and to numerous third parties having business relationships with Anthem. No limitation of liability shall apply to a breach of this paragraph.

17. **MISCELLANEOUS**.

17.1 Assignment. Supplier may not assign its rights or obligations under the Agreement to any third party without the prior written consent of Anthem. Anthem may assign this Agreement to any Affiliate or in the case of a merger or acquisition of all or substantially all of Anthem's assets. The Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns.

17.2 Trademarks and Branding/No Publicity.

17.2.1 Except as may be explicitly set forth in this Agreement, neither Party shall use the name, logo, service marks, domain names, symbols or any other name or mark of the other Party or the other Party's Affiliates, without the prior written consent of the other Party. Without limiting the foregoing, except as may be required by applicable law or legal process, neither Party shall at any time either during the Term or at any time after any expiration or termination of this Agreement: (i) disclose in advertising campaigns, public relation campaigns or otherwise publicize or disclose the existence of this Agreement, or any terms or conditions of this Agreement, or Anthem's or its Affiliates' status as a customer of Supplier (provided that each Party may disclose the existence of this Agreement when responding to a request for proposal or request for information) or (ii) provide a hyperlink from any Internet site that it maintains to any Internet site maintained by the other Party or any of the other Party's Affiliate. Supplier shall not extract any information or other data from any Internet site maintained by Anthem or any Anthem Affiliate, including framing and deep linking, without the express written consent of Anthem

17.2.2 In addition, Supplier has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Supplier to use the Brands. Any references to the Brands made by Supplier in its own materials are subject to review and approval by Anthem.

17.2.3 Supplier shall have the sole right to label and brand its services and products, and shall have the sole right to use its service and product names and brands. Anthem shall have the sole right to label and brand its services and products that are provided by Supplier or that use Supplier IP as permitted under this Agreement.

17.3 Governing Law. The Agreement shall be governed by and construed in accordance with the laws of the State of Indiana, without giving effect to its conflict of laws principles.

17.4 Notices. All notices, requests, claims, demands, and other communications (each a "***Notice***") under the Agreement shall be in writing and shall be given or made by delivery in person, by email, by facsimile, by courier service, or by certified mail (postage prepaid, return receipt requested) to the respective Party at the following address set forth below or at such other address as such Party may hereafter notify the other Party in accordance with this Section. Each such Notice will be effective as follows: (a) as of the day transmitted by facsimile if receipt has been electronically confirmed; (b) as of the date emailed if receipt has been electronically confirmed or so long as a duplicate copy is

contemporaneously provided by another Notice methodology set forth in this Section; (c) as of the date actually delivered if sent by a recognized commercial express delivery service that uses delivery tracking technology; (d) four (4) business days after the date actually deposited with the U.S. mail if sent postage-paid First Class; and (e) as of the date actually delivered if delivered by personal courier to the office location of the recipient during normal business hours.

For Anthem:

Anthem, Inc.
220 Virginia Avenue
Indianapolis, IN 46204
Attention: General Counsel

With a mandatory copy to:

Anthem, Inc.
220 Virginia Avenue
Indianapolis, IN 46204
Attention: Procurement - Contract Administration

For Supplier:
Please provide the following and then delete this list
Vendor name
Vendor Contact Name
Vendor Contact Address
Vendor Contact Phone Number
Vendor Contact E-Mail

17.5 Modification; Waiver.

17.5.1. No modification to the Agreement shall be valid unless in writing and signed by each Party. No delay or omission by either Party to exercise any right or power it has under this Agreement shall impair or be construed as a waiver of such right or power. A waiver by any Party of any breach or covenant shall not be construed to be a waiver of any succeeding breach or any other covenant. All waivers must be in writing and signed by the Party waiving its rights.

17.5.2. Nothing on any invoice, purchase order acknowledgment, click wrap, shrink wrap license or any other "boilerplate" or standard terms issued by Supplier at any time during the Term shall contradict, vary or amend the terms of this Agreement and any contrary or differing term shall have no force and effect.

17.6 No Gratuities or Kickbacks. Anthem may, by written notice to Supplier, terminate the Agreement, any SOW, and some or all rights of Supplier hereunder, if Anthem has a reasonable cause to believe that gratuities (in the form of entertainment, gifts or otherwise that are of inappropriate value and/or not in accordance with Anthem's policies in excess of that which is reasonable and customary in Anthem's industry, or which would not be considered in good taste if publicly scrutinized) were offered or given by Supplier, or any employee, subcontractor, agent or representative of Supplier, to an officer or

employee of Anthem or any Anthem Affiliate in a position to secure or influence the awarding or amendment of the entire Agreement or, of any SOW or any determination with respect to Supplier's performance hereunder, or any decision or action favorable to Supplier.

17.7 Force Majeure.

17.7.1 General. A delay by a Party in the performance of its obligations under this Agreement shall not be deemed a default of this Agreement to the extent that such delay is attributable to a Force Majeure Event and could not have been prevented or minimized by the non-performing Party by means of the exercise of reasonable precautions, or cannot reasonably be circumvented by the non-performing Party in a commercially reasonable manner, including through the use of alternate sources or work-around plans. Notwithstanding the foregoing, Supplier acknowledges and agrees that this Section 17.7 shall not limit Supplier's obligation to initiate the applicable BCP and provide timely and effective disaster recovery for the Services described in this Agreement, the applicable Statement of Work, or any Exhibits and schedules thereto.

17.7.2 Right to Terminate. If a Force Majeure Event prevents, hinders or delays a Party's ability to perform for more than ten (10) days and materially and adversely affects the other Party, then in such event the other Party may, in its reasonable discretion, choose to terminate the applicable Statement of Work upon written notice.

17.7.3 Force Majeure Event. The term "Force Majeure Event" shall mean a fire, flood, earthquake, terrorism, or similar act beyond the reasonable control of a Party. A strike, lockout or similar labor dispute by Supplier personnel shall be deemed to be within Supplier's reasonable control. In addition, if Supplier reasonably believes that an act of war, riot, civil disorder, or rebellion is likely, either Party may request that certain changes to the Services be proposed in light of such Force Majeure Event. Unless otherwise mutually agreed by the Parties, if Anthem agrees to changes initiated by Supplier due to an act of war, riot, civil disorder, or rebellion, Supplier shall bear all costs and expenses to perform and implement the changes. If Anthem does not agree to so change the Services, or if the event of war, riot, civil disorder, or rebellion occurs, such event shall be deemed to be a Force Majeure Event.

17.7.4 Allocation of Resources. If a Force Majeure Event causes Supplier to allocate limited resources between or among Supplier's customers, and if the Services are disrupted by such Force Majeure Event, Supplier shall not treat any other customer better than Anthem nor reduce process capacity or performance below the business continuity requirements stipulated in BCP. If a Force Majeure Event causes Supplier to allocate limited resources between or among Supplier's customers, and if the Services are not disrupted by such Force Majeure Event, Supplier shall not reduce process capacity or performance below the level of the process capacity and performance immediately prior to the Force Majeure Event. In addition, Supplier shall not redeploy or reassign any key personnel to another Supplier account in the event of a Force Majeure Event without Anthem's prior written consent.

17.8 Severability. If any provision of the Agreement is held to be invalid, illegal or unenforceable in any respect under Applicable Law, such provision shall be excluded from the Agreement and the balance of the Agreement shall be interpreted as if such provision were so excluded and shall be enforceable in accordance with its terms.

17.9 Relationship of Parties. The Parties intend to be, are, and shall at all times be independent contractors with respect to this Agreement and all performance under this Agreement. Under no circumstances shall Supplier, any Supplier personnel, or any other of Supplier's employees, subcontractors, agents, or representatives be considered to be employees or agents of Anthem or any of Anthem's Affiliates, or be entitled to participate in any of Anthem's or its Affiliates' employee benefit programs including workers compensation and disability insurance, group health, dental and vision

insurance, unemployment insurance, retirement plans, or stock-based benefits or plans. Neither Party is an agent, partner or employee of the other Party, or its Affiliates, and neither Party has any right or any other authority to enter into any agreements or undertaking in the name of or for the account of the other Party or to create or assume any obligations of any kind, express or implied, on behalf of the other Party nor will the act or omissions of either create any liability for the other Party. No form of joint employer, joint venture, partnership, or similar relationship between the Parties, or between either Party and any Affiliate of the other Party, is intended or hereby created. This Agreement shall in no way constitute or give rise to a partnership or joint venture between the Parties. In no way shall Anthem be construed to be a provider of health services or responsible for the provision of such health services.

17.10 Titles and Subtitles. The titles and subtitles used in the Agreement are used for convenience only and are not to be considered in construing or interpreting the Agreement.

17.11 Counterparts. The Agreement and any Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same instrument.

17.12 Electronic Signatures. The Parties agree electronic signatures may be utilized for execution of this Agreement and any attachments hereto, including but not limited to, Statements of Work. The Parties acknowledge and agree that (i) the issuance of an electronic signature shall be valid and enforceable as to the signing Party to the same extent as an inked original signature; and (ii) these documents shall constitute "original" documents when printed from electronic files and records established and maintained by either Party in the normal course of business. Unless otherwise agreed to by the Parties, the purchase order number (issued by Anthem) shall constitute Anthem's electronic signature and consent to any purchase order and the Supplier's invoice number shall constitute Supplier's electronic signature and consent to provide the Software and/or other related services. Each Party agrees that the Anthem purchase order number or the Supplier invoice number, as issued by the respective Party, shall be sufficient to verify that such Party originated the document. Neither Party shall disclose to any unauthorized person the purchase order Number or the invoice number.

17.13 Deficit Reduction Act Notification to Supplier. Section 6032 of the Deficit Reduction Act of 2005 ("DRA") and state laws enacted pursuant to the DRA require certain entities such as Anthem to establish policies and procedures to help the entity, and its contractors and agents, detect and prevent fraud, waste and abuse relating to services provided for certain government funded programs, including Medicaid. The DRA and state laws also require certain entities to make their suppliers aware: (a) of the provisions of the False Claims Act and similar state statutes prohibiting anyone from knowingly submitting or causing another person or entity to submit false claims for payment of government funds; and (b) that any person in violation is potentially liable for three times the damages or loss to the government plus substantial civil penalties (currently $5,500 to $11,000). In addition, the False Statements Act prohibits anyone from making false statements or withholding material information in connection with the delivery of services to, or payments from, the government. Violations of these acts can also result in criminal convictions and imprisonment of up to five (5) years. As part of Anthem's policies designed to prevent fraud, waste and abuse, Anthem does not retaliate against personnel who report violations (or suspected violations) of state of federal False Claims Acts.

17.14 Covenant Not to Trade on Insider Knowledge. Supplier acknowledges that Anthem, Inc. is a publicly traded corporation. Supplier agrees that it will not purchase or sell any stock of Anthem based on Anthem Confidential Information. Supplier further agrees that, if it discloses Anthem Confidential Information to any other person or entity in accordance with this Agreement, it will advise that other person or entity of the duty not to trade based on Anthem Confidential Information.

17.15 Cumulative Remedies. Except as otherwise expressly provided in this Agreement, all remedies provided for in this Agreement shall be cumulative and in addition to, and not in lieu of, any other remedies available to either Party at law, in equity or otherwise.

17.16 No Third Party Beneficiaries. This Agreement shall not benefit, or create any right or cause of action in or on behalf of, any person or entity other than Anthem its Affiliates and assignees, or Supplier; provided that if either Party's Affiliates' has a cause of action under this Agreement against the other Party, such action must be initiated by a Party to this Agreement against the other Party, and not against such Party's Affiliates directly.

17.17 Entire Agreement. This Agreement sets forth the entire agreement of the Parties with respect to the subject matter thereof, and supersedes any and all prior proposals, agreements, understandings, and contemporaneous discussions, whether oral or written, between the Parties with respect to the subject matter of this Agreement.

IN WITNESS WHEREOF, the undersigned have read, understood and executed this Agreement and agree to be bound by its provisions as of the Effective Date.

_____	Anthem, Inc.
Supplier	Anthem
By: _____	By: _____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

EXHIBIT A

BUSINESS ASSOCIATE AGREEMENT

If, during the term of any Agreement between Supplier and Anthem, Inc. and/or any of its affiliates (collectively, "Anthem"), Supplier requires the use or disclosure of Protected Health Information, including creating, receiving, maintaining, or transmitting Protected Health Information, then Supplier shall be deemed a Business Associate of Anthem and the following provisions shall apply:

This agreement ("Agreement") shall be effective on the date of Supplier's signature and is between the Supplier ("Business Associate") identified in this Agreement and Anthem, Inc. ("Anthem") on behalf of itself and its affiliates who are Covered Entities or Business Associates and who have a business relationship with Business Associate, if any (hereinafter collectively "Anthem"). The purpose of this Agreement is to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164, including Subpart E of 45 CFR Part 164), any applicable state privacy laws, any applicable state security laws, any applicable implementing regulations issued by the Insurance Commissioner or other regulatory authority having jurisdiction and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates.

All capitalized terms in this Agreement that are not defined in this Agreement will have the meaning ascribed to those terms by 45 C.F.R. Parts 160-164, or applicable insurance regulations that are applicable to Anthem's relationship with Business Associate.

A. Privacy of Protected Health Information and Nonpublic Personal Financial Information.

1. **Permitted and Required Uses and Disclosures.** Business Associate is permitted or required to Use or disclose Protected Health Information ("PHI") it requests, creates, or receives for or from Anthem (or another business associate of Anthem) only as follows:

   a) Functions and Activities on Anthem's Behalf. Business Associate is permitted to request, Use, or disclose PHI it creates or receives for or from Anthem (or another business associate of Anthem), consistent with the Privacy Rule, the Security Rule, and the HITECH Act, only as described in this Agreement, or other agreements during their term that may exist between Anthem and Business Associate.

   b) Business Associate's Operations. Business Associate may Use PHI it creates or receives for or from Anthem as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may disclose such PHI as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

      (i) The Disclosure is Required by Law; or

(ii) Business Associate obtains reasonable assurance evidenced by written contract, from any person or organization to which Business Associate will disclose such PHI that the person or organization will:

a. Hold such PHI in confidence and Use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as Required by Law; and

b. Notify Business Associate (who will in turn promptly notify Anthem) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

c) Data Aggregation Services. If specifically directed by the Anthem, the Business Associate will provide Data Aggregation services relating to the Health Care Operations of the Anthem.

d) Minimum Necessary and Limited Data Set. In any instance when Business Associate Uses, requests or discloses PHI under this Agreement or in accordance with other agreements that exist between Anthem and Business Associate, Business Associate shall utilize a Limited Data Set, if practicable. Otherwise, Business Associate may Use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose, except that Business Associate will not be obligated to comply with this minimum necessary limitation with respect to:

(i) Disclosure to or request by a Health Care Provider for Treatment;
(ii) Use for or Disclosure to an Individual who is the subject of Anthem's PHI, or that Individual's Personal Representative;
(iii) Use or Disclosure made pursuant to an authorization compliant with 45 C.F.R. §164.508 that is signed by an Individual who is the subject of Anthem's PHI to be used or disclosed, or by that Individual's Personal Representative;
(iv) Disclosure to the United States Department of Health and Human Services ("HHS") in accordance with Section C(5) of this Agreement;
(v) Use or Disclosure that is Required by Law; or
(vi) Any other Use or Disclosure that is excepted from the Minimum Necessary limitation as specified in 45 C.F.R. §164.502(b)(2).

e) Use by Workforce. Business Associate shall advise members of its workforce of their obligations to protect and safeguard PHI. Business Associate shall take appropriate disciplinary action against any member of its workforce who uses or discloses PHI in contravention of this Agreement.

2. **Prohibitions on Unauthorized Requests, Use or Disclosure.**

a) Business Associate will neither Use nor disclose Anthem's PHI it creates or receives from Anthem or from another Business Associate of Anthem, except as permitted or required by this Agreement or as Required by Law or as otherwise permitted in writing by Anthem. This Agreement does not authorize Business Associate to request, Use, disclose, maintain or transmit PHI in a manner that will violate 45 C.F.R. Parts 160-164.

b) Business Associate will not develop any list, description or other grouping of Individuals using PHI received from or on behalf of Anthem, except as permitted by this Agreement or in writing by Anthem. Business Associate will not request, Use or disclose any list, description or other grouping of Individuals that is derived using such PHI, except as permitted by this Agreement or in writing by Anthem.

3. **Sub-Contractors and Agents.** Business Associate will require any of its Subcontractors and/or agents that create, receive, maintain, or transmit such PHI to provide reasonable assurance, evidenced by written contract, that Subcontractor or agent will comply with the same privacy and security obligations as Business Associate with respect to such PHI, including the obligations described in Section 4 herein.

4. **Information Safeguards.** Business Associate must use appropriate safeguards to comply with Subpart C of 45 CFR Part 164 and must implement, maintain and use a written information security program that contains the necessary administrative, technical and physical safeguards that are appropriate in light of the Business Associate's size and complexity in order to achieve the safeguarding objectives as detailed in Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 C.F.R. Part 164.530(c), the HITECH Act and any other implementing regulations issued by the U.S. Department of Health and Human Services, as such may be amended from time to time and as required by the Required Information Security Controls document attached to the Agreement between the parties as **Exhibit F** and incorporated herein. Business Associate shall notify Anthem should Business Associate determine it is unable to comply with any such law, regulation, or official guidance. Further, Business Associate shall comply with any applicable state data privacy or security law.

   During the term of this Agreement, Business Associate may be asked to complete a security survey and/or attestation document designed to assist Covered Entity in understanding and documenting Business Associate's security procedures and compliance with the requirements contained herein. Business Associate's failure to complete either of these documents within the reasonable timeframe specified by Covered Entity shall constitute a material breach of this Agreement.

   Business Associate shall provide Anthem with information concerning the aforementioned safeguards and/or other information security practices as they pertain to the protection of Anthem's PHI, as Anthem may from time to time request. Upon reasonable advance request, Business Associate shall provide Anthem access to Business Associate's facilities used for the maintenance or processing of PHI, and to its books, records, practices, policies and procedures concerning the Use and Disclosure of PHI, in order to determine Business Associate's compliance with this Agreement.

B. PHI Access, Amendment and Disclosure Accounting.

1. **Access.** Business Associate will promptly upon Anthem's request make available to Anthem or, at Anthem's direction, to the Individual (or the Individual's Personal Representative) for inspection and obtaining copies any PHI about the Individual which Business Associate created or received for or from Anthem and that is in Business Associate's custody or control, so that Anthem may meet its access obligations pursuant to and required by applicable law, including but not limited to 45 C.F.R. 164.524, and where applicable, the HITECH Act. Business Associate shall make such information available in electronic format where directed by Anthem.

2. **Amendment**. Business Associate will, upon receipt of notice from Anthem, promptly amend or permit Anthem access to amend any portion of the PHI which Business Associate created or received for or from Anthem, pursuant to and required by applicable law, including but not limited to 45 C.F.R. Part 164.526.

   Business Associate will not respond directly to an Individual's request for an amendment of their PHI held in the Business Associate's Designated Record Set. Business Associate will refer the Individual to Anthem so that Anthem can coordinate and prepare a timely response to the Individual.

3. **Disclosure Accounting.** So that Anthem may meet its Disclosure accounting obligations pursuant to and required by applicable law, including but not limited to 45 C.F.R. Part 164.528:

   a) Disclosure Tracking. Business Associate will promptly, but no later than within seven (7) days of the Disclosure, report to Anthem for each Disclosure, not excepted from Disclosure accounting under Section B.3(b) below, that Business Associate makes to Anthem or a third party of PHI that Business Associate creates or receives for or from Anthem, (i) the Disclosure date, (ii) the name and (if known) address of the person or entity to whom Business Associate made the Disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the Disclosure (items i-iv, collectively, the "disclosure information"). For repetitive Disclosures Business Associate makes to the same person or entity (including Anthem) for a single purpose, Business Associate may provide (x) the disclosure information for the first of these repetitive Disclosures, (y) the frequency, periodicity or number of these repetitive Disclosures and (z) the date of the last of these repetitive Disclosures. Business Associate further shall provide any additional information, to the extent required by the HITECH Act or any regulation adopted pursuant thereto.

   b) Exceptions from Disclosure Tracking. Business Associate need not report Disclosure of information or otherwise account for Disclosures of PHI that this Agreement or Anthem in writing permits or requires (i) for the purpose of Anthem's Treatment activities, Payment activities, or Health Care Operations (except where such recording or accounting is required by the HITECH Act), and as of the effective dates for any such requirements, (ii) to the Individual who is the subject of the PHI disclosed, to that Individual's Personal Representative or to another person or entity authorized by the Individual (iii) to persons involved in that Individual's Health Care or Payment for Health Care; (iv) for notification for disaster relief purposes, (v) for national security or intelligence purposes, (vi) to Law Enforcement Officials or Correctional Institutions regarding Inmates; or (vii) disclosed in a limited data set.

      Business Associate need not report any Disclosure of PHI that was made before April 14, 2003.

   c) Except as provided below in subsection d) below, Business Associate will not respond directly to an Individual's request for an accounting of Disclosures. Business Associate will refer the Individual to Anthem so that Anthem can coordinate and prepare a timely accounting to the Individual.

   d) Disclosure through an Electronic Health Record. However, when Business Associate is contacted directly by an individual based on information provided to the individual by Anthem, Business Associate shall make the accounting of disclosures available directly to the individual, but only if required by the HITECH Act or any related regulations.

4. **Confidential Communications and Restriction Agreements**. Business Associate will promptly, upon receipt of notice from Anthem, send an Individual's communications to the identified alternate address. Business Associate will comply with any agreement Anthem makes that restricts Use or Disclosure of Anthem's PHI pursuant to 45 C.F.R. §164.522(a), provided that Anthem notifies Business Associate in writing of the restriction obligations that Business Associate must follow. Anthem will promptly notify Business Associate in writing of the termination or modification of any confidential communication requirement or restriction agreement.

5. **Disclosure to U.S. Department of Health and Human Services.** Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of PHI received from Anthem (or created or received by Business Associate on behalf of Anthem) available to the Secretary of the United States Department of Health and Human Services, for purposes of determining Anthem's compliance with 45 C.F.R. Parts 160-164. Unless the Secretary directs otherwise, Business Associate shall promptly notify Anthem of Business Associate's receipt of such request, so that Anthem can assist in compliance with that request.

C. Breach of Privacy and Security Obligations.

Reporting. Business Associate will report to Anthem: (i) any Use or Disclosure of PHI (including Security Incidents) not permitted by this Agreement or in writing by Anthem;(ii) any Security Incident; (iii) any Breach, as defined in the HITECH Act; or (iv) any other breach of a security system, or the like, as such may be defined under applicable state law (collectively a "Breach"). Except as described in subparagraph "e)" below, Business Associate will, without unreasonable delay, but no later than within one business day after Business Associate's discovery of a Breach, make the report by sending a report to Anthem. Such report will be made on a form made available to Business Associate, or by such other reasonable means of reporting as may be communicated to Business Associate by Anthem. Business Associate shall cooperate with Anthem in investigating the Breach and in meeting Anthem's obligations under the HITECH Act, and any other security breach notification laws or regulatory obligations.

a) Report Contents. To the extent such information is available Business Associate's report will at least:

   (i) Identify the nature of the non-permitted or prohibited access, Use or Disclosure, including the date of the Breach and the date of discovery of the Breach;
   (ii) Identify the PHI accessed, used or disclosed, and provide an exact copy or replication of the PHI, as appropriate, in a format reasonably requested by Anthem, and to the extent available;
   (iii) Identify who caused the Breach and who received the PHI;
   (iv) Identify what corrective action Business Associate took or will take to prevent further Breaches;
   (v) Identify what Business Associate did or will do to mitigate any deleterious effect of the Breach; and
   (vi) Provide such other information, including a written report, as Anthem may reasonably request.

b) Examples of Security Incidents. Anthem requires prompt notification from Business Associate if Business Associate experiences any Security Incidents that impact the confidentiality, integrity or availability of Anthem data or information systems. Below are some examples:
   (i) Business Associate's information systems are exposed to malicious code, such as a virus or worm, and such code could be transmitted to Anthem data or systems.

(ii) Unauthorized access is granted or obtained to servers or workstations that contain Anthem data or Business Associate discovers that Anthem data is being used, copied, or destroyed inappropriately.

(iii) Business Associate experiences an attack or the compromise of a server or workstation containing Anthem information requiring that it be taken offline.

(iv) Unauthorized access or disclosure has occurred involving Protected Health Information, which is an obligation under the HIPAA Privacy Rule.

c) Unsuccessful Security Incidents. Except as noted in C.(e) below, the parties acknowledge and agree that this section constitutes notice by Business Associate to Anthem of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Anthem shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

d) Breach of Unsecured Protected Health Information. A Breach of Unsecured Protected Health Information includes any Breach as defined in the HITECH act or regulations adopted pursuant thereto.

e) Medicare Supplier Reporting Requirements –To the extent that Business Associate is subject to any Center for Medicare and Medicaid ("CMS") incident reporting requirements (including applicable timeframes for such reporting) as detailed in the services agreement between Anthem and Business Associate (including any amendments, exhibits or addenda), Business Associate shall comply with all such reporting requirements, in addition to those imposed hereby.

2. **Breach.** Without limiting the rights of the parties elsewhere set forth in the Agreement or available under applicable law, if Business Associate breaches its obligations under this Agreement, Anthem may, at its option:

a) Exercise any of its rights of access and inspection under paragraph 4 of section A of this Agreement

b) Require Business Associate to submit to a plan of monitoring and reporting, as Anthem may determine appropriate to maintain compliance with this Agreement and Anthem shall retain the right to report to the Secretary of HHS any failure by Business Associate to comply with such monitoring and reporting; or

c) Immediately and unilaterally, terminate this Agreement and/or any other agreements between the parties, without penalty to Anthem, and with or without an opportunity to cure the breach. Anthem's remedies under this Section and set forth elsewhere in this Agreement or in any other agreement between the parties shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other. If for any reason Anthem determines that Business Associate has breached the terms of this Agreement and such breach is not curable or if curable, has not been cured, but Anthem determines that termination of this Agreement and/or any other agreements between the parties is not feasible, Anthem may report such breach to the U.S. Department of Health and Human Services.

3. **Mitigation**. Business Associate agrees to mitigate to the extent practicable, any harmful effect that is known to Business Associate of any security incident related to PHI or any use or disclosure of PHI by Business Associate in violation of the requirements of this BA Agreement. To the extent Anthem incurs any expense Anthem reasonably determines to be necessary to mitigate any Breach or any other non-permitted use or disclosure of Individually Identifiable Information, Business Associate shall reimburse Anthem for such expense.

D. Compliance with Standard Transactions.

1. If Business Associate conducts in whole or part Standard Transactions, for or on behalf of Anthem, Business Associate will comply, and will require any Subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162 for which HHS has established Standards. Business Associate will comply by a mutually agreed date, but no later than the date for compliance with all applicable final regulations, and will require any Subcontractor or agent involved with the conduct of such Standard Transactions, to comply, with each applicable requirement of the Transaction Rule 45 C.F. R. Part 162. Business Associate agrees to demonstrate compliance with the Transactions by allowing Anthem to test the Transactions and content requirements upon a mutually agreeable date. Business Associate will not enter into, or permit its Subcontractors or agents to enter into, any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of Anthem that:

   a) Changes the definition, data condition or use of a data element or segment in a Standard Transaction.

   b) Adds any data elements or segments to the maximum defined data set;

   c) Uses any code or data element that is marked "not used" in the Standard Transaction's Implementation Specification or is not in the Standard Transaction's Implementation Specification; or

   d) Changes the meaning or intent of the Standard Transaction's Implementation Specification.

2. **Concurrence for Test Modification to Standard Transactions.** Business Associate agrees and understands that there exists the possibility that Anthem or others may request from HHS an exception from the uses of a Standard in the HHS Transaction Standards. If this request is granted by HHS, Business Associate agrees that it will participate in such test modification.

3. **Incorporation of Modifications to Standard Transactions** Business Associate agrees and understands that from time-to-time, HHS may modify and set compliance dates for the Transaction Standards. Business Associate agrees to incorporate by reference into this Agreement any such modifications or changes.

4. **Code Set Retention (Only for Plans).** Both parties understand and agree to keep open code sets being processed or used in the Agreement for at least the current billing period or any appeal period, whichever is longer.

5. **Guidelines and Requirements.** Business Associate further agrees to comply with any guidelines or requirements adopted by Anthem consistent with the requirements of HIPAA and any regulations

promulgated thereunder, governing the exchange of information between Business Associate and the Anthem.

E. Obligations upon Termination.

1. **Return or Destruction.** Upon termination, cancellation, expiration or other conclusion of the Agreement, Business Associate will if feasible return to Anthem or destroy all PHI, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Anthem, including all copies of and any data or compilations derived from and allowing identification of any Individual who is a subject of the PHI. Business Associate will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of Agreement. Business Associate shall destroy all PHI in accordance with any guidance set forth by the Secretary of HHS and/or any other government agency or other entity to whom HHS delegates such authority Business Associate will identify any PHI that Business Associate created or received for or from Anthem that cannot feasibly be returned to Anthem or destroyed, and will limit its further Use or Disclosure of that PHI to those purposes that make return or destruction of that PHI infeasible and will otherwise continue to protect the security any PHI that is maintained pursuant to the security provisions of this Agreement for so long as the PHI is maintained. Within such 30 days, Business Associate will certify in writing to Anthem that such return or destruction has been completed, will deliver to Anthem the identification of any PHI for which return or destruction is infeasible and, for that PHI, will certify that it will only Use or disclose such PHI for those purposes that make return or destruction infeasible.

2. **Continuing Privacy and Security Obligation.** Business Associate's obligation to protect the privacy and security of the PHI it created or received for or from Anthem will be continuous and survive termination, cancellation, expiration or other conclusion of this Agreement, so long as the data is maintained.

F. General Provisions.

1. **Definitions.** Except as otherwise provided, the capitalized terms in this Agreement have the meanings set out in 45 C.F.R. Parts 160-164, as may be amended from time to time. The term Protected Health Information ("PHI") includes any information without regard to its form or medium, gathered by Business Associate in connection with Business Associate's relationship with Covered Entity that identifies an individual or that otherwise would be defined as Protected Health Information under HIPAA.

2. **Amendment.** From time to time local, state or federal legislative bodies, boards, departments or agencies may enact or issue laws, rules, or regulations pertinent this Agreement. In such event, Business Associate agrees to immediately abide by all said pertinent laws, rules, or regulations and to cooperate with Anthem to carry out any responsibilities placed upon Anthem or Business Associate by said laws, rules, or regulations.

3. **Conflicts.** The terms and conditions of this Agreement will override and control any conflicting term or condition of any other agreement between the parties with respect to the subject matter herein. All non-conflicting terms and conditions of the said other agreement(s) remain in full force and effect.

4. **Owner of PHI.** Anthem is the exclusive owner of PHI generated or used under the terms of the Agreement.

5. **Subpoenas.** Business Associates agrees to relinquish to Anthem control over subpoenas Business Associates receives with regard to PHI belonging to Anthem.

6. **Disclosure of De-identified Data.** The process of converting PHI to De-identified Data (DID) is set forth in 45 C.F.R Part 164.514. In the event that Anthem provides Business Associate with DID, Business Associate shall not be given access to, nor shall Business Associate attempt to develop on its own, any keys or codes that can be used to re-identify the data. Business Associate shall only use DID as directed by Anthem.

7. **Creation of De-identified Data.** In the event Business Associate wishes to convert PHI to DID, it must first subject its proposed plan for accomplishing the conversion to Anthem for Anthem's approval, which shall not be unreasonably withheld provided such conversion meets the requirements of 45 C.F.R. Part 164.514. Business Associate may only use DID as directed or otherwise agreed to by Anthem.

8. **Assignment/Subcontract.** Anthem shall have the right to review and approve any proposed assignment or subcontracting of Business Associate's duties and responsibilities arising under the Agreement, as it relates to the Use or creation of PHI (or DID if applicable).

9. **Audit.** Anthem shall have the right to audit and monitor all applicable activities and records of Business Associate to determine Business Associate's compliance with the requirements relating to the creation or Use of PHI (and DID, if applicable) as it relates to the privacy and security sections of this Agreement.

10. **Intent.** The parties agree that there are no intended third party beneficiaries under this Agreement.

11. **Indemnity.** Business Associate will indemnify and hold harmless Anthem and any Anthem affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or prohibited Use or Disclosure of PHI or other breach of this Agreement by Business Associate or any Subcontractor, agent, person or entity under Business Associate's control.

    a) Right to Tender or Undertake Defense. If Anthem is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted or prohibited Use or Disclosure of PHI or other breach of this Agreement by Business Associate or any Subcontractor, agent, person or entity under Business Associate's control, Anthem will have the option at any time either (i) to tender its defense to Business Associate, in which case Business Associate will provide qualified attorneys, consultants and other appropriate professionals to represent Anthem's interests at Business Associate's expense, or (ii) undertake its own defense, choosing the attorneys, consultants and other appropriate professionals to represent its interests, in which case Business Associate will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants and other professionals.

    b) Right to Control Resolution. Anthem will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it,

notwithstanding that Anthem may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Anthem under Section F.11 of this Agreement.

IN WITNESS WHEREOF, Anthem and Business Associate execute this Agreement in multiple originals to be effective on the date of Business Associate's Signature below:

_____	Anthem, Inc.
Name of Business Associate	
By: _____	By: _____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

EXHIBIT B
Medicare Advantage and
Medicare Part D Regulatory Exhibit

Effective [INSERT EFFECTIVE DATE], the following Medicare Advantage and Medicare Part D terms and conditions shall be incorporated into the attached Agreement between [INSERT ANTHEM ENTITY NAME] and its commonly owned and controlled affiliates (herein referred to as "Anthem") and [INSERT SUPPLIER NAME] (herein referred to as "Supplier.") These provisions shall only apply to services provided by Supplier to or for Anthem's Medicare Advantage and/or Medicare Part D plans, including those plans for members dually eligible for Medicare and Medicaid in accordance with and pursuant title XVIII of the Social Security Act (Act) (specifically, but not limited to, Social Security Act Parts C and Part D), and any subsequent amendments or relevant provision in the Act and applicable regulations. In the event that there is a conflict between the attached agreement and these Medicare Advantage and Medicare Part D terms and conditions, the Medicare Advantage and Medicare Part D terms and conditions shall control, but only as they relate to services provided to Covered Individuals enrolled in Anthem's Medicare Advantage and/or Medicare Part D plans.

A. Definitions:

1. **Downstream Entity**: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between [Anthem entity name] and [Supplier name] a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

2. **First Tier Entity**: Any party that enters into a written agreement, acceptable to CMS, with [Anthem entity] or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

3. **Related Entity**: Any entity that is related to [Anthem entity] by common ownership or control and 1. Performs some of the [Anthem] entity's management functions under contract or delegation. 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to [Anthem entity] at a cost of more than $2,500 during the contract period.

B. Terms:

1. **Federal Funds.** Supplier acknowledges that payments Supplier receives from Anthem to provide services to Medicare Advantage and/or Medicare Part D enrollees are, in whole or part, from Federal funds. Therefore, Supplier and any of its subcontractors may be subject to certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, 42 C.F.R. 423.100, 42 C.F.R. Part 422, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans With Disabilities Act; the Rehabilitation Act of 1973 and other regulations applicable to recipients of Federal Funds.

2. **Confidential Information.** Supplier recognizes that in the performance of its obligations under this Agreement it may be party to Anthem's proprietary, confidential, or privileged information, including, but not limited to, information concerning Anthem's members. Supplier agrees that, among other items of information, the identity of, and all other information regarding or relating to

any of Anthem's customers is confidential. Supplier agrees to treat such information as confidential and proprietary information of Anthem, and all such information shall be used by Supplier only as authorized and directed by Anthem pursuant to this Agreement, and, unless required by law, shall not be released to any other person or entity under any circumstances without express written approval of Anthem. During and after the term of this Agreement, Supplier shall not disclose or use any of the information described in this Section for a purpose unrelated to the terms and obligations of this Agreement. Further, Supplier agrees to abide by all Federal and State laws regarding confidentiality and disclosure of Medicare Advantage and/or Medicare Part D enrollee information. In addition, Supplier agrees to abide by the confidentiality requirements established by Anthem and CMS for the Medicare Advantage and/or Medicare Part D program.

2.1 To the extent applicable, [Supplier] will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal and State law or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§422.504(a)(13) and 422.118.]

3. **Inspection of Books and Records.** In accordance with, but not limited to, 42 C.F.R. 422.504(i) and/or 42 C.F.R. 423.505(i), Supplier acknowledges that Anthem, Health and Human Services department (HHS), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Supplier, or its first tier, downstream and related entities, including but not limited to subcontractors or transferees involving transactions related to Anthem's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this provision, Supplier agrees to make available Supplier's premises, physical facilities and equipment, records relating to Anthem's Covered Individuals, including access to Supplier's computer and electronic systems and any additional relevant information that CMS may require. Supplier acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Facility to a $15,000 penalty for each day of failure to comply.

4. **Independent Status**. Supplier is an independent contractor and nothing contained in this Agreement shall be construed or implied to create an agency, partnership, joint venture, or employer and employee relationship between Supplier and Anthem. At no time shall either party make commitments or incur any charges or expenses for or in the name of the other party except as otherwise permitted by this Agreement.

5. **Subcontractors.** In accordance with, but not limited to, 42 C.F.R. 422.504(i)(3)(ii) and/or 42 C.F.R. 423.505(i)(3), Supplier agrees that if Supplier enters into subcontracts to perform services under the terms of the Agreement, Supplier's subcontracts shall include an agreement by the subcontractor to comply with all of the Supplier obligations in this Medicare Advantage and Medicare Part D Regulatory Exhibit and applicable terms in the attached Agreement. In addition, Supplier will insure that such subcontractors understand that Anthem retains the necessary control and oversight over Supplier and all downstream subcontractors.

6. **Federal and State Laws**. Consistent with, but not limited to, 42 C.F.R. 422.504(i)(4) and 422.504(i)(3)(iii) and/or 423.505(i)(4) and 423.505(i)(3)(iii) Supplier agrees to comply, and to require any of its subcontractors to comply, with all applicable Federal and State laws, regulations, CMS instructions, and policies relevant to the activities to be performed under the Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Clients, and any requirements for CMS prior approval of materials. Further, Supplier agrees that any services provided by the Supplier or its subcontractors to or on behalf of Anthem's Medicare Advantage and/or Medicare Part D enrollees will be consistent with and will comply with Anthem's Medicare Advantage and/or Medicare Part D contractual obligations.

7. **Compliance Program.** Anthem maintains an effective Compliance Program and Standards of Business Conduct, and requires its employees to act in accordance therewith. Anthem will provide a copy of its then current Standards of Business Conduct to Supplier upon request. Consistent with the preceding and to the extent applicable, Anthem and its subcontractors may be required to monitor for Fraud, Waste and Abuse consistent with CMS guidance. To the extent applicable, Supplier acknowledges that certain CMS guidance on Fraud, Waste and Abuse may be implicated by the Agreement and agrees to take appropriate actions to identify and/or monitor for such activities, including but not limited to producing Supplier's plan to monitor for Fraud, Waste and Abuse.

   7.1 Validation of Compliance. Supplier agrees to provide documentation at least annually, as required by Anthem, demonstrating compliance with the CMS guidance as outlined in part in this Exhibit. In addition, the required monitoring form is attached hereto as Attachment 1. The parties acknowledge that Attachment 1 may be amended by Anthem, from time to time, on an annual basis or as needed to comply with CMS oversight and monitoring requirements.

8. **Hold Harmless.** In accordance with, but not limited to, 42 C.F.R. 422.504(i) and 422.504(g)(1) and (2) and/or 423.505(i) and 423.505(g), Supplier agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall Supplier bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Advantage and/or Medicare Part D enrollee for covered services provided pursuant to the Agreement. This provision does not prohibit the collection of supplemental charges or Copayments made in accordance with the terms of the Medicare Advantage and/or Medicare Part D enrollee's benefits.

   8.1 Dual Eligible Cost Sharing. Supplier further agrees that for those individuals who are enrolled in Medicare Advantage and/or Part D and who are eligible for some form of Medicaid benefit (Dual Eligible enrollees), that Supplier will not bill the enrollee for cost sharing that is not the Dual Eligible enrollee's responsibility and will ensure that such Dual Eligible enrollees will not be held liable for Medicare Parts A and B cost sharing when the State is liable for the cost sharing. In addition, Supplier agrees to accept the reimbursement by Anthem as payment in full, or, if applicable, to bill the the appropriate State source.

9. **Ineligible Persons.** Supplier warrants and represents that at the time of entering into this Agreement and monthly thereafter when providing services to or for the benefit of Medicare Advantage and/or Medicare Part D members under this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at

https://www.epls.gov/) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://exclusions.oig.hhs.gov/). Supplier agrees to sign a certification consistent with the meaning and requirements of this provision as required by Anthem.

In the event Supplier or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Supplier shall have an obligation to (1) immediately notify Anthem of such ineligible person status and (2) immediately remove such individual from responsibility for, or involvement with, Anthem's business operations related to this Medicare Advantage and Medicare Part D attachment.

Anthem retains the right to provide notice of immediate termination of the Agreement to Supplier in the event it receives notice of Supplier's ineligible person status.

10. **Conflict of Interest.** To the extent required by CMS or Anthem, Supplier agrees to certify that it will require its managers, officers and directors responsible for the administration or delivery of Medicare Advantage and/or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Medicare Advantage and/or Part D benefits.

11. **Illegal Remunerations**. Supplier specifically represents and warrants that activities to be performed under the Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in § 1128B(b) of the Social Security Act.

12. [THIS PROVISION CAN BE DELETED IF THE BASE AGREEMENT ADDRESSES THIS TYPE OF INDEMNIFICATION] **Indemnification for Non-compliance**. Supplier agrees to indemnify and hold Anthem harmless from and against any and all liabilities, claims and expenses connected therewith, including reasonable attorneys fees, arising from any acts or omissions of Supplier, not specifically authorized or directed by Anthem, violating or resulting in an investigation under § 1128B(b) of the Social Security Act or any other Federal or State law or regulation.

13. **Termination-Regulatory Issues.** In accordance with, but not limited to, 42 C.F.R. 422.504(i)(5) and/or 423.505(i)(5), if during the term of the Agreement, Anthem concludes that it is necessary to cancel any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, policies, or for any other purpose to comply with CMS Anthem may, at its discretion, cancel the activity and be relieved of any related obligations under the terms of the Agreement. If Anthem or Supplier concludes that it is necessary to reorganize or restructure any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, or policies, Anthem or Supplier may request to renegotiate such terms.

14. **Oversight Responsibility.** Supplier acknowledges that Anthem shall oversee and monitor Supplier's and all of Supplier's subcontractors' providing Services under this Agreement. Accordingly, Anthem will regularly review the performance of Supplier and, if applicable, Supplier's subcontractors, as part of its normal operations to confirm ongoing compliance and to ensure any identified corrective actions are undertaken and effective. Supplier further acknowledges that Anthem is ultimately responsible to CMS for the performance of such services and that Anthem shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage and Medicare Part D regulatory standards and ultimately responsible to CMS for the performance of all services.

14.1 To the extent applicable, Supplier's credentialing process must be approved and monitored by the Plan.

15. **Revocation**. Supplier agrees that Anthem has the right to revoke this agreement if CMS or Anthem determines that Supplier or any of its independent contractors or subcontractors has not performed the services satisfactorily and/or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner. Such revocation shall be consistent with the termination provisions of the Agreement.

16. **Approval of Materials.** Any printed materials, including but not limited to letters to Anthem's members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Supplier or any of its subcontractors pursuant to this Agreement must be submitted to Anthem for review and approval at each planning stage (*i.e.,* creative, copy, mechanicals, blue lines, etc.) to assure compliance with Federal, state, and Blue Cross/Blue Shield Association guidelines. Anthem agrees its approval will not be unreasonably withheld or delayed.

17. **Medicare Advantage and Medicare Prescription Drug Plan - Compliance Training, Education and Communications.** In accordance with, but not limited to 42 C.F.R. 422.503(b)(4)(vi)(C)&(D) and 42 C.F.R. 423.504(b)(4)(vi)(C)&(D) Supplier agrees and certifies that it, as well as its employees, subcontractors, downstream entities, related entities and agents who provide services to or for Anthem's Medicare Advantage and/or Part D Covered Individuals or to or for Anthem itself shall participate in CMS required fraud waste and abuse training and general compliance training, education and/or communications annually or as otherwise required by applicable law, and must be made a part of the orientation for a new employee, new first tier, downstream or related entity and for all new appointments of a chief executive, manager, or governing body member. Supplier or its subcontractors or Downstream Entities can complete the CMS training module located on the CMS Medicare Learning Network ("MLN") or incorporate the exact content of the CMS training into Providers existing compliance training and/or systems. If necessary and upon request, Anthem or its designee can make such compliance training, education and lines of communication available to Supplier in either electronic, paper or other reasonable medium. Supplier shall be responsible for documenting applicable employee's, subcontractor's, downstream entity's, related entity's and/or agent's attendance and completion of such training on an annual basis. Supplier shall provide such documentation to Anthem annually and as required to support a Anthem or CMS audit. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.

18. **Audit.** Supplier agrees to comply with any and all requests for Compliance documentation, as set forth in section 7 above, in order to support a CMS audit request. Supplier must provide all requested documentation demonstrating compliance with all CMS regulations and/or Anthem requirements for first tier, downstream and/or related entities.

19. **Prompt Payment.** [ALTERNATE - CAN DELETE IF THERE ARE EQUIVALENT PROMPT PAYMENT TERMS IN THE BASE AGREEMENT OR DELETE FIRST SENTENCE ONLY IF ONLY THAT PORTION IS CONTAINED IN THE BASE AGREEMENT] To the extent applicable under law as related to claims for medical or pharmacy services, Anthem agrees to make best efforts to pay Supplier within __ days of receipt of an undisputed invoice. Should Supplier

enter into any downstream agreements with any subcontractors to provide services under this Agreement, Supplier agrees to have a prompt payment provision as negotiated by Supplier and the subcontractor.

21. [IN ADDITION IF APPLICABLE]**Delegated Activities**. If Anthem has delegated activities to Supplier, then Anthem will provide the following information to Supplier and Supplier shall provide such information to any of its subcontracted entities:

a. A list of delegated activities and reporting responsibilities;
b. Arrangements for the revocation of delegated activities;
c. Notification that the performance of the contracted and subcontracted entities will be monitored by Anthem;
d. Notification that the credentialing process, if applicable, must be approved and monitored by Anthem; and
e. Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

22. [IN ADDITION IF APPLICABLE]**Delegation of Provider Selection**. In addition to the responsibilities as set forth in section 21 above, to the extent that Anthem has delegated selection of the providers, contractors, or subcontractor to Supplier, Anthem retains the right to approve, suspend, or terminate any such arrangement.

EXHIBIT C
FEDERAL PROGRAM COMMERCIAL ITEM ADDENDUM

This Addendum is hereby incorporated into the Agreement. The provisions of this Addendum apply to commercial items and/or services provided to National Government Services, Inc. and/or the Anthem Federal Employees Health Benefits Program.

The clauses herein are applicable to contracts for Commercial Items. "Commercial Item" has the meaning contained in Federal Acquisition Regulation 2.101, definitions. "Subcontract" includes transfer of commercial items between divisions, subsidiaries or affiliates of the Vendor at any tier [(Section 5.60 Subcontracts for Commercial Items OCT 2015) (FAR 52.244-6)].

The following Federal Acquisition Regulation Clauses referenced in this document are incorporated by reference with the same force and effect as if they were given in full text:

FAR/CFR Reference	Clause	Effective Date	Threshold
52.202-1	Definitions	Nov 2013	>$150,000
52.203-3	Gratuities	Apr 1984	>$150,000 or Contract is for personal services
52.204-9	Personal Identity Verification of Contractor Personnel	Jan 2011	Contractor will have access to GOV facilities and/or systems
52.203-6 (Alt I)	Restrictions on Subcontractor Sales to the Government	Sep 2006	>$150,000
52.203-13	Contractor Code of Business Ethics and Conduct	Oct 2015	> $5,500,000 and more than 120 days in duration
52.203-15	Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 - if the subcontract is funded under the Recovery Act.	Jun 2010	Contract funded under the Recovery Act
52.203-19	Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements	Jan 2017	All Contracts
52.204-21	Basic safeguarding of covered contractor information systems.	Jun 2016	All Contracts
52.204-23	Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities	Oct 2018	All Contracts
52.209-7	Updates of Information Regarding Responsibility Matters	Jul 2013	>$550,000
52.219-8	Utilization of Small Business Concerns	Nov 2016	>$700,000 with subcontracting opportunities
52.222-21	Prohibition of Segregated Facilities	Apr 2015	All Contracts
52.222-26	Equal Opportunity	Sep 2016	Total value of all Federal work > $10,000
52.222-29	Notification of Visa Denial	Apr 2015	>$3,500 for items or >$2,5000 for services
52.222-35	Equal Opportunity for Veterans	Oct 2015	> $100,000
52.222-36	Affirmative Action for Workers with Disabilities	Jul 2014	> $15,000
52.222-37	Employment Reports on Veterans	Feb 2016	>$150,000
52.222-40	Notification of Employee Rights Under the National Labor Relations Act	Dec 2010	>10,000

52.222-50	Combating Trafficking in Persons	Mar 2015	All Contracts
52.222-54	Employment Eligibility Verification	Oct 2015	>$3,500 and Non-COTS
52.222-55	Minimum Wages under Executive Order 13658	Dec 2015	All Contracts
52.222-62	Paid Sick Leave under Executive Order 13706	Jan 2017	All contracts subject to the Service Contract Labor Standards statute
52.223-18	Encouraging Contractor Policy to Ban Text Messaging While Driving	Aug 2011	All Contracts
52.224-3	Mandatory Privacy Training	Jan 2017	All Contracts
52.225-26	Contractors Performing Private Security Functions Outside the United States	Oct 2016	All Contracts performed in area of contingency or combat operations
52.232-33	Payment by Electronic Funds Transfer-Central Contractor Registration	Jul 2013	All Contracts
52.232-40	Providing Accelerated Payments to Small Business Subcontractors	Dec 2013	All Subcontracts with Small Business Concerns
52.233-4	Applicable Law for Breach of Contract Claim	Oct 2004	All Contracts
52.244-5	Competition in Subcontracting	Dec 1996	>$150,000 and not Firm-Fixed-Price
52.244-6	Subcontracts for Commercial Items	Nov 2017	All Contracts
52.247-64	Preference for Privately Owned U.S. Flag Commercial Vessels	Feb 2006	Contracts that may involve ocean transportation of supplies
41 CFR	Contractor shall abide by the requirements of 41 CFR §§ 60-1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity, or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status or disability.	Mar 2014	All Contracts

Full text of CFR provisions may be found here: **http://farsite.hill.af.mil/**

In the event of a conflict between the terms of this Addendum and other terms in the Agreement, the terms of this Addendum shall control.

##End of Addendum##

EXHIBIT D

Diversity Supplier Compliance

The Supplier agrees to comply fully with Anthem's Supplier Diversity Initiative, as further described in the Guidelines for Prospective Suppliers (found at https://www.antheminc.com/cs/groups/wellpoint/@wp_suppliers/documents/wlp_assets/d19l/mji2/~edisp/pw_e226860.pdf) and any participation plan that may have been submitted to Anthem. The following certified diverse suppliers will be participating in this Contract.

Diverse Suppliers	Phone	Email	Anthem Name	Scope of Goods and/or Services	Utilization Date	Amount or Percent

The Supplier must obtain the approval of Anthem's Supplier Diversity Director before changing any Supplier Diversity participation plan submitted in connection with this Agreement.

EXHIBIT E

STATE MEDICAID ATTACHMENTS

The following Exhibits are applicable to all of the services performed by Supplier/Licensor for any member enrolled in a Medicaid Program in the particular state to which the Exhibit pertains. Notwithstanding the foregoing, all provisions contained in the Exhibits may not be applicable to certain services provided by administrative services Suppliers/Licensor as certain provisions are applicable solely to Providers of medical services. Only those provisions applicable to the specific services provided by Supplier/Licensor shall be deemed to be incorporated into the Agreement. State-specific regulatory requirements may be added/updated from time to time without need for additional amendment. In the following documents, "Subcontractor", "Contractor" and "Vendor" refer to the "Supplier" or "Licensor" under the Agreement.

Exhibit E-1	**California Medicaid Subcontract Exhibit** (09.06.17)
Exhibit E-2	**Florida Medicaid Subcontract Exhibit** (09.06.17)
Exhibit E-3	**Georgia Medicaid Exhibit** (06.02.17)
Exhibit E-4	**Medicaid Exhibit Indiana HHW HIP HCC** (09.28.16)
Exhibit E-5	**Iowa Medicaid Exhibit** (06.29.17)
Exhibit E-6	**Kansas Medicaid Subcontract Exhibit** (08.01.17)
Exhibit E-7	**Medicaid Exhibit Kentucky** (08.28.17)
Exhibit E-8	**Medicaid Exhibit Louisiana** (07.07.17)
Exhibit E-9	**Medicaid Exhibit Maryland** (04.25.15)
Exhibit E-10	**Medicaid Exhibit Nevada** (05.28.14)
Exhibit E-11	**New Jersey Medicaid Subcontract Exhibit** (07.01.17)
Exhibit E-12	**New York Medicaid Requirements** (08.31.15)
Exhibit E-13	**Medicaid Exhibit South Carolina** (07.10.17)
Exhibit E-14	**Medicaid Exhibit Tennessee – Enrollee Contact** (08.10.17)
Exhibit E-15	**Medicaid Exhibit Tennessee – No Enrollee Contact** (08.10.17)
Exhibit E-16	**Medicaid Tennessee BAA – Utilize for all TN Vendors** (11.02.16)
Exhibit E-17	**Medicaid Exhibit Texas & Affiliates (Seton)** (06.22.17)
Exhibit E-18	**Virginia Medicaid Requirement** (08.03.17)
Exhibit E-19	**Medicaid Exhibit Washington** (08.29.17)
Exhibit E-20	**District of Columbia Specific Requirements** (07.27.17)
Exhibit E-21	**West Virginia Medicaid Requirements** (09.08.16)
Exhibit E-22	**Medicaid Exhibit Wisconsin** (10.29.15)

EXHIBIT F

Required Information Security Controls

As part of Anthem's commitment to the protection of Confidential Information, Anthem has established its information security requirements for its suppliers as outlined in this Required Information Security Controls Exhibit ("Exhibit"). The Exhibit shall be effective as of the date the party identified in the attached Agreement (herein "Supplier") first receives, maintains, transmits, accesses or otherwise comes into contact with Anthem Confidential Information. The requirements are intended to describe the minimum standard for physical, technical and, administrative controls affecting Confidential Information in relation to the services Anthem has retained Supplier to provide (herein "Services").

Definitions

Anthem Confidential Information (or Confidential Information), as may be defined in underlying agreements, is further clarified for purposes of this Exhibit to mean any data that is subject to applicable state and federal data security and privacy laws, regulations and guidance, including personally identifiable information and protected health information and any data that contains Anthem trade secrets, proprietary, competitive or sensitive information or systems information that could negatively impact Anthem if made public.

Incident. An occurrence that actually or potentially jeopardizes the confidentiality, integrity, or availability of an information system or the information the system processes, stores, or transmits or that constitutes a violation or imminent threat of violation of security policies, security procedures, or acceptable use policies.

Event. Any observable occurrence in a system and/or network that may indicate than an incident is occurring or has occurred.

1. Compliance

1.1. Supplier will comply with all applicable state and federal data security laws, regulations and guidance, and shall abide by all required security controls as stated herein, based upon the nature of the Services provided, the data involved, and/or the location where such Services are rendered. Supplier is responsible for understanding which state and federal laws apply to the Services and the data in scope for the agreement.

1.2. Supplier is responsible for its subcontractors. For subcontractors who collect, transmit, share, store, control, process, manage or access Anthem Confidential Information, Supplier is responsible for assessing and monitoring subcontractor control environments for compliance with Anthem's standards as documented in this Exhibit. Supplier shall ensure that any of its subcontractors having greater than incidental access to Anthem Confidential Information shall also be contractually bound to meet or exceed these information security provisions.

2. Information Security Program

2.1. Supplier must maintain a written Information Security Program ("WISP") including documented policies, standards, and operational practices that meet or exceed the requirements and controls set forth in this Exhibit to the extent applicable to the Services, and identify an individual within the organization responsible for its enforcement. Supplier's WISP shall address, at a minimum, all security requirements as listed in this Exhibit, as amended from time to time, and comply with all state and federal data security and privacy laws applicable to Anthem. This documentation will be reviewed by Supplier's security official, or its designee, at least annually and shall be updated periodically with changes to organization, technology, or Services. When implementing security controls Supplier shall take a risk-based approach. Any control exceptions which represent risk will be formally documented, monitored, and periodically reviewed.

2.1.1. Supplier's WISP shall be made available to and reviewed by Anthem or Anthem's representative prior to Supplier having access to any Anthem Confidential Information. At Anthem's request and at no cost to Anthem, Supplier shall make commercially reasonable modifications to its WISP or to its data security controls in order to conform to the requirements set forth in this Exhibit, and Anthem reserves the right, in its sole discretion, to terminate Supplier's access to Confidential Information until such time as Supplier has made such modifications to its WISP or data security controls. Supplier shall notify Anthem of any changes to systems, facilities or WISP controls affecting Anthem Confidential Information. This notification should set forth in detail how such changes which will impact Confidential Information.

2.2. Supplier shall apply appropriate sanctions against workforce members who fail to comply with security policies and procedures.

2.3. Supplier shall have processes and procedures in place so that information security events will be reported through appropriate communications channels as quickly as possible. Such processes and procedures for event reports must be tested, reviewed and updated, by Supplier periodically. All employees, contractors and third party users shall be made aware of their responsibility to report any information security events prior to being granted access to any Anthem Confidential Information. If at any time during the Agreement, Supplier becomes aware of an information security event or that it or any of its subcontractors will or do not meet the obligations described within this Exhibit, Supplier will immediately notify the Anthem Cybersecurity Incident Response Team at csirt@anthem.com.

2.4. Supplier shall periodically conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of sensitive data (including Anthem Confidential Information). The assessment must be reviewed by Supplier's security official and used to inform the Supplier's information security program.

2.5. Upon request, the Supplier shall identify the security official who is responsible for the development and implementation of the policies and procedures.

3. Right to Assess, Audit, & Certify

3.1. Anthem, or its designated subcontractors, may assess the design, implementation, and operating effectiveness of Supplier's compliance with this Exhibit.

3.2. Upon request, Supplier shall complete a security controls assessment conducted by Anthem ("Security Assessment"). Anthem may require additional Security Assessments in connection with Statements of Work for new or additional Services. To the extent that the Security Assessment identifies any risks or deficiencies for which remediation is required, such remediation requirements or compensating controls (and the timeframes within which they must be successfully implemented) will be set forth in an attachment to this exhibit or the applicable Statement of Work. Supplier's failure to complete any remediation requirements set forth in an attachment to this exhibit or the applicable Statement of Work within the required timeframe shall be deemed to be a material breach of the Agreement.

3.3. Certification in the HITRUST Common Security Framework (CSF) is required.

3.3.1. If the Supplier has a HITRUST (HITRUST) Common Security Framework (CSF) Certification applicable to the Services and/or applications in scope for the engagement as of the Effective Date and maintains it throughout the engagement, then that HITRUST certification will be accepted in lieu of the Security Assessment only. Anthem may ask questions specifically related to the protection of Anthem Confidential Information if needed after review of documentation supporting the HITRUST CSF Certification. Provided, however, that Supplier's HITRUST Certification does not waive Anthems rights to assess under Section 3.1 of this Exhibit.

3.4. For Suppliers without a HITRUST CSF certification at the time of engagement:

3.4.1. SUPPLIER SHALL (I) COMPLETE AND PROVIDE TO ANTHEM A HITRUST CSF SELF-ASSESSMENT REPORT NO LATER THAN 90 DAYS AFTER THE EFFECTIVE DATE; AND

3.4.2. OBTAIN AND PROVIDE TO ANTHEM A HITRUST CSF VALIDATED REPORT NO LATER THAN 18 MONTHS AFTER THE EFFECTIVE DATE; AND

3.4.3. OBTAIN AND PROVIDE TO ANTHEM A HITRUST CSF CERTIFICATION AND ASSOCIATED DOCUMENTATION, INCLUDING BUT NOT LIMITED TO COMPLETE VALIDATED REPORTS AND CORRECTIVE ACTION PLANS, NO LATER THAN 24 MONTHS AFTER THE EFFECTIVE DATE.

3.6. If Supplier has begun the process of obtaining a HITRUST CSF Certification before the Effective Date, then Supplier represents and warrants to Anthem that all corrective action plans that are necessary to obtain a HITRUST CSF Validated Report and/or HITRUST CSF Certification and that have been identified to Supplier prior to the Effective Date shall be communicated to Anthem and documented as an attachment to this exhibit.

3.7. Supplier shall promptly (and in any event with 30 days of identification) report to Anthem Information Security at AnthemVendorInfoSec@anthem.com any findings through HITRUST engagement that materially impact Anthem Confidential Information and associated corrective action plans identified during a self-assessment or any third party assessment, including any assessment related to Supplier's independent certification / attestation. Supplier will provide Anthem with any further information associated with such findings, as reasonably requested by Anthem.

3.9. If at any time during the engagement, the HITRUST CSF Certification is withdrawn for

any reason, Supplier will contact AnthemVendorInfoSec@anthem.com within 24 hours of learning of the issue to provide information and remediation plans regarding the withdrawal.

3.10. From time to time Supplier may be requested to respond to, inform and provide updates regarding specific high risk security gaps or exposures that exist for new or emerging security vulnerabilities that are made publicly known for systems, applications, hardware devices, etc. In all instances Supplier will provide a response to any inquiry within 5 business days, and will provide specific details as to the questions asked to ensure that Anthem can appropriately evaluate the risk or exposure to Anthem Confidential Information.

4. Encryption

4.1. Where required by Anthem, Supplier shall apply encryption methodology that, at minimum, conforms to the Federal Information Processing Standards Publication 140-2 Security Requirements for Cryptographic Modules and applicable state and federal regulations ("Approved Encryption").

4.2. In instances where Anthem Confidential Information is stored, hosted, or processed in a cloud computing environment Anthem must control the encryption key.

4.3. Cryptographic key management procedures must be documented and include references to key lifecycle management (including provisioning, distribution, and revocation) and key expiration dates.

4.4. Access to encryption keys must be restricted to named administrators. Encryption keys must be protected in storage. Example methods of acceptable key storage include encrypting keys or storing encryption keys within a hardware security module (HSM). Data-encrypting keys should not be stored on the same systems that perform encryption/decryption operations.

4.5. Anthem Confidential Information must be encrypted while in transit and at rest across at least the following types of assets:

- 4.6.1. Public shared networks
- 4.6.2. Non-wired networks
- 4.6.3. Cloud services
- 4.6.4. Desktop and portable computing devices
- 4.6.5. Mobile devices
- 4.6.6. Portable media
- 4.6.7. Back-ups
- 4.6.8. 'Plug & play' storage devices

5. Network and Systems Security

5.1. Supplier shall utilize and maintain a commercially available, industry standard malware detection program which includes an automatic update function to ensure detection of new malware threats.

5.2. An intrusion detection or prevention system which detects and/or prevents unauthorized activity traversing the network will be maintained.

5.3. Supplier shall have technical controls to detect, alert, and prevent the unauthorized movement of data from Supplier's control (commonly referred to as Data Loss Prevention).

5.4. Networks or applications that contain Anthem Confidential Information must be separated from public networks by a firewall to prevent unauthorized access from the public network.

5.5. At managed interfaces, network traffic is denied by default and allowed by exception (i.e., deny all, permit by exception).

5.6. Supplier shall establish security and hardening standards for network devices, including Firewalls, Switches, Routers, Servers, and Wireless Access Points (baseline configuration, patching, passwords, access control).

5.7. Web content filtering must be in place to restrict external webmail, instant messaging, file sharing and other data leak vectors for any Supplier Personnel with direct or indirect access to Anthem Confidential Information.

5.8. Quarterly vulnerability scans must be performed, and intrusion detection and identity management systems must be installed and monitored on all systems and components that handle, process, or store Anthem Confidential Information. Upon request, report summaries, including confirmation of remediation for vulnerabilities identified as high- or medium-risk, must be provided to Anthem.

5.9. At a minimum, Supplier shall engage a qualified third party to perform annual penetration testing of Supplier's networks containing Anthem Confidential Information. The scope of the penetration testing must, at a minimum, include all internal/external systems, devices and applications that are used to process, store, or transmit Confidential Data, physical security controls for all applicable facilities, and social engineering tests. Supplier must provide Anthem with summary results and a remediation plan at Anthem's request.

5.10. Suppliers providing products or Services related to Anthem's members through Anthem member portal or mobile applications, especially those which are internet-facing, or use Anthem domains, are subject to Anthem Information Security's Application Security Program scanning and assessments. Supplier agrees to remediate vulnerabilities identified during this process in a manner and timeline acceptable to Anthem.

5.11. Supplier shall ensure that no unencrypted Anthem Confidential Information is stored in any system that is internet facing.

6. System and Application Controls

6.1. All Anthem Confidential Information must be securely stored at all times to prevent loss and unauthorized access or disclosure.

6.2. Laptop and workstation systems that access Anthem Confidential Information remotely must utilize endpoint protection which includes a personal firewall and anti-malware protection.

6.3. Operating systems and application software used must be currently supported by the manufacturer.

6.4. Current versions of operating system and application software must be maintained, and patches applied in a timely manner for all systems and applications that receive, maintain, process, or otherwise access Anthem Confidential Information.

6.5. Anthem Confidential Information must not be used in any non-production environment such as testing or quality assurance unless de-identification of the data has been performed. In the event that de-identification is not practical or feasible, compensating controls must be in place protecting the data to the same level of protection as afforded to the production environment.

6.6. Anthem Confidential Information must be segmented from non-Anthem Information so that appropriate controls are in place to identify the data as Anthem's in all instances, including backup and removable media, and to appropriately restrict access only to users authorized to view the data. Logical separation must allow data to be deleted when it is no longer required.

6.7. Logical controls, virtual machine zoning, virtualization security and segregation must be in place to help prevent attacks and exposure in multi-tenancy environments containing Anthem Confidential Information.

6.8. Supplier shall maintain an asset management system which records the movement of hardware and electronic media and any persons responsible therefore.

7. Software Development Lifecycle

7.1. Supplier must use industry standards such as BSIMM, NIST, OWASP, etc. to build in security for its Systems Development Lifecycle (SDLC).

7.2. Supplier must use both an automated and manual source code analysis tool to detect and remediate security defects in code prior to production deployment.

7.3. Supplier must have policies and procedures in place to triage and remedy reported bugs and security vulnerabilities for the products/Services it provides to Anthem.

7.4. Supplier must have controls in place to prevent unauthorized access to its or Anthem's application, program, or object source code and ensure that access is restricted to authorized Personnel only.

7.5. National identifiers or Social Security Numbers must not be utilized as User IDs for logon to applications.

8. Data Destruction

8.1. All Anthem Confidential Information, whether such information is in paper, electronic or other form, requires secure disposal or destruction when no longer required. When requested by Anthem or upon the termination or expiration of the Agreement, Supplier must return to Anthem a valid copy of its Confidential Information. After receiving confirmation from Anthem that it has received the valid copy, Supplier must delete Anthem Confidential Information on its systems using security techniques consistent with accepted standards such as NIST 800-88 Guidelines for Media Sanitization. If media containing Anthem Confidential Information is to be reused then that device shall be sanitized according to NIST SP 800-88 Guidelines for Media Sanitization before it may be used by Supplier for any purpose.

9. Physical Controls for the Protection of Anthem Confidential Information

9.1. All Anthem Confidential Information received or created in paper form must be protected from viewing by unauthorized persons.

9.2. A clean desk policy will be enforced to ensure proper safeguarding of all hard copy Anthem Confidential Information.

9.3. Visitor logs documenting all individuals who are not employed by Supplier or Supplier's subcontractors who gain access to the facility where Anthem Confidential Information is processed will be maintained.

9.4. Anthem Confidential Information will not leave control of the Supplier without the written approval of Anthem.

9.5. Servers, enterprise data storage devices, backup tapes and media, and other computing devices that contain Anthem Confidential Information used to support network communications must be located in a secure and restricted access location within the facility.

9.6. Monitoring cameras (e.g., CCTVs) must monitor ingress and egress to sensitive areas within the facility. The monitoring equipment (e.g. CCTV) feed must be monitored either internally or externally by a qualified team. Alerting procedures must be defined and notification performed to qualified Supplier personnel. Processes for retention and review of security logs (e.g. access and visitor logs, CCTV) must be in place.

10. Access Control

10.1. Prior to gaining access to Anthem Confidential Information, workforce members will have appropriate background checks completed in compliance with state and federal law.

10.2. Security awareness training will be completed prior to access being granted to Anthem Confidential Information, and then completed on an annual basis going forward so long as access to Anthem Confidential Information continues. This training should include, at a minimum, guidance on defending against malware, protecting passwords, monitoring and reporting system notifications, social engineering, and handling sensitive data.

10.3. Physical and logical access will be granted to the minimum Anthem Confidential Information necessary to meet the requirements of the user's scope of responsibilities.

10.4. Access reviews will be performed at least quarterly for privileged user accounts and twice annually for non- privileged user accounts.

10.5. Only those individuals providing Services to Anthem, or those who are responsible for administering or managing systems that contain Anthem Confidential Information, shall be authorized to access systems containing Anthem Confidential Information.

10.6. All users that are no longer required or authorized to access Anthem Confidential Information or systems that contain Anthem Confidential Information must have access promptly disabled.

10.7. Access to Anthem Confidential Information and systems that contain Anthem Confidential Information must be access controlled through the use of individual user IDs and passwords that meet healthcare industry standard complexity rules and password lifetimes.

10.8. If it is suspected a password has been compromised, the password must be immediately changed or reset.

10.9. Processes must be in place to create the audit trails capable of determining who has accessed Anthem Confidential Information and/or systems that contain Anthem Confidential Information.

10.10. Remote access to systems or networks that contain Anthem Confidential Information must use multi-factor authentication and a connection with Approved Encryption as defined in Section 4 of this Exhibit.

10.11. Upon request, Supplier shall provide reports within 48 hours for:

10.11.1. List of all individuals with access to Anthem Confidential Information and/or systems that contain Anthem Confidential Information and the level of access granted;

10.11.2. List of activity associated with any user ID who has access to Anthem Confidential Information.

10.12. Supplier workforce will not access or permit other third parties, except for third parties expressly authorized by Anthem, to access Anthem Confidential Information transported by Supplier in the provision of Services.

10.13. Account management capabilities, such as account lockouts for unsuccessful logon attempts, defined inactivity times, remote access allowances, specific success and failure events, and management of elevated privilege accounts must be enforced.

10.14. All identity credentialing, authentication, authorization, and access control events must be logged and those logs are subject to periodic audit. At a minimum, the logs of all specified success and failure events associated with identity and access management in the computing environment it manages must be produced. These logs must then be archived for at least twelve months. These archived logs must be searchable and or discoverable.

11. Offshore Security Requirement

11.1. Anthem Confidential Information is not permitted to be hosted or stored offshore. Offshore locations may be utilized for the processing of data. However, all data must reside on servers located in the United States for the duration of the processing.

11.2. Offshore locations will not receive, maintain, process, or otherwise access data backups of Anthem Confidential Information.

11.3. Offshore workstation computers must adhere to baseline system security requirements defined by Anthem which enforce the most restrictive mode consistent with operational requirements. All unnecessary services, features and networks must be disabled on workstations used to support Anthem operations, including but not limited to:

11.3.1. Disabling workstations from simultaneously connecting to the Anthem network and other networks (split tunneling);

11.3.2. Disabling access to non-Anthem instant messaging (IM) clients;

11.3.3. Disabling access to non-Anthem email systems;

11.3.4. Disabling access to the Internet;

11.3.5. Disabling user access to local workstation storage or Supplier network storage (such as that to which Anthem Confidential Information or screenshots could be copied);

11.3.6. Disabling access to printers.

11.4. Wireless access is prohibited from being used to access Anthem Confidential Information from offshore locations.
11.5. All work from offshore locations must be performed in Anthem-approved facilities.

12. **Enterprise Standards Governance**

12.1. Anthem Confidential Information must not be placed into a cloud computing environment without review and approval by Anthem's Enterprise Standards Governance group.
12.2. If upon review by Anthem's Enterprise Standards Governance, items are identified for remediation, such remediation must be completed in agreed upon timeframes.

13. Contingency Planning

13.1. Supplier will have a documented Business Continuity and Disaster Recovery plans in place that include information security controls. Such plans will be tested at least annually.

14. Incident Response

14.1. Supplier will have a documented Incident Response Plan. Such plan will be tested at least annually.
14.2. Incident response roles and responsibilities must be clearly outlined between Supplier and Anthem as appropriate.

15. Payment Card Industry Data Security Standard

15.1. If, in performing Services to or on behalf of Anthem, Supplier acts as a Merchant or payment card processor as defined by the Payment Card Industry Data Security (PCI DSS) standard, then Supplier agrees to comply with the applicable PCI DSS requirements.

16. Litigation Holds

16.1. The Supplier must provide a detailed mechanism for how litigation holds will be implemented. This will include how metadata will be created, accessed, and stored in a cloud environment.

17. No Sale of Anthem Confidential Information Permitted

17.1. The sale of Anthem Confidential Information, or derivatives thereof, especially Anthem member data (such as PHI, PII, or PCI data) is prohibited. For clarification, this prohibition applies regardless of whether or not the data has been de-identified.

EXHIBIT G

Qualified Health Plan
Regulatory Exhibit

The following Qualified Health Plan terms and conditions shall be incorporated into the Agreement. These provisions shall only apply to services provided by Vendor to or for Health Plan's "Qualified Health Plans" as defined in and in accordance with 45 CFR Parts 155 and 156, and any subsequent amendments or relevant provision in the regulations.

Federal Requirements - Applicable to all Health Plans that are Qualified Health Plans

1. **Qualified Health Plans.** Vendor acknowledges that payments Vendor receives from Health Plan may be used to provide services to Qualified Health Plan Covered Individuals. Therefore, Vendor and any of its subcontractors may be subject to certain laws that are applicable to individuals and entities providing services to Qualified Health Plans, including but not limited to, 45 CFR §§155.1210 and 156.340. Vendor agrees to comply with the requirements of 45 CFR §§155.1210 and 156.340, including but not limited to those set forth in the following sections of this Exhibit.

2. **Maintenance of Books and Records.** In accordance with 45 CFR §§155.1210 and 156.340, Vendor agrees that it will maintain all books and records related to its provision of services to Qualified Health Plans for ten (10) years.

3. **Inspection of Books and Records.** In accordance with, 45 CFR §§155.1210 and 156.340, Vendor acknowledges that the State where Health Plan is located, the Department of Health and Human Services (HHS), the Office of Inspector General, State regulatory agencies, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Vendor, or its first tier, downstream and related entities, including but not limited to subcontractors or transferees involving transactions related to Health Plan's Qualified Health Plans through ten (10) years from the final date of the contract period or from the date of the completion of any audit. For the purposes specified in this provision, Vendor agrees to make available Vendor's premises, physical facilities and equipment, records relating to Health Plan's Covered Individuals, including access to Vendor's computer and electronic systems and any additional relevant information that the State, HHS, OIG or their designees may require.

4. **Subcontractors.** In accordance with, 45 CFR §§155.1210 and 156.340, Vendor agrees that if Vendor enters into subcontracts to perform services under the terms of the Agreement, Vendor's subcontracts shall include an agreement by the subcontractor to comply with all of the Vendor obligations in this Qualified Health Plan Regulatory Exhibit and applicable terms in the attached Agreement. Such subcontract shall specify the delegated activities and reporting requirements.

5. **Termination-Regulatory Issues.** In accordance with 45 CFR §§155.1210 and 156.340, if during the term of the Agreement, the Health Plan concludes that it is necessary to cancel any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, or policies applicable to Qualified Health Plans, Health Plan may, at its discretion, cancel the activity and be relieved of any related obligations under the terms of the Agreement. If Health Plan or Vendor concludes that it is necessary to reorganize or restructure any of the activities to be performed

under this Agreement in order to comply with Federal or State laws, regulations, or policies applicable to Qualified Health Plans, Health Plan or Vendor may request to renegotiate such terms.

6. **Revocation**. Vendor agrees that Health Plan has the right to revoke this Agreement for its Qualified Health Plans if HHS, the applicable State regulatory agency or Health Plan determines that Vendor or any of its independent contractors or subcontractors has not performed the services satisfactorily and/or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner. Such revocation shall be consistent with the termination provisions of the Agreement.

State-Specific Requirements

The following additional provisions apply if and only to the extent that Vendor provides services to or for Qualified Health Plans in the specified state.

Connecticut - If Vendor is a "Material subcontractor", Vendor will comply with all of the applicable provisions of the contract between Health Plan and the State Exchange Board. "Material subcontractor" means "any entity from which Health Plan procures or re-procures, or proposes to subcontract with for the provision of, all or part of its administrative services for any major program area or function that relates to the delivery of care including but not limited to behavioral health, claims processing, or pharmacy benefit and/or actuarial support."

Nevada - Vendor agrees that if it receives from or creates for Health Plan, as a Qualified Health Plan in the State of Nevada, any PHI (protected health information) or PII (personally-identifiable information), Vendor will implement reasonable and appropriate safeguards to protect such PHI or PII. Prior to any Vendor employee or agent receiving or having access to any PHI or PII, Vendor must first have entered into a business associate agreement with Health Plan.

New York - Vendor agrees that all work performed by it for Health Plan must be in accordance with the terms of this contract between Health Plan, as a Qualified Health Plan, and the State of New York (the "QHP Contract"), including, without limitation, the confidentiality provisions set forth therein. Under no circumstances shall Vendor subcontract any of its duties or obligations under the Agreement without the prior written approval and knowledge of the Health Plan and New York Department of Health.

Vendor shall promptly notify Health Plan in writing of any inquiry, audit, investigation, litigation, claim, examination or other proceeding involving Vendor, or any of its personnel, that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability of Vendor to perform in accordance with the terms set forth in the Agreement or in the QHP Contract. Vendor shall provide such notice within ten (10) days of the date when Vendor learns of such action/event. Vendor acknowledges that Health Plan is obligated to notify the State of New York of such actions/events under the terms of the QHP Contract. Vendor shall comply with the State of New York's reasonable requests for information relating to the reported action/event; provided, however than any such exchange of information shall be subject to compliance with law and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal or regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action.

Performance Indicator Report
VSP
WV Medicaid
Mar-19

	Performance Standard	Jan	Feb	Mar	Qtr 1 Current Year
Provider Network					
Total Number of Vision Providers		151	153	152	152
Total Number of Optometrists		143	145	144	144
Total Number of Ophthalmologists		8	8	8	8
Member Call Center Statistics					
Total Call Volume		211	131	212	554
Number of Calls Answered		110	88	124	322
Number of Calls Abandoned		1	1	0	2
Abandonment Rate		0.91%	1.14%	0.00%	0.68%
Blocked Call Rate		6.64%	0.00%	0.00%	2.21%
Average Speed of Answer/Average Wait Time		3	3	3	3

Performance Indicator Report
Skygen USA
WV Medicaid
Mar-19

	Performance Standard	Jan	Feb	Mar	Qtr 1 Current Year
Provider Network					
Total Number of Dental Providers		691	677	663	633
Total Number of Endodontists		10	10	10	10
Total Number of Oral Surgeons		49	46	46	46
Total Number of Orthodontists		41	41	42	42
Total Number of Pediatric Dentists		40	37	33	33
Total Number of Periodontists		3	2	2	2
Total Number of Prosthodontists		4	3	3	3
Member Call Center Statistics					
Total Call Volume		180	160	203	543
Number of Calls Answered		176	160	203	539
Number of Calls Abandoned		3	0	0	3
Abandonment Rate		2%	0%	0%	1%
Blocked Call Rate		0%	0%	0%	0%
Average Speed of Answer/Average Wait Time		21	6	3	10



Accessibility Analysis - Driving Distance

Unicare Health Plan of West Virginia

July 30, 2019

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Accessibility Analysis - Driving Distance - Members With and Without Access

Access Overview

July 30, 2019

Access Analysis
1 in 30

Member / Provider Groups
Unicare Health Plan of West Virginia
Medicaid Independent

Access Map
Member locations
With access
Without access

Comparison Graph
Percent of members with access to a choice of providers over miles
1st closest
2nd closest
3rd closest

[1] The Access Standard is defined as (Unicare Health Plan of West Virginia) members accessing:
1 (Medicaid Independent) provider in 30 miles

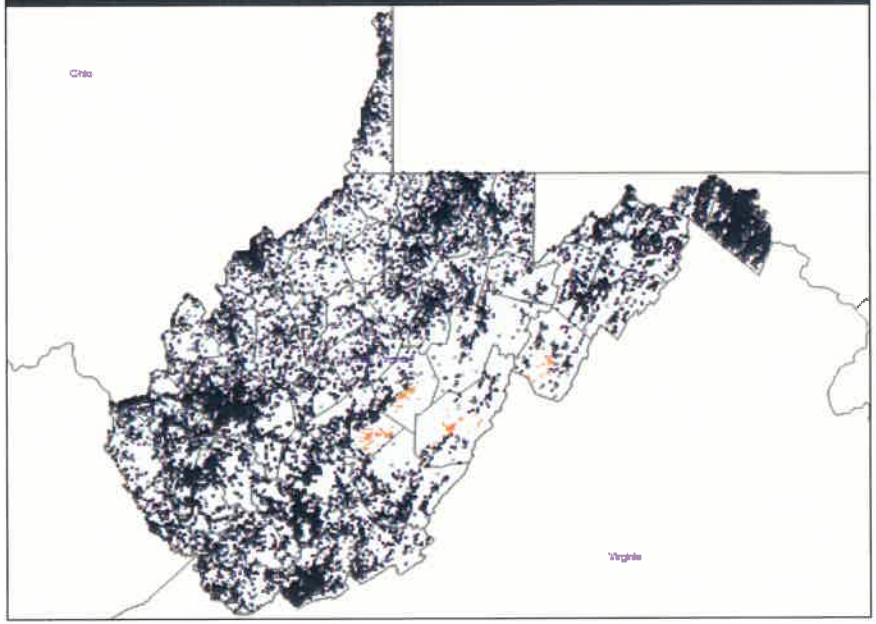
Overall Access[1]

83,201 Members
10,676 providers at 8,036 locations (Medicaid Independent)

82,271 (98.9%) Members with access
930 (1.1%) Members without access



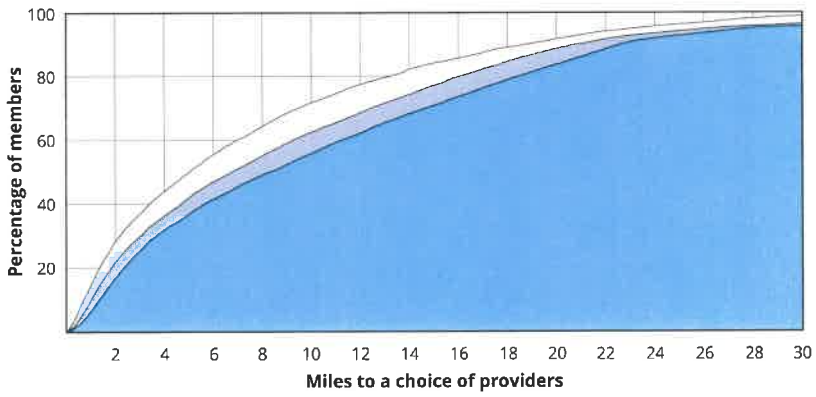
Members With and Without Access



Distances

	Average
Distance to 1st closest provider	7.6 miles
Distance to 2nd closest provider	9.4 miles
Distance to 3rd closest provider	10.8 miles

Access Standard Comparison



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SKYGEN USA
POWERING HEALTHCARE FOR THE DIGITAL AGE

Network Access Analysis

July 26, 2019

Created with the Quest Analytics Suite
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Members With and Without Access

Access Overview

July 26, 2019

Access Analysis
Generals 1 in 30 minutes

Employee Group
Members

Provider Group
Generals

Access Map
Member locations
- With access
- Without access

Service areas:
- West Virginia
- West Virginia

1 in = 62.86 miles

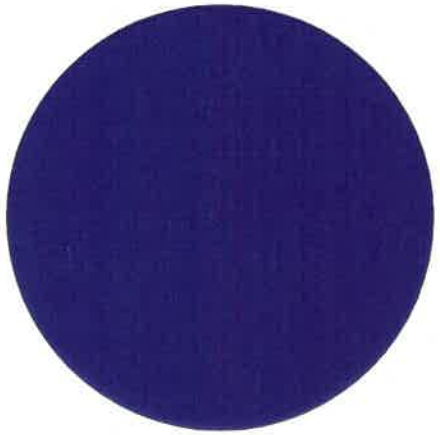
Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest

[1] The Access Standard is defined as members (Members) having:
- Providers (Generals) - 1 within 30 minutes

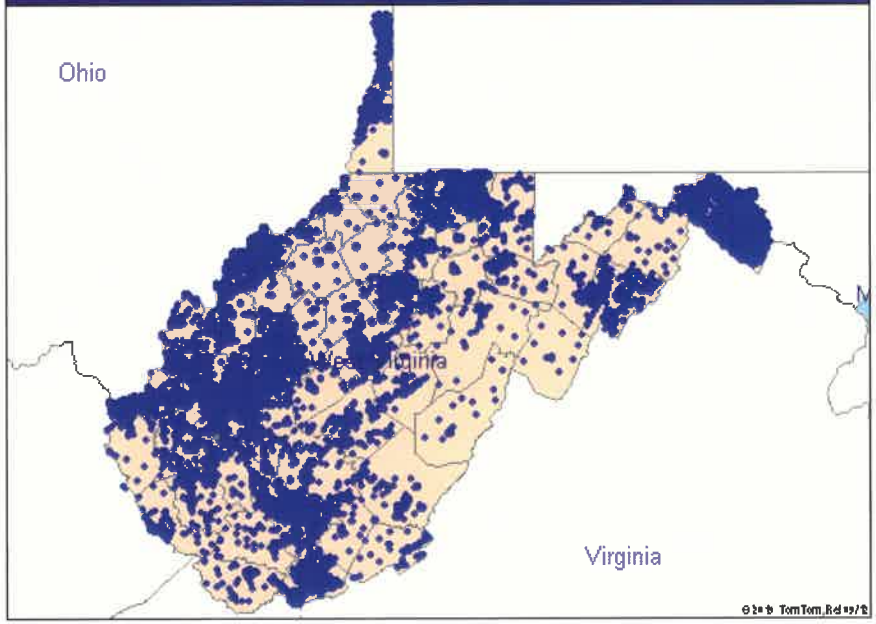
Overall Access[1]

154,241 Members
557 providers at 534 locations (Generals)

154,241 (100.0%) Members with access
0 (0.0%) Members without access



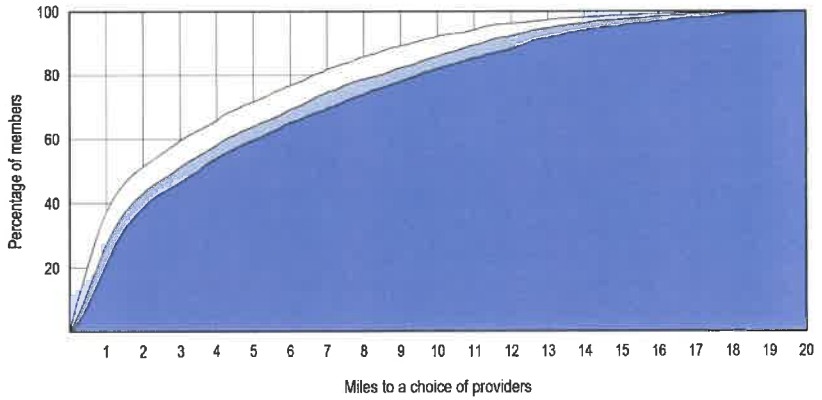
Members With and Without Access



Times

	Average
Time to 1st closest provider	3.9 mins
Time to 2nd closest provider	4.9 mins
Time to 3rd closest provider	5.6 mins

Access Standard Comparison



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2. Use of Department Staff

Describe the required staffing of business and technical resources the Department should provide to support the Vendor. Specifically, the Vendor should address the following:

- The nature and extent of Department support required, in terms of staff roles and percentage of time available
- Assistance from Department staff and the experience and qualification levels of required staffing for both implementation and operations phases

The Department may not be able or willing to provide the additional support the Vendor lists in this part of its proposal. Therefore, the Vendor should indicate whether its request for additional support is a requirement for its performance. If any part of the list is a requirement, the Department may reject the Vendor's proposal, if the Department is unwilling or unable to meet the requirements.

2. Use of Department Staff



UniCare does not require any staffing of business and technical resources from DHHR to meet the requirements of this RFP. We are proud to be a longstanding, committed partner to the State of West Virginia, and value collaboration and close coordination. We intend to continue working collaboratively to make sure implementation of this program is as seamless as possible and to fully meet the State's goals. In addition to having a designated, co-located DHHR Liaison, our leadership and key staff will be available to meet regularly with DHHR and other agency leadership to identify, discuss, and resolve issues affecting the delivery of services to members. We will also work collaboratively with DHHR to monitor and report on key stakeholder issues we identify, program outcomes, and lessons learned so that West Virginia children and families receive the best possible services and supports from the Program and stakeholder abrasion is kept to a minimum. Further, we will assign qualified individuals with decision-making authority and technical expertise to be our meeting representatives to reduce any potential administrative delays, increase the strength of our partnership, and support our goal of open and transparent collaboration with DHHR.

3. Key Staff and Resumes

Key staff consist of the Vendor's senior leadership for the Specialized Managed Care for Children and Youth project. These resources are responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the program. Resumes for key staff named in the Vendor proposal should indicate the role of the staff on the Specialized Managed Care for Children and Youth project and demonstrate how each staff member's experience and education will contribute to successful implementation and operations. The Vendor's proposed key staff should be available for an in-person interview upon the Department's request.

To ensure successful operations for this contract, the project should be led by key staff identified in the list below:

- Contract Liaison/Medicaid Administrator
- Chief Financial Officer
- Medical Director
- Behavioral Health Medical Director
- Medical Management Director
- Care Management Director
- Social Services Director
- SNS Liaison
- Quality Director
- Program Integrity Lead
- Network Development Director
- Provider Relations Director
- Information Technology Director
- Member Services Director
- Claims Payment Director
- Community Engagement Director
- Dental Director
- Medicaid Member Advocate

The qualifications, experience, and responsibilities for each key staff role are defined in ***Appendix 2: Staff Qualifications, Experience, and Responsibilities***.

3.1 Resumes

The Vendor should complete Table 12 and embed resumes of all proposed key staff to this section of the proposal. Each resume should demonstrate experience relevant to the position proposed. If applicable, resume should include work on projects cited under the Vendor's corporate experience, and the specific functions performed on such projects. This section should include the following:

- Resumes (not exceeding two pages each) for key staff and support staff members assigned to this project, including their licenses, credentials, and experience. The Department considers key staff resumes as a key indicator of the Vendor's understanding of the skill sets required for each staffing area.

A letter of intent for each proposed staff member not currently employed by the Vendor. Each letter of intent should be signed by the named individual, indicating that the individual is willing to accept employment if the Vendor is awarded the contract.

3. Key Staff and Resumes

Table 12. Resumes for Proposal Key Staff

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor
Tadd Haynes	Chief Executive Officer	• Health care executive with a 13-year history of progressive leadership roles serving West Virginia • Master of Public Health, focus areas of Maternal/Child Health and Health Policy from the University of West Virginia	2015–Present
John Marks	Interim Contract Liaison/ Medicaid Administrator	• Twenty years of experience with social services, child welfare, managed care, provider and policy development • Experience leading managed care programs to achieve strategic goals for West Virginia	Letter of intent attached
Kevin Dean	Chief Financial Officer	• Eighteen-year tenure developing and directing a range of financial activities for publicly funded health plan markets	2014–Present
Tracy Dlott, MD	Interim Medical Director	• Licensed physician with more than two decades of clinical experience providing direct patient care • Knowledge of managed care, with a proven history of developing strategies to improve quality and care coordination for West Virginia members	2013–Present
Jorge Cortina, MD	Behavioral Health Medical Director	• Licensed physician with a 30-year history in psychiatric medicine serving a diverse range of patients across managed care and other federal and commercial programs • Exceptional leadership skills overseeing clinical programs and services, specialized knowledge in trauma and substance use disorder services	2016–Present
Anita Blackburn, RN	Medical Management Director	• Registered Nurse with 20 years of nursing experience plus extensive knowledge and skills across utilization management, care management, and disease management with specialized knowledge in behavioral health and substance use disorders	2015–Present
Vicky Gallaher, RN	Care Management Director	• Current Director of Health Care Management at Anthem, Inc. overseeing all aspects of utilization review and care management • Dedicated Registered Nurse who brings almost two decades of experience that includes case management, utilization review, and discharge planning in West Virginia	2015–Present
Nancy Graham, LCSW	Social Services Director	• 20-year human and social services veteran with extensive experience across all aspects of case management, medically necessary and socially necessary services, plus almost 10 years supporting child welfare programs • Licensed clinical social worker, holds a master's degree from West Virginia University	2015–Present

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor
Stephanie Harper	Socially Necessary Services (SNS) Liaison	• Dedicated health care professional with more than a decade of experience serving children and adolescents in the child welfare system • Strong knowledge of West Virginia's Medicaid populations, SNS, behavioral health, trauma-informed care, and coordination across the system of care	2015–Present
Victoria Warner, MPH	Quality Director	• Certified Managed Care Nurse, American Association of Managed Care Nurses. Master's in Public Health with specialization in social and behavioral sciences • Five years' experience in West Virginia with expertise in quality assurance, claims, NCQA/HEDIS, and HIPAA compliance	2015–Present
Megan Lombard	Interim Program Integrity Lead	• Extensive experience in compliance and Medicaid Managed Care	2005–Present
Carrie Blankenship	Network Development Director	• Experienced provider relations and network development professional with eight years of experience serving and supporting a diverse range of providers across West Virginia	2014–Present
Terri Roush	Interim Provider Relations Director	• Over 15 years developing relationships with all provider types and delivering information and educational content to support their delivery of care and services	2004–Present
Leslie Caluya	Interim Information Technology Director	• Ten years of experience across information technology • Led management information systems teams, implemented technology programs and solutions that improve efficiency, and streamlined information flow through system maintenance and upgrades	2009–Present
Sylvia Berger	Member Services Director	• Twenty years overseeing hundreds of customer care employees and managers	2016–Present
Chris Kearney	Claims Payment Director	• Ten years of experience working with providers supporting and promoting billing, claim, and coding best practices	2012–Present
Natalie Robinson	Interim Community Engagement Director	• Fifteen years of experience in combined customer service and marketing. Exceptional skills nurturing community and client relationships, creating and executing unique events and initiatives, strategic planning, and collaborative work with diverse populations	2011–Present
Diane Paletta, DDS	Dental Director	• Practicing dentist for more than two decades • Leads strategy and development of clinical integration to support children and adults in maximizing their health through comprehensive dental programs	2013–Present (Employee of SKYGEN)
Sabrina Payne, BSW, LSW	Medicaid Member Advocate	• Experience in case management, outreach, care coordination, and health coaching	2015–Present

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor
		• Adept communicator accustomed to building rapport with members and working with those who have behavioral health conditions	

Tadd Haynes — Chief Executive Officer

Qualifications

Accomplished health care executive with a 13-year history of progressive leadership roles serving West Virginia Medicaid. Strong business and operational acumen, with a proven track record of leading initiatives that drive improved quality and outcomes, stronger relationships with West Virginia communities, and effective stewardship of Medicaid funds. Holds a Master of Public Health, with focus areas of Maternal/Child Health and Health Policy from the University of West Virginia.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2018-Present**

Regional Vice President and Plan President

- Spearheads operations for West Virginia's largest Medicaid managed care plan, with responsibility for overall delivery of the program and for making key contractual, financial, administrative, and operational decisions
- Oversees a multidisciplinary staff responsible for all aspects of plan operations, including Quality Management, Network Management, Community Relations, Medical Management, and Compliance
- Fosters strong ties with community and state agencies acting as the representative on behalf of the plan meetings and interactions with legislators, regulators, and key decision makers
- Maintains positive relationships and acts as the key liaison with the Department of Health and Human Resources (DHHR)
- Aligns strategy to achieve business goals and build a culture of accountability with people who are results driven, innovative, and committed to excellence
- Maintains accountability for the organization's profit and loss, overseeing operating gain, growth, cost of care commitments, revenue, and quality accreditation goals
- Ensures contract compliance, as well as oversight of risk management programs
- Manages customer and regulatory relationships, including state regulatory and legislative processes
- Hires, trains, coaches, counsels, and evaluates performance of direct reports

Regional Vice President, Chief Operating Officer ***2015-2018***

- Provided day-to-day oversight, under leadership of the CEO, of the organization's operations, including medical management, provider services, member services, claims, quality management, and more
- Oversaw medical performance for health services area and clinical decision-making aspects of programs
- Developed, directed, and implemented clinical and non-clinical activities that positively affected health care quality cost and outcomes
- Supported the Medical Management staff ensuring timely and consistent responses to members and providers

Director, Medicaid Field Operations **2013-2015**

- Administered the company health plan medical services to make sure that members received the most appropriate care and that services were delivered cost effectively
- Collaborated with and assisted the Plan President with management of fiscal and day-to-day operations for a significant and diverse product portfolio, including specialty products and complex provider contracting arrangements of significant revenue value

Program Manager **2010-2013**

- Managed project implementations, cost of care initiatives, and marketing and health promotion staff

Outreach Specialist, Senior **2005-2010**

- Maintained responsibility for advocating for members, marketing, building and delivering health education programs

Thomas Memorial Hospital **2003-2005**
Intake and Assessment Counselor

- Conducted initial patient interviews in a clinical psychiatric setting
- Worked with physicians to determine most appropriate course of treatment and established initial diagnosis
- Coordinated referrals to various partial hospitalization and outpatient psychiatric and substance use disorder programs as well as community resources
- Conducted pre-certification procedures with insurance companies to obtain authorization for patient treatment

Education

West Virginia University
Master of Public Health, focus areas of Maternal/Child Health and Health Policy, 2006-2009
University of Charleston
Bachelor of Arts, Psychology, 1995-1999

John L. Marks, Jr. — Interim Contract Liaison/Medicaid Administrator

Qualifications

Accomplished and experienced health care professional with expertise including over 20 years of progressively growing experience in the areas of executive management, social services including child welfare, managed care, compliance, legal, health policy, health delivery systems, finance, health insurance, and government/regulatory affairs. Proven track record as key leadership for public and private markets

Resume/Professional Experience

Beacon Health Options **2015-2019**
Director, Account Partnerships, West Virginia

- Responsible for the overall client relationship and strategy related to retention, growth, and innovation
- Executed strategic goals
- Ensured contractual, regulatory, and delegation agreement compliance
- Cultivated key stakeholder relationships to advance Beacon's standing on behalf of its current client base and to support business expansion and retention efforts in West Virginia
- Improved client satisfaction year-over-year by serving as a strong go-to expert on all delegated activities
- Fostered business development opportunities and strategic relationships in the state
- Actively engaged internal subject matter experts and operational leads to achieve contractual and strategic goals for West Virginia contract

West Virginia Medical Institute **2001-2015**
Director of State Services

- Responsible for the operational and financial performance of business units that provide services to various State agencies
- Led all marketing and sales efforts directed at increasing the company's portfolio of State contracts
- Successfully negotiated contracts with various State Medicaid agencies, generating revenues in excess of $10.5 million annually
- Developed strategic business partnership arrangements with a mental health administrative services organization, pharmacy benefits manager, information technology vendors, disease management vendor, commercial insurance carriers, and third-party administrators
- Co-chaired a team tasked with securing national accreditation designation for the company

CCO HealthCare System **1999-2001**
Executive Director

- Served as Chief Executive Officer for this physician-hospital organization
- Responsible for the development of the company's strategic plan and implementation of strategies to achieve corporate objectives
- Developed the company's initial sales and marketing program targeting both public and private sector payer arrangements
- Successfully brokered payer arrangements on behalf of the network
- Led the development and implementation of the network's medical management program

CareLink Health Plan **1992-1999**
Vice President of Provider Relations and Network Development

- Responsible for the development, implementation, and operation of West Virginia's first physician/hospital organization (PHO)
- Served as the PHO's Executive Director and led the development and startup of West Virginia's first provider-owned managed care organization until the corporation was granted a certificate of authority to operate as a health maintenance organization in 1994
- Responsible for the development and execution of the Plan's network expansion and provider relations strategy
- Negotiated service agreements, including various risk sharing arrangements for a provider network of more than 1,500 physicians and 30 hospitals
- Negotiated terms of the State's first Medicaid Managed Care program, serving more than 12,500 members

West Virginia Bureau for Medical Services **1991-1992**
Director

- Responsible for the management, oversight, and operation of West Virginia's Medicaid agency, serving more than 300,000 beneficiaries with a budget in excess of $600 million
- Improved timeliness of reimbursement to Medicaid providers with over 80% of all claims processed and paid within a 45-day period, and fees to key provider groups increased by more than 60%
- Increased access and availability of services to Medicaid beneficiaries

King's Daughters' Medical Center **1982-1990**
Vice President of Professional Services

- Held several senior level management positions including Vice President of Human Resources and Interim President/CEO for this 300-bed not-for-profit community hospital with an annual budget of over $70 million and employing 950 individuals
- Directed twelve clinical departments employing more than 215 individuals with operating budgets in excess of $10.5 million
- Responsible for the planning, coordination, and establishment of the following programs: 27-bed physical rehabilitation unit, facility-based Skilled Nursing Facility, the Medical Center's first cardiac catheterization unit, and development of a 29-bed inpatient psychiatric unit
- Reviewed and modified the Medical Center's facility expansion/renovation program that resulted in cost savings of $3.5-$4.0 million
- Responsible for a physician recruitment and retention program resulting in nineteen new physicians recruited in a three-year period
- Negotiated four separate collective bargaining agreements
- Implemented a hospital-wide job evaluation and wage and salary program for all nursing, professional, and technical positions

Qualifications

West Virginia University
Master of Social Work, 1974

Fairmont State College
Bachelor of Arts, Sociology/Psychology, 1972

Professional Affiliations/Community Service

AARP West Virginia
The Arc of the Three Rivers, Charleston, West Virginia

John L. Marks, Jr.

[redacted]

August 8, 2019

Tadd Haynes, MPH,
President, UniCare Health Plan of West Virginia, Inc.
200 Association Drive, Suite 200,
Charleston, WV 25311

Dear Tadd:

I am pleased to provide this letter indicating my intent to work with UniCare to support implementation and operational activities should you be awarded the contract to provide managed care services to the child welfare population in West Virginia. I am pleased to be included in the bid response to assist you with provider communications, networking and recruitment of future personnel, as well as a wide range of operational activities to ensure the model is successfully implemented.

As you know, during my time with Beacon, we worked well together. At Beacon I was an active participant in discussions around the design and implementation of a managed care model for this population. Working with UniCare, should you be selected as the single managed care entity, would be the perfect way to continue this work and bring this program to fruition.

Thank you for including me, and I look forward to hearing the news of award with you.

Sincerely,

John L. Marks, Jr.

Kevin Dean — Chief Financial Officer

Qualifications

Health care finance executive who brings an 18-year tenure developing and directing a range of financial activities for publicly funded health plan markets. Highly skilled in providing thought leadership and driving the organization's overall financial health. Strong background and knowledge in finance, health plan operations, and leadership with a proven record of implementing cost-effective processes, including developing a cost reduction plan for $22 million annually across West Virginia Medicaid operations. Holds a Master's of Public Administration in Health Management and Finance.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2014-Present**
Director, Government Business Division Finance

- Oversees financial operations for UniCare's $400 million local Medicaid health plan serving 140,000 members across West Virginia
- Plays an integral role as a key staff member during a period of substantial expansion from 15 to 135 full-time employees
- Spearheads a cost reduction plan to slash cost by $22 million on an annualized basis
- Collaborated on development, implementation, and management of a provider incentive plan designed to improve quality scores and maximize return of premium withhold from the state
- Developed suite of financial modeling and standard financial reports and created finance educational workshops and presentations for staff

UnitedHealthcare Group **2007-2014**
National Director, Intersegment Finance

- Interfaced actively with field finance staff of approximately 20 and corporate finance staff of approximately 200
- Provided financial management and analysis services for Fortune-20 health insurance corporation within highly-complex matrix environment
- Supervised staff of up to 25 in various locations throughout the country, and communicated with a range of finance staff, both in local field operations and in corporate headquarters
- Managed internal revenue/service exchange process of over $5 billion annually
- Played an instrumental role in operationalizing national field finance reorganization, including reorganization of staff and responsibilities among local, national, and corporate staff, development of standard reporting packages shared with staff at all matrix levels and providing detailed variance analyses for individual markets
- Developed corresponding forecasting tools, comparing monthly results to budget and prior forecasts, assisting in the development of current forecasts

National Director, Acquisition Integration ***2005-2007***

- Integrated acquired entities into the finance department, which included participation in due diligence, regulatory approval processes, staff realignment, synergy tracking, and functional assimilation

National Director, Field Support ***2004-2005***

- Collaborated with national corporate and field finance staff on development and implementation of a $1.2 billion budget, including specific product-line and major/minor market designations, as well as the implementation of online budgeting and forecasting tool, and Essbase data repository reporting system

Divisional Finance Manager ***2001-2003***

- Developed monthly financial reporting package including standardized schedules and ad hoc reporting, for monthly health plan performance meetings (Financial Oversight Committee) attended by local executive staff as well as key national leadership for the seven Northeast Region health plans
- Implemented reporting function in four additional health plans
- Developed corresponding forecasting tools, comparing monthly results to budget and prior forecasts, assisting in the development of current forecasts, approximately four times per year

Education

New York University, Robert F. Wagner Graduate School of Public Service
Master of Public Administration, Health Management and Finance, 1996

Georgetown University, College of Arts and Sciences
Bachelor of Arts, Cum Laude, Government/Economics, 1989

Professional Certifications

Healthcare Alumni Advisory Council — charter member advising Program Director on curriculum, marketing, and admissions strategies

Tracy Dlott, MD — Interim Medical Director

Qualifications

Licensed physician with more than two decades of clinical experience providing direct patient care. Keen understanding of managed care, with a proven history of developing strategies to improve quality and care coordination for West Virginia members. Skilled in serving a diverse range of individuals across varied settings, collaborating with key leadership on clinical and quality initiatives, and driving improved outcomes. Received a medical degree from the University of Texas Health Science Center, San Antonio, and completed residency in obstetrics and gynecology at the University of Louisville's School of Medicine. Certified by the American Board of Obstetrics and Gynecology, and is a Fellow of the American College of Obstetrics and Gynecology.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2015-Present**
Medical Director

- Provides clinical oversight to assure members receive the most appropriate services and supports, which includes managing and supporting clinical staff
- Plays a key role as part of leadership team to develop clinical and quality strategies designed to support the integration and coordination of care and improve the health status of our members
- Works collaboratively across the health plan with provider services, QM, and others to maximize the quality of health services provided to members
- Stays abreast of the latest evidence-based and emerging practices, aids in developing new policies based on changes in the health care and/or medical arena, and evaluates new clinical programs and partnerships to bring the best in innovation and quality to members
- Develops and implements clinical and non-clinical initiatives that impact cost of care and quality outcomes
- Serves as a resource and consultant to other areas of the health plan, and in providing peer-to-peer consultations when needed
- Oversees treatment policies, protocols, quality improvement activities, and UM decisions

Anthem, Inc. **2013-2015**
Physician Case Reviewer, Medicaid and Medicare Division

- Conducted physician-level case review, following initial nurse review, for the company's Medicaid and Medicare health plans in Indiana, South Carolina, West Virginia, and Wisconsin to determine medical necessity
- Held peer-to-peer discussions with ordering providers, and provided education regarding established guidelines and accepted standards of care
- Recommended alternative services to ordering providers, when appropriate
- Documented the pre-certification review in a complete, concise, and accurate manner
- Maintained up-to-date knowledge of clinical guidelines, clinical policies and procedures, new and emerging technology, and best practices
- Assisted pre-certification staff in understanding utilization principles
- Acquired, demonstrated, and maintained proficiency in ICD-9, ICD-10, and CPT coding

Kaiser Permanente, Mid-Atlantic Permanente Medical Group, P.C. **2006-2013**

Women's Health Alliance, P.C. **1998-2005**

OB/GYN Primary Care, P.C. **1997-1998**
Practicing Physician in Obstetrics and Gynecology

- Provided compassionate care to a diverse range of patients across inpatient and outpatient settings
- Performed all types of surgeries, including, but not limited to, cesarean sections, operative vaginal deliveries, minimally invasive hysterectomies, Essure sterilization procedure, and Novasure endometrial ablation
- Managed electronic medical records for all patients
- Acquired substantial knowledge of the inner workings of nation's largest health care organization and its philosophy of delivery of integrated health care
- Assisted in updating technology in the existing practice
- Mentored and counseled family practice residents in obstetrics and gynecology

Education

University of Louisville School of Medicine
Resident in Obstetrics and Gynecology, 1993-1997

University of Texas Health Science Center at San Antonio
Doctor of Medicine, 1989-1993

University of Texas at Austin
College of Liberal Arts, Honors History and Pre-medicine, Cum Laude, 1989

Professional Certifications

American Board of Obstetrics and Gynecology, 1999
Fellow of the American College of Obstetrics and Gynecology, 1999
Health Care Quality Management and Patient Safety from American Board of Quality Assurance and Utilization Review Physicians, 2014

Medical Licenses

West Virginia — 2015-Present
Maryland — 2011-Present
Washington D.C. — 2011-Present
Drug Enforcement Agency — 1994-Present
Virginia — 2005-Present
Indiana — 1997-Present
Texas — 1994-Present
Kentucky — 1994-Present

Jorge Cortina, MD DFAPA — Behavioral Health Medical Director

Qualifications

Licensed physician with a 30-year history in psychiatric medicine serving a diverse range of patients across managed care and other federal and commercial programs. Exceptional leadership skills overseeing clinical programs and services, with specialized knowledge in trauma and substance abuse services. Holds MD Distinguished Fellow of the American Psychiatric Association (DFAPA) from the University of Virginia Health Sciences Center.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2016-Present**
Medical Director for Behavioral Health

- Provides day-to-day guidance, support, and leadership with regard to clinical functions
- Supports leadership in ensuring the clinical integrity of a broad spectrum of clinical programs
- Identifies and participates in opportunities for innovation in order to increase effectiveness and quality

Veterans Affairs Mid-Atlantic Network **2001-2016**
Service Line Coordinator for Geriatrics and Extended Care

- Oversaw Geriatric and Extended Care programs in health care systems in North Carolina, Virginia, and West Virginia; programs included nursing homes (total census 700), home care, palliative care, and outpatient clinics for 20,000 frail and disabled veterans
- Served as a physician representative on the Veteran Mid-Atlantic Network Survey Readiness Team conducting annual visits to facilities to review compliance with standards established by Joint Commission, Veterans Health Administration (VHA), OSHA, and other regulatory and oversight entities
- Provided consultation to the Veterans Health Administrations Office of Medical Inspector from 2007 to 2015, serving as subject matter expert in Geriatrics, Psychiatry, and Hospice and Palliative Medicine
- Led the systems redesign for Veterans Mid-Atlantic Integrated Service Network from 2014 to 2016, serving as point of contact for VHA health care systems in North Carolina and Virginia to promote Lean Management principles

Veterans Health Administration (VHA) **2015**
National Center for Ethics in Health Care Acting Chief, IntegratedEthics®

- Oversaw Veteran Affairs (VA) national operations of Ethics Consultation, Preventive Ethics, and Ethical Leadership programs
- Supported the development and implementation of IntegratedEthics across the VHA (IntegratedEthics is a comprehensive approach to managing ethics in health care organizations)

Hampton Veterans' Affairs Medical Center **1992-2002**
Associate Chief of Staff for Geriatrics and Extended Care

- Held various progressive roles that included staff psychiatrist (1992-1997) and Associate Chief of Staff for Geriatrics and Extended Care, Veterans' Affairs Medical Center (1997-2001), serving as administrator for all geriatrics and extended care programs at the Hampton Veterans Affairs of Virginia medical center including a 120 bed Extended Care and Rehab Center, 200 bed Residential Treatment Center, Palliative Care Programs, Home and Community Care programs, and the Physical Medicine and Rehab Service

- Also held positions as the Interim Chief of Staff (1998-2000 and in 2002) and was the Medical Director of a 500-bed/1000 employee multi-specialty medical center/nursing home/domiciliary and outpatient programs serving 24,000 patients annually

Education

University of Virginia School of Medicine
Medical Doctor, 1986

University of Virginia Health Sciences Center
Resident, Department of Behavioral Medicine and Psychiatry
MD DFAPA, 1986-1990 (Chief Resident, 1989-1990)

Professional Certifications

Hospice and Palliative Medicine, 2012
American Board of Hospice and Palliative Medicine, 2005
Geriatric Psychiatry, American Board of Psychiatry and Neurology (ABPN), 1994
Addictions Psychiatry, American Board of Psychiatry and Neurology (ABPN), 1993
American Board of Psychiatry and Neurology (ABPN), 1992
Diplomate of the National Board of Medical Examiners, 1987
Commonwealth of Virginia Board of Medicine, 1987

Anita Blackburn, RN — Medical Management Director

Qualifications

Registered Nurse with 20 years of nursing experience plus extensive knowledge and skills across utilization management, care management, and disease management with specialized knowledge in BH and substance use disorders. Strong skills in all aspects of care coordination, including providing one-on-one support to members and in developing, implementing, coordinating, monitoring, and evaluating Care Plans to make sure members receive health care across the continuum.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2015-Present**
Manager I Behavioral Health Case Management

- Ensures appropriate utilization of BH services through level of care determination, accurate interpretation/application of benefits, corporate medical policy, cost efficient, and quality care
- Supports case managers with outreach to members; oversees staff assessing, developing, implementing, coordinating, monitoring, and evaluating Care Plans designed to optimize member health care across the care continuum and assuring member access to services appropriate to their health needs; monitors and evaluates effectiveness of Care Plan
- Collaborates with implementation, operations, claims, quality, and network education team members to ensure excellent customer service and consultation to providers and members
- Provides education to team members regarding provider manuals and expectations

American Health Holding/Aetna **2013-2015**
Behavioral Health and Substance Use Disorder Case Manager

- Reviewed medical necessity of inpatient and outpatient behavioral health/substance use disorder services according to Aetna and Milliman guidelines
- Established rapport and built trusting relationships with members to provide education and support for the services they need, making sure they fully understand the services available to them and how to access them through their plan

APS Healthcare **2010-2013**
Behavioral Health and Substance Use Disorder Care Manager

- Reviewed for prior authorization of inpatient and outpatient BH services according to West Virginia Medicaid guidelines
- Held regular case discussions with providers regarding service utilization and CareConnection needs
- Assisted team members with updating utilization criteria, developing internal review protocols, and establishing individual recommendations for provider assistance and training related to best practices
- Assisted providers and subcontractors with claims and other issues

Sirona Health (formerly Intellicare) **2008-2010**
Nurse Consultant

- Practiced computer-assisted expert nursing through inbound and outbound telephone interactions with patients whose physicians, hospitals, insurers, employers or other sponsors/providers were clients
- Provided individualized direct patient care in accordance with policies, procedures, and established standards of nursing care and practice. Two major clinical work types, which included telephonic triage and disease management

- Worked efficiently and assisted coworkers in daily use of program-specific and Microsoft applications

Wells Fargo TPA **2003-2008**
Behavioral Health and Substance Use Disorder Case Manager

- Performed medical review activities to ensure the provision of safe, timely, appropriate, and necessary covered health care services to members
- Promoted effective resource management by directing member care to accessible cost-effective network providers and services at the appropriate level of care
- Facilitated timely discharge planning and continuity of care across health care settings

United Health Group Optum Nurseline **1998-2003**
Telephonic Triage Nurse

- Practiced computer-assisted expert nursing through inbound and outbound telephone interactions with patients whose physicians, hospitals, insurers, employers, or other sponsors/providers were clients
- Provided individualized direct patient care in accordance with policies, procedures, and established standards of nursing care and practice

Education

Bluefield State College
Associate Degree in Nursing, 1992

Professional Certifications

Multistate Compact RN License, 2018
Commission for Case Manager (CCM), 2013

Vicky Gallaher — Interim Care Management Director

Qualifications

Dedicated Registered Nurse who brings almost two decades of experience that includes case management, utilization review, and discharge planning in West Virginia. Strong leadership and management skills, adept at leading and championing the growth and development of staff, overseeing inpatient units and outpatient clinics, program policies, and clinical program operations.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2015-Present**
Director of Health Care Management

- Oversees all aspects of utilization review and care management processes, which includes monitoring, reporting, and addressing utilization, cost, and quality objectives
- Drives strategies and processes that ensure continued program compliance that meet state and federal requirements as well as NCQA guidelines
- Develops and implements relevant policies, procedures, and clinical guidelines to ensure consistent decision making
- Manages day-to-day activity of health care management operations and more than 50 full-time employees, with responsibility for the growth, development, and success of the team

United BioSource Corporation **2014-2015**
Senior Operations Manager

- Managed launch of a Clinical Adherence Program in accordance with Scope of Work, Standard Operating Procedures, and established budget with continued responsibility for monitoring program statistics and metrics
- Managed daily program operations, including supervision of 120 full-time employees (FTEs), and routine daily interaction with clients to identify and resolve issues promptly
- Maintained responsibility for employee growth and development, including mentoring and growing associates' supervisory skills and providing direction for performance management and corrective actions

HealthSouth Corp. **2013-2014**
Unit Administrator

- Helped orchestrate the planning and development of a new inpatient unit, and facilitated successful Joint Commission and OHFLAC survey
- Managed 19-bed inpatient unit with accountability for quality patient care, functional integrity, and for ensuring compliance with applicable laws, regulations, policies, and procedures
- Delegated nurse executive for nursing operations of unit
- Reviewed financial performance and instituted corrective actions when needed
- Maintained responsibility for human resource management of 50 FTEs as well as the cultivation of strong community relations

HealthSouth Corp. – MountainView Regional Rehab Hospital **2010-2013**
Director Care Management Services/Regional Director of Case Management

- Spearheaded the hospital's strategies and initiatives to ensure patient satisfaction and exceptional customer service
- Oversaw case management, utilization review, and operations of 14 hospitals
- Restructured case management paradigm with KPMG consultant
- Business development of potential inpatient rehabilitation units

HealthSouth Corp. **2008-2010**
Unit Administrator
- Managed a 16-bed inpatient unit and an offsite outpatient clinic, with accountability for quality patient care and functional integrity
- Ensured compliance with applicable laws, regulations, policies, and procedures
- Delegated nurse executive for nursing operations of unit
- Utilized statements of financial performance and took necessary corrective action
- Managed 40 FTEs and community relations

HealthSouth Corporation – MountainView Regional Rehab Hospital **2004-2008**
Director of Case Management
- Oversaw delivery of case management services, and monitored financial reports, budgets, and staff scheduling
- Monitored CMS-13 compliance and provided education to staff
- Coordinated admissions, discharges, and task assignment to staff
- Reviewed pre-admission assessments and evaluated for admission criteria
- Educated patients, families, and communities about diagnosis-specific programs

HealthSouth Corporation **2000-2004**
Case Manager/Team Leader for Traumatic Brain Injury
- Monitored insurance authorization/utilization reviews
- Performed discharge planning through collaboration with treatment team
- Authorized and ordered durable medical equipment/community referrals
- Facilitated Brain Injury team meetings and family conferences
- Educated patients and families on traumatic brain injury and life thereafter

Education

Alderson Broaddus College School of Nursing
Bachelor of Science Nursing, 1986

Professional Certifications

West Virginia Registered Professional Nurse, License Number [redacted]
Case Management Certification, 2008
Respecting Choices Advance Care Planning Facilitator, 2010
Nonviolent Crisis Intervention Training, 2008
Life Care Planning Certification Program, Kaplan University, 2007

Nancy E. Graham MSW, LCSW, ACSW — Social Services Director

Qualifications

20-year human and social services veteran with extensive knowledge and experience across all aspects of case management, medically necessary, and socially necessary services, plus almost 10 years directly supporting child welfare programs. Licensed clinical social worker with a master's degree from West Virginia University. Strong clinical acumen, including specialized knowledge in BH, working with youth in psychiatric residential treatment facilities and other settings. Strong leadership and communication skills; history includes overseeing, mentoring, and training clinical staff.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company

Behavioral Health Case Manager Lead ***2018-Present***

- Oversees the referral process for accurate and timely case assignment, and provides support to BH case managers and other clinical staff to help ensure members receive needed services and supports
- Drives clinical integration and coordinates cross-functional teams, facilitating consistent and exceptional care coordination, conducting quality audits, and holding daily clinical rounds for the team
- Works with manager to ensure individual team and overall operational metrics are achieved
- Assists with process improvement activities for regulatory requirements, and acts as a departmental liaison to other areas of the business unit
- Champions the development of new clinical staff through extensive training and mentoring

Case Manager II ***2015-2018***

- Ensured medically appropriate, high-quality, cost-effective care by assessing the medical necessity of inpatient admissions, outpatient services, out-of-network services, and appropriateness of treatment setting using the applicable medical policy, clinical criteria, and industry standards, accurately interpreting benefits and managed care products, and steering members to appropriate providers, programs, or community resources
- Worked with medical directors to interpret appropriateness of care and accurate claims payment, and assisted in managing appeals for services denied
- Conducted pre-certification, retrospective, out-of-network, and appropriateness of treatment setting reviews to comply with applicable criteria, medical policy, and member eligibility, benefits, and contracts
- Consulted with clinical reviewers and/or medical directors to ensure medically appropriate, high-quality, cost-effective care throughout the medical management process
- Collaborated with providers to assess member needs for early identification of and proactive discharge planning
- Facilitated member care transitions through the health care continuum and referred treatment plans/plan of care to clinical reviewers
- Stayed up-to-date and complied with all accrediting body (such as NCQA) and regulatory requirements and standards

APS Healthcare/Kepro **2013-2015**
Trainer/Consultant
- Conducted retrospective reviews of Medicaid BH providers to ensure compliance with Medicaid requirements
- Analyzed data and prepared reports for providers utilizing APS UM guidelines, Medicaid manual, Bureau for Children and Families manual, Behavioral Health Clinic Rehabilitation manual, and/or Federally Qualified Health Centers manual according to established timeframes
- Provided training and technical assistance to Medicaid providers

Valley HealthCare System **2010-2013**
Chemical Dependency Program Manager
- Coordinated and supervised outpatient services of the Chemical Dependency Programs, which included adolescent treatment services, the Crossroad Program, adult outpatient treatment services, prevention program services, Suboxone Program, and the DUI Safety and Treatment Program

Crittenton Services Inc. — Wellspring Family Services Division **2006-2010**
Site Director/Clinical Team Leader
- Clinically and administratively supervised therapists and case managers for medically necessary and socially necessary services for five counties
- Managed and coordinated referrals for admission

Valley Addiction Recovery Unit Valley HealthCare System **1999-2006**
Interim Program Supervisor
- Supervised a 20-bed residential detoxification unit for chemically dependent adults on an involuntary and voluntary basis, with oversight responsibility for 15 employees

Education

West Virginia University
Master of Social Work, 2002

Fairmont State College
Bachelor of Science in Sociology, Human Services, Magna Cum Laude, 1999

Professional Certifications

Licensed Clinical Social Worker, Academy of Certified Social Workers

Stephanie Harper — Socially Necessary Services (SNS) Liaison

Qualifications

Dedicated health care professional who brings more than a decade of experience serving children and adolescents in the child welfare system. Strong knowledge of West Virginia's Medicaid populations, socially necessary services, BH, trauma-informed care, and the integration and coordination across the system of care. Proven history developing and playing a key role in training, education, outreach, and initiatives aimed towards supporting youth and families. Also brings a decade of quality improvement activities, including gathering and reporting data for state agency reporting.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2015-Present**
Behavioral Health Outreach Care Specialist

- Provides outreach and education to a range of stakeholders for Medicaid membership, and stays abreast of policies and requirements regarding foster care, SNS, DHHR-BHHF and DHHR-BCF, Dual Diagnostic Treatment, Cultural Competency, Youth implementations
- Develops initiatives to serve members with substance use disorders and mothers of neonatal abstinence syndrome infants
- Seeks opportunities to support and provide trauma-informed training within communities and school systems and to also support teaching mindfulness in schools and residential rehab programs
- Attends and participates in advisory and specialized workgroup meetings to address the needs of children and youth
- Provides ASO (Administrative Services Only) training, community resource materials, desk guides, and technical assistance to all stakeholders

APS Healthcare Inc., dba KEPRO **2007-2015**
Administrative Service Organization Family Support Educator, SNS Department

- Coordinated, created, and facilitated relevant consumer feedback focus groups and satisfaction activities statewide for youth, foster care, biological, foster-adoptive families and kinship relatives involved with Child Protective and Youth Services (receiving services from Psychiatric Residential Treatment Facility, shelters, ASO-SNS, BH Community and Residential services), in order to identify systemic issues thus improving the quality of care, service delivery, and communication within the system and program outcomes
- Analyzed data gathered, identified measurable factors to increase success of the program for Consumer Stakeholder reports, and submitted to DHHR
- Created and delivered trainings, user manuals, desk guides, PowerPoints, forums, and data analysis reports using effective technology for document preparation, electronic communication, presentation development/delivery and library keeping

WV Mental Health Planning Council **2007-2009**
Events Coordinator

- Served as Liaison for Chair and Committees, conducted regional stakeholder forums, reviewed block-grant data report analysis, and planned all events

Data Entry WVSU Institutional Research & Development Institute **2006-2007**

- Researched and conducted statistical analysis in support of the management decision-making process, and database quality control and changes for state (Higher Education Policy Commission), regional (Southern Regional Education Board), and federal (US Department of Education) reports

Education

West Virginia State University (WVSU)
Bachelor of Arts, Psychology, Magna Cum Laude
Global College of Natural Medicine Santa Cruz, CA
Master Herbalist, Nutritional Consultant

Professional Certifications

CPR and ACE renewals: 2015-Present
Teacher Certification-Teaching Tai Chi for Arthritis & Fall Prevention — Sun Style, 2015
PYP Certification: Prisons & Rehabs Trauma Informed — Prison Yoga Project, 2015
Tai Chi Chuan Instructor promotion certification — Yang Style, 2014
Nutritional Consultant, 2008
Emotional Freedom Techniques (EFT) Certification I — LifeQuest International, 2008
Holistic Health Practitioner — American Association of Drugless Practitioners, 2007

Victoria Warner — Quality Director

Qualifications

Certified Managed Care Nurse and Licensed Practice Nurse who holds a Master's in Public Health, specializing in social and BH sciences. Progressive history of roles with increasing responsibilities across quality, including data collection and reporting, NCQA and HEDIS measures, and overseeing quality initiatives to drive improved outcomes in West Virginia. Strong communication skills, accustomed to collaborating with internal staff across all areas to improve quality, and provider relations staff to help address provider needs.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company

Clinical Quality Program Director ***2019-Present***

- Develops and maintains pertinent compliance plans
- Monitors adherence to plans and prepares status reports
- Conducts audits, identifies training and communication needs, and implements related programs
- Ensures all policies and procedures are updated as legislation or accreditation standards change
- Implements standardization of procedures and documentation within the health plan
- Develops and delivers executive level presentations and represents senior management on compliance issues and related committees
- Obtains and analyzes BH quality metrics and reports for care opportunities, supports practice implementation of care coordination and care management, identifies action plans for providers to implement to improve cost, quality, and the patient experience and participates in design, development, and implementation of community learning forums
- Collaborates with Patient Centered Primary Care team — including but not limited to engagement manager, clinical liaison, provider contractors and network relations representatives — to meet provider and practice service needs
- Actively participates in developing program recommendations and action plans

Behavioral Health Clinical Quality Compliance Administrator Sr. ***2016-2019***

- Developed annual HEDIS data collection strategy to direct the planning, prioritization, approval, implementation and compliance of ongoing external quality programs
- Established program governance when needed to assure response to issue escalation; developed program budget and ensured program meets its stated objectives
- Provided subject matter expertise in response to day-to-day business issues; researched applicable subject matter practices and remained aware of industry trends
- Ensured compliance with state and regulatory requirements
- Developed communication documents and training criteria related to external client-facing program success measures
- Developed documentation to support meeting presentations and the tracking and reporting of the program's success
- Provided leadership to program managers and project managers
- Managed external client-facing programs that require resources of multiple departments or business areas of the organization
- Supported business strategies through an integrated portfolio of external client-facing programs, projects, and initiatives

- Collaborated with multi-departmental teams to leverage subject matter expert support to achieve mutual goals and ensure coordination, enabling a "One Anthem" approach in our engagement with providers

Patient Centered Care Consultant ***2015-2016***

- Obtained and analyzed quality metrics and reports for care opportunities, supported practice implementation of care coordination and care management, identified action plans for providers to implement to improve cost, quality, and the patient experience and participated in design, development, and implementation of community learning forums
- Collaborated with Patient Centered Primary Care team including but not limited to: engagement manager, clinical liaison, provider contractors and network relations representatives to meet provider and practice service needs

Community Care of WV, Pocahontas County **2014-2015**
School Based Health, Care Manager

- Outreach Coordinator for pediatric populations for preventive health initiatives such as well-child checks and recommended childhood immunizations as well as gaps in care for preventive screenings
- Served as a spokesperson for School Based Health matters
- Collaborated with other departments and agencies such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Vaccines for Children (VFC), and Family Planning
- Assisted in the development of processes for improving quality measure and outcomes

Education

Capella University
Master's in Public Health with Specialization in Social and Behavioral Sciences, 2018
New River Community and Technical College
Kaplan University Bachelors of Science in Health Care Administration, 2014

Professional Certifications

Certified Managed Care Nurse – American Association of Managed Care Nurses
WV LPN Board Examination: Licensed Practical Nurse, 2010

Megan Lombard — Interim Program Integrity Lead

Qualifications

Dedicated health plan professional with more than 15 years of compliance, operations, and risk management experience in the health care industry. Her accomplishments at UniCare include developing and driving implementation of the organization's Medicaid Compliance Work Plan and overseeing fraud, waste, and abuse investigations. Her focus on program integrity and compliance drove her to become a Certified Health Care Compliance professional in 2016.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company

Operations Director, Medicaid ***2019-Present***

- Oversees execution of operational support services, including Claims, Enrollment, Call Centers, Provider Data Management, and Pricing and Benefit Configuration
- Drives compliance with operational requirements, including timely and accurate claims payments and call center service levels
- Ensures timely implementation of rate changes and adjustments to claims impacted by retroactive changes
- Ensures timely, accurate, and complete submission of encounters to State agency
- Facilitates timely resolution of operational issues
- Implements key operational indicators use to monitor and drive operational performance
- Plans, directs, and secures resources to enable staff to effectively accomplish operational needs and strategic initiatives

Compliance Director, Medicaid ***2014-2019***

- Developed and drove implementation of UniCare's Medicaid Compliance Work Plan, which is updated annually and based on direction from Anthem's Medicaid Compliance Plan and guidance from the Office of the Inspector General (OIG)
- Ensured development, implementation, and ongoing assessment of internal controls, including policies and process to combat fraud, waste, and abuse
- Oversaw activities of the Special Investigations Unit (SIU) and other Program Integrity departments to ensure effective implementation of fraud, waste, and abuse investigations, over and under-utilization analyses, and overpayment recoveries
- Acted as liaison with the department for program integrity matters and the help drive SIU responses to state and Medicaid Fraud Control Unit requests
- Drove compliance with contractual and regulatory requirements, including annual contract changes
- Manage risk and issue management processes, including identifying, rating, tracking and mitigating of risk and issues

Risk, Compliance and Audit Advisor, Operations and IT ***2011-2014***

- Integrated operational and IT risk assessments; managed timely implementation of corrective action plans for risks and issues
- Advised management on practices and controls to provide reasonable assurance of compliance with requirements and standards
- Facilitated development and submission of cross-functional responses to external audits
- Coordinated development of HIPAA risk assessment, and managed components of HITECH certification process
- Drove development of process documentation for key control IT activities such as system backups and change management

Director, Account Management ***2010-2011***

- Managed relationship between three Medicaid health plans and operational shared services support teams
- Ensured shared services leaders understood health plan objectives and requirements
- Managed cross-functional projects in support of health plan management objectives
- Facilitated resolution of complex issues, including those related to provider contracting, claims processing, encounters, and care management
- Acted as technical liaison between Medicaid health plan and state Medicaid agencies

Senior Manager, Process Improvement ***2008-2010***

- Analyzed business processes and identified opportunities to improve efficiency and effectiveness
- Facilitated cross-functional identification of opportunities to achieve cost reductions or improve processing accuracy and efficiency
- Collaborated with shared services partners to implement improvement opportunities
- Managed multiple process improvement projects that supported strategic initiatives and met ROI objectives
- Completed Black Belt training, exam, and project, which resulted in significant reduction in claims payment errors for DRG claims

Senior Risk Management Consultant, Service Operations ***2007-2008***

- Directed risk management and compliance activities for five operational departments in Shared Services
- Managed cross-functional initiatives to resolve compliance issues and improve performance
- Facilitated risk assessment sessions for management and oversaw implementation of enhanced monitoring and reporting controls
- Identified and oversaw resolution of control deficiencies in Claims, Provider Data Management, and Pricing and Benefits Configuration

Management Consultant, Corporate Risk Management ***2005-2007***

- Led implementation of Sarbanes Oxley (SOX) program for Medical Finance and Shared Services Operations
- Prepared risk assessments and process flows, and assisted business owners with development of test plans
- Managed annual SOX testing of Medical Finance and Operations SOX controls; prepared test plans and work papers
- Drove effort to implement enterprise governance, risk, and compliance tool

Education

University of Connecticut
MBA, Concentration in Finance, 1998

State University of New York, Oneonta
Bachelor of Arts, Economics, 1986

Professional Certifications

Juran Six Sigma Black Belt Training, 2010
Certified Health Care Compliance professional, 2016

Carrie Blankenship — Network Development Director

Qualifications

Experienced provider relations and network development professional with eight years of experience serving and supporting a diverse range of providers across the state of Virginia. Skilled in building and sustaining relationships and in making sure providers have the information and resources they need to be successful in caring for members.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2014-Present**
Sr. Network Education Representative

- Assists providers with inquiries and claims issues, providing information, problem resolution, and support to minimize their administrative burden and maximize satisfaction and ease of processes
- Works closely with the Operations team on a daily basis as part of developing and implementing training and education for network providers
- Assisted in a BH implementation, which involved creating the BH provider manual and deploying network development strategies to help build a comprehensive network from scratch

Molina Medicaid Solutions, Charleston, WV **2011-2014**
Provider Relations Representative

- Served as the primary contact for a number of specific provider groups, hospitals, and provider associations within West Virginia
- Spearheaded annual workshops throughout the state to inform and educate providers
- Investigated claims and eligibility issues for providers, and maintain responsibility for informing providers on the new provider enrollment criteria from BMS

Kimberly Rossi, MD, Charleston, WV **2001-2005**
Appalachian Pain Therapy, Charleston, WV **2003-2006**
Day Surgery Center, Charleston, WV **2001-2003**
Office Manager

- Manage the day-to-day operations of various provider offices, including a physician's practice, a pain therapy center, and a surgery center
- Maintained responsibility for billing and collecting, accounts receivable and accounts payable, credentialing for various insurance companies, and staffing the office

Education

Carver Career Center
Health Occupations Certificate, 1992

Terri Roush — Interim Provider Relations Director

Qualifications

Seasoned Director with a strong history managing and developing comprehensive provider networks, supporting and training a diverse range of provider types and specialties, and making sure processes are streamlined and easy for providers. Excellent communication and contract negotiation skills, capable of handling all types of inquiries and complaints from providers, and promptly finding resolutions. Holds bachelor's degree in health service administration from West Virginia University Institute of Technology.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company

Director, Provider Solutions ***2017-Present***

- Directs the activities related to the development and maintenance of the company's physician and provider delivery system
- Oversees and directs efforts across a shared services platform related to provider performance to achieve market goals related to provider delivery system
- Oversees and directs efforts to align contracting strategy with medical management strategy
- Hires, trains, coaches, counsels, and evaluates performance of direct reports
- Oversees and directs efforts to resolve operational issues related to specific areas of responsibility
- Synchronized communications between network and cross-functional accountable areas
- Responsible for budget accountability
- Oversees and directs efforts to develop, coordinate, and review provider communications
- Served as committee member in cross-functional shared partner teams
- Develops provider networks that provide a competitive advantage

Manager I, Network Relations ***2014-2017***

- Oversaw activities related to development and maintenance of company's physicians and provider delivery system
- Responsible for provider network recruitment and retention
- Seven direct reports and supported four additional associates
- Managed, coordinated, and resolved operational issues
- Served as contact person for internal departments
- Successfully completed network build for BH, ACA, and SSI expansion
- Developed, coordinated, and reviewed provider communications
- Synchronized communications between network and cross-functionally accountable areas
- Handled escalated provider grievances
- Managed and coordinated provider events, conferences and workshops
- Served as committee member in cross-functional partner teams

Senior Network Education Representative ***2004-2014***

- Liaison between contracted and non-contracted providers, facilities, associations, and government organizations
- Recruited and contracted providers to grow the existing provider network
- Proactively educated professional and institutional providers on health plan's guidelines, policies, processes, billing, and reimbursement methodologies
- Conducted face-to-face education sessions with professional and institutional providers on a regular basis

- Conducted educational webinars for professional and institutional providers
- Responsible for maintaining provider network satisfaction
- Identified, researched, and resolved provider concerns, claim, eligibility, authorization, provider database and benefit inquiries
- Assisted with credentialing of providers
- Developed West Virginia educational material for Customer Care Center
- Conducted training sessions for Customer Care Center and new employees
- Assisted multiple departments in additional education and troubleshooting techniques to resolve provider concerns
- Assisted with provider communications
- Participated in and prepared material for statewide provider workshops, association meetings, and conferences
- Built positive and collaborative relationships with providers

Moose Surgical & Hand Specialist, P.A **2000-2004**
Practice Manager

- Supervised multiple employees and coordinated the activities of all employees
- Assisted with the daily workflow of the practice
- Managed physicians' calendar
- Proactively analyzed and resolved inquiries related to patient accounts and office matters
- Performed accounting functions to include accounts payable, accounts receivable, financial report, monthly and annual budget
- Scheduled and obtained pre-certification for surgeries
- Organized, distributed, and initiated action on all incoming and outgoing correspondence
- Physician credentialing and re-credentialing
- Interviewed and hired staff
- Developed and implemented office policies and procedures
- Established a HIPAA workbook
- Conducted HIPAA, OSHA, and policy and procedure staff education
- Conducted annual personnel performance reviews and other related personnel functions
- Demonstrated ability to maintain composure and work efficiently, preserving patient confidentiality in this environment
- Resolved problems effectively dealing with complaints

Education

West Virginia University Institute of Technology
Bachelor of Science, Health Service Administration, 1998

Leslie Caluya — Interim Information Technology Director/HIPAA Compliance Officer

Qualifications

IT health care executive with more than 10 years of experience across information technology. Proven track record of leading information system teams, implementing technology programs and solutions that improve efficiency, and streamlining information flow through system maintenance and upgrades. Has built trusted relationships with executives, vendors, and technology staff to bring the most effective technology applications and systems to best serve West Virginia Medicaid members.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company

GBD Account Management, Account Management Sr. Advisor ***2014-Present***

- Functions as liaison between end users and information technology (IT) to deliver technical solutions for business needs including identifying, developing, evaluating, and coordinating implementations of IT solutions
- Develops and maintains primary relationship with state partners and represents Anthem at state led technical meetings
- Leads process improvement initiatives on behalf of the infrastructure organization, to improve efficiencies and add value to the business
- Initiates formal/informal communications and meetings with area lead contacts to gather needs and issues; reviews other needs statements and requirements
- Works with corporate support/enterprise teams to implement small system change requests and new state mandates. Identify business partners for requirement gathering
- Offers support to health plan leadership, direct reports, and business account manager as issues are identified. Proposes interim solutions or workarounds until long term fix can be implemented
- Works closely with technical teams when requirements are received from the business. Coordinates meetings between business and IT for requirement clarification. Represents business on IT calls to make sure requirements are clear and the intent of requirement is being met
- Provides visibility to health plan and IT leadership on open issues that require escalation. Engage necessary area leaders for action on escalated issues, follow through to resolution
- Single point of contact for business when technical questions/needs arise or when assistance is needed for determining IT contacts for system-related issues

Program Administration Support, Business Consultant ***2011-2014***

- Professional/Institutional Pricing Configuration Lead for multiple ASO, Blue, and UniCare Medicaid plans. Responsible for steady state maintenance, cost of care initiatives, and new requirement development as defined by the plans
- Reviewed current system configuration to ensure contractual compliance and update as necessary. Developed and built improved methodologies for pricing and claims processing to be consistent with State requirements
- Performed root cause analysis of pricing and claims system issues, provided resolution to issue, documented findings and communicated to management, Claims Operations, Field Staff and Legal Support as necessary

- Supported and implemented cost of care initiatives. Worked closely with Enterprise partners to develop requirements for implementing new fee schedules that will prove as a financial savings to Medicaid
- Led workgroup discussions and document decisions for developing New Code Rates for California Medicaid on newly implemented American Medical Association codes. Implemented New Code Rate policy for Medicaid
- Interpreted state documentation and translate into pricing configuration requirements to support state changes, new state implementations, and business initiatives. Successfully implemented Texas Blue Implementation for Pricing and Claims
- Worked closely with IT, contracting, network development, field staff, and provider relations partners to develop solutions for pricing and claims to ensure contractual obligations are fulfilled
- Interacted extensively with the business area subject matter experts to understand the Product and Business Processes thoroughly. Identified opportunities for business process improvement through meetings with business users and developers and initiated efforts to make improvements
- Provided support to leadership and various internal departments in regard to system capabilities, business processes, and requirement development

Center of Requirements Excellence, Business Analyst III ***2009-2011***

- Responsible for supporting Claim Operations in day-to-day functions dealing with system issues and claim questions that directly relate to system changes. Claims Business Lead for Veteran Affairs Special Separation Benefits (SSB) Amisys to World Gedetic System (WGS) System Migration
- Translated basic and complex business needs into system driven requirements that assisted the Operations team with higher adjudication rates and less manual claim intervention
- Provided support to Operations by analyzing and troubleshooting claim issues, reviewed errors and claims system issues. Created documentation on how to handle complex issues and disseminated to the Operations team
- Successfully implemented the CARS project for the migration of six states from Diamond 950 to WGS 2.0 platform and providing continued support post-warranty period to minimize abrasion to internal and external customers
- Worked closely with Claims IT and program developers in determining a solution for the business need. Provided various solutions based on knowledge of how Operations conducts their business
- SSB Business contact for the maintenance and configuration of the STOP tables. Configured STOP edits as a short-term solution to assist with the correct handling of claims until the long-term solution is identified. Worked with supporting functional areas to determine long term solution by way of SAP Software Change Registration (SSCR) or Lights-On Production Issue

Education

Ventura Community College

Associate of Arts, May 1999

Professional Certifications

SAFe 4 Certified Agilist, 2017

Sylvia Berger — Member Services Director

Qualifications

Customer service professional with two decades of experience that includes overseeing, training, and supporting staff to achieve the highest level of satisfaction for individuals served. Background also includes overseeing multi-site call centers, which will be an invaluable in making sure members have access to a comprehensive toll-free line staffed with appropriately trained and qualified employees.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company **2016-Present**
Project Leader

- Responsible for submitting Small System Change Requests (SSCRs) for the West Virginia health plan when there is a change needed in a system/application
- Develops Process Documents for the Operations department in West Virginia when a new process is developed or when an aged process needs to be improved or enhanced
- Assists Business Change Manager in identifying issues within the WGS system and developing solutions to concerns within the system that may require a Process Documentation and/or SSCR
- Leads workgroups to develop process flows, review system issues, implement WAVE initiatives, and additional items as needed
- Developed ad hoc training in conjunction with system releases to ensure that network team is able to navigate the new WGS system for Provider research
- Creates SharePoint sites/pages for IRU and the Network team to help locate information quickly
- Participates in monthly quality meetings and Network Touch point meetings to stay engaged in what the Network team is seeing out in the field
- Supports efforts to build a membership database and attends the monthly membership meetings
- Collaborates with the Cost of Care team and attends weekly calls to stay engaged in cost of care within UniCare

CASCI
Senior Trainer ***2013-2016***

- Led new hire trainings and established Customer Service Representatives, Managers, and Supervisors within the CareFirst organization
- Developed ad hoc training sessions when requested by management and/or operations to meet the ever-changing business need
- Analytical skills used to review current operational trends to determine the best suited training needs to improve customer satisfaction as well as associate satisfaction
- Assisted in project team for development and training of CareFirst 360 and NCompass
- Developed, created, and updated the service representative's knowledge management tool

Supervisor ***2007-2013***

- Responsible for leading and mentoring a team ranging from 10-15 associates
- Tracked daily inventory, attendance, production and quality goals, average speed of answer, and other operational goals
- Reviewed daily audit results and adjustments to ensure quality and accurate claims payment
- Provided recommendations on hiring decisions
- Completed performance appraisals

- Proficient with analytical and problem solving skills
- Responsible for monthly Incentive reporting for NASCO Member Services & Pay for Performance Incentive
- Responsible for performance guarantee management
- Responsible for the House Account migration to CASCI — development of workflows and Standard Operating Procedures
- Participant in the Community web based initiatives — development of initiative goals and quality work flows
- Leader among peers; always willing to help out with any questions or concerns they may have

Quality Assurance Analyst I ***2005-2007***

- Monitored calls and reviewed casework of customer service representatives to ensure quality performance
- Acted in a supervisory role in the absence of leadership
- Assisted in the training of new associates

Customer Service Representative ***2000-2005***

- Received and responded to incoming calls
- Departmental Adjuster
- Responsible for initial implementation of home adjustments in the Charleston office
- Responsible for training the Supervisors, Quality staff, and peers as well as implementation of SOPs and work flows

Education

West Virginia Junior College
Legal Secretary Certificate, 1992

Chris Kearney — Claims Payment Director

Qualifications

Senior director with 20 years of health care industry experience, plus expert knowledge to support all aspects of the claims process. Directly supports our West Virginia Medicaid claims operations and has a demonstrated history of planning, implementing, and leading claims initiatives that assure timely, accurate, and efficient processing and adjudication. Has also assisted in developing and executing strategies to streamline the claims process, build stronger relationships with the provider community, and increase both member and provider satisfaction.

Professional Experience

Anthem, Inc.

Director II, Claims Appeals and Adjustments ***2013-Present***

- Leads Medicaid claims operations across 20 markets, including front-end electronic data interchange, planning and governance, audits, new-day claims, adjustments, and Appeals
- Drives strategic direction and assures claims processing and operations meet performance goals, contract requirements, and state and federal regulations
- Serves as a key contact for the health plan, state, and regulatory departments
- Identifies reporting specifications and develops claims-related reports, conducts data reviews, and oversees submission of various state-mandated reports
- Plans, directs, and coordinates all inventory management activities
- Supports claims-related projects, initiatives, system migrations, and implementations

Director, Account Management ***2012-2013***

- Direct responsibilities include account management of the New York health plan; a health plan with membership in excess of 450,000
- Alignment of corporate and health plan departments to systematically implement strategic initiatives; coordination and facilitation of cross-functional issue resolution; analysis and root cause analysis to drive performance improvement initiatives; and ensuring compliance with state regulatory and contract requirements

The Kempsville Center **2009-2011**

Universal Health Services (UHS), Administrator

- Direct responsibilities include the operations management and business development of 83-bed facility, with budget of more than $18 million
- Developed new inpatient line of service; including operational development, physician recruitment, business development and marketing strategy, state and federal compliance, and Joint Commission accreditation; this service added $4 million in additional net revenue
- Led organization's Quality Assurance program, ensuring ongoing organizational and operational improvement and maximizing efficiency
- Ensured ongoing compliance with organization/corporate policy, federal and state regulations, and accrediting body statutes
- Recruited and managed campus physicians, including recruitment of two additional physicians

Acadia Abilene

Chief Executive Officer ***2007-2008***

Chief Operating Officer ***2001-2007***

- Conceived, built, and operated Abilene Psychiatric Center (Acadia Abilene) and Abilene Psychiatric Associates. This inpatient hospital and multi-physician specialty clinic produced annual revenues of $18 million and more than 125 employees. Daily management of

hospital and physician clinic operations including strategic planning and business development, quality and process improvement, Profit and Loss management, medical billing, technology, human resources management, health information management, and plant operations
- Led system's Quality and Process Improvement Program that monitored, analyzed, and implemented improvement initiatives for processes across organization
- Successfully recruited eight doctors to underserved area and managed their contracts, credentialing and re-credentialing, negotiations and maintenance of third party insurance contracts, outpatient and inpatient operations
- Cultivated external relationships to establish and grow clinic business, and developed collaborative associations with numerous community agencies

Red River Hospital **2000-2001**

Vice President of Strategic Planning & Marketing
- Responsible for all strategic planning, marketing, and sales efforts of 64-bed facility with revenues of $15 million
- Developed additional lines of key service offerings, including Medicare and Medicaid programs, increasing patient days by 50% and revenues by more than $5 million
- Strategically drove marketing efforts, resulting in an increase in admissions by 46%
- Increased net revenue through negotiation of insurance contracts. Increased contractual adjustments by average of 5%, adding $250,000 per annum directly to the bottom-line

Education

University of Kansas
Masters of Healthcare Administration, 1999

Loyola University of Chicago
Bachelor of Arts, Psychology, 1995

Professional Certifications/Memberships

ACHE, Member
Health Care Administrators of Tidewater, Member
Contributing Columnist "Mental Health Matters," Abilene Reporter News, 2004-2008
Member, Community Investment Panel, United Way of Abilene, 2005-2008
Chairman, Community Investment Committee Board, United Way of Abilene, 2006-2008
Member, Abilene Mental Health Taskforce, 2003-2008
Member, Abilene Jail Diversion Committee, 2004-2008

Natalie Robinson — Interim Community Engagement Director

Qualifications

Experienced manager with knowledge across customer service, outreach, community engagement, and marketing to managed care stakeholders. Exceptional skills nurturing community and client relationships, creating and executing unique events and initiatives, strategic planning, and collaborating with diverse teams to enrich existing programs and address complex issues, and often times find creative solutions. Leads a team focused on membership growth and retention through the execution of creative marketing events and initiatives, providing services and referrals to members, staying abreast of marketing trends and competitor intel, and fostering authentic relationships with community leaders and key stakeholders for partnership development and sustainability.

Professional Experience

UniCare Health Plan of West Virginia, Inc., an Anthem Company
Community Outreach Manager, Marketing ***2016-Present***

- Develops objectives, policies and programs for marketing activity related to membership growth, retention, acquisitions and business initiatives
- Establishes priority approaches and strategic planning to increase brand awareness and market share in targeted regions to improve on ROI for member acquisition and retention
- Ensures compliance with state and municipal laws, rules, and guidelines for marketing and outreach across the state. Initiate quality and compliance reviews on all marketing collateral, media, and marketing representative outreach
- Establishes and maintains high level partnerships with national organizations, local and statewide key stakeholders to address needs, report trends, uphold accountability, and maintain a robust, positive rapport with members, partners, and government relations
- Researches market trends, incorporates best practices, and embarks on new, innovative ways to enhance member experience in order to maintain plan of choice among our constituents. Analyzes feedback from current members and makes adjustments when needed
- Aligns marketing events and initiatives to not only grow membership, but to also improve upon the health and wellness of the communities we serve by providing tailored events and resources that address community-specific health and wellness issues and/or social determinants of health. Incorporates diversity and inclusive measures into marketing collaterals, sites, events, programing, and initiatives
- Supports business development initiatives to capture growth opportunities by providing research data and comprehensive marketing reports on partnerships, sponsorships, events and initiatives that positively impact wins on new business RFP and state rebids
- Instrumental in leading the marketing team to successfully drive membership growth. Increased marketing engagement by 20% in target markets resulting in successfully retaining and growing market share in 2018 despite an overall decline month over month in eligible populations
- Established and implemented new signature events in selected markets that created relationships within new industries. This provided an increase in brand awareness, membership growth, partnership recruitment, and integrated health promotion
- Created internal marketing SharePoint site to house important documents, post statewide events, collect internal feedback and improve processes for interdepartmental collaborative work
- Nominated and Awarded by Plan President for Values in Action Award in 2017

Senior Outreach Specialist, Marketing ***2012-2016***

- Responsible for carrying out health plan's marketing initiatives, event planning, community collaborations, and market research and analysis in the highest member, 10-county territory, led team in increased engagement rates and events, and new partnerships
- Provided direct support to the Marketing Director and maintained leadership role in training and mentoring all outreach staff on job responsibilities including presentations, scheduling, networking, and event planning and execution
- Created comprehensive monthly marketing team reports, meeting agendas, and market share analysis
- Conducted presentations on benefit and services to community members, stakeholders, and interdepartmental colleagues
- Served on various community boards, committees, and roundtables to provide advice and accountability to organizations as well as to stay abreast of community needs and to communicate changes within the company to community leaders and stakeholders
- Planned and executed annual Community Advisory Committee and the Member Advisory Committee to receive feedback on company initiatives and address partner and client needs. Responsible for relaying updates to leadership and internal Medical Advisory Committee

Ferguson Manning Associates, East Market, Charleston, WV **2014-2015**
Marketing & Communications (Contracted)

- Establishes and strengthens relationships with diverse suppliers who provide goods and services to West Virginia (and surrounding east market states) companies throughout the enterprise
- End-to-end logistic event planning and execution for supplier diversity marketing and engagement events for recruitment; provides marketing support and advice to existing clients when needed
- Drives company's marketing strategies to support diversity goals and objectives. Develops strategic plans and administrative budget
- Measure and track progress of all contracted marketing projects and provide timely follow-up with clients. Leads execution of variable projects within scope

Education

West Virginia University
Bachelor of Arts, Communications, General Studies, 2017

Cornell University
Diversity & Inclusion Certification, 2019

Diane Paletta, DDS — Dental Director

Qualifications

Compassionate and dedicated professional who has been a practicing dentist for more than two decades and a Dental Director serving Medicaid members for the last six years. As a Member of the Board of Dentistry, served as an examiner for the Commission on Dental Competency Assessments and Southern Regional Testing Agencies to administer dental licensing exams to graduating dental students. Highly skilled in conducting clinical reviews, utilization reviews, and quality of care audits for SKYGEN. Leads strategy and development of clinical integration to support children and adults in maximizing their health through comprehensive dental programs.

Professional Experience

SKYGEN USA, LLC (SKYGEN) (*Subcontractor for UniCare) **2013-Present**
Consultant, West Virginia Dental Director

- Formulates and implements strategy to meet key performance measures and expand dental programs to address member needs across the continuum of care
- Drives clinical innovations that integrate and connect health care data and deliver increases clinical quality
- Provides clinical expertise and business direction in support of dental programs through participation in clinical team activities
- Renders consistent opinions on emerging dental trends, utilization review, dental plan coverage, network management, claims policy and standards of care
- Develops, implements, and evaluates policies and procedures, which meet business needs. Uses data analysis to identify opportunities for quality improvement, cost containment, and to positively influence practice patterns or benefit plan designs and collaborate with partners

West Virginia Board of Dentistry **2007-2014**

- Served as an examiner to prepare and clear dental students to obtain their licensure; assessed students from West Virginia University School of Dentistry, New York University School of Dentistry (SoD), University of Pittsburgh SoD, Medical University of South Carolina SoD, the Ohio State University SoD, University of Detroit SoD, Columbia University, Howard and Howard University

West Virginia University Tech, Division of Dental Hygiene **2006-2007**
Professor of Pharmacology and Periodontology
Clinical Advisor
Private Practice of Dentistry ***1983-2005***

- Diagnosed and treated problems with patients' teeth, gums, and related parts of the mouth
- Provided advice and instruction on taking care of the teeth and gums and on diet choices that affect oral health
- Met with patients, assessed their dental health, performed scheduled cleanings, handled complex procedures, such as root canals, extractions, and oral surgery, and worked with other staff members, such as dental hygienists and assistants, to provide clients with quality dental services

Education

West Virginia University
Bachelor of Science, Dental Hygiene, Magna Cum Laude, 1978
Doctor of Dental Surgery, 24111983

Sabrina Payne — Medicaid Member Advocate

Qualifications

Dedicated professional with skills and experience in case management, outreach, care coordination, and health coaching. Adept communicator who is accustomed to building rapport with members and working with those who have BH conditions. Bachelor's in Social Work and strong clinical acumen that includes collaborating with the multidisciplinary team, conducting assessments, and connecting members to the most appropriate services and supports to address their needs.

Professional Experience

Anthem, Inc.

Health Coach ***2016-Present***

- Works with members who have chronic mental illness and substance use disorder issues
- Conducts brief interviews/assessments of members to identify specific health care needs and barriers (socioeconomic, cultural) that may prevent them receiving treatments
- Coordinates and collaborates with a multifaceted team to determine how to best meet the needs of members
- Maintains detailed reports regarding the progress of members who have recently been inpatient for psychiatric and BH needs
- Encourages members to change their behavior and present alternatives and additional supports

Outreach Care Specialist ***2015-2016***

- Identified members who were inpatient and in need of case management services
- Reviewed and created reports to also identify these members
- Established relationships with agencies and various doctors' offices pertaining to the treatment of our members

Prestera Center **2007-2015**

Assertive Community Treatment (ACT) Case Manager

- Responsible for a case load of 10 intensive consumers with severe and persistent mental illness, substance use disorder, and dual diagnosis
- Coordinated all medical and psychiatric appointments, assisted in managing medications, provided or coordinated transportation, assisted with Activities of Daily Living and teaching
- Completed treatment plans for 80 consumers on the ACT team
- Evaluated the mental stability and, when appropriate, filed mental hygiene warrants, involving law enforcement and the court system

Education

Marshall University
Social Work, Bachelor's Degree, 2007

ATTACHMENT D: MANDATORY REQUIREMENTS

NARRATIVE RESPONSES

MANDATORY REQUIREMENTS	
MR001	The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.
MR002	The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.
MR003	The Vendor must have all requirements operational as agreed upon with the Department, by January 1, 2020.
MR004	The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located.
MR005	The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate.
MR006	The Vendor must comply with requirements for qualified residential treatment program (QRTP) placements as described in the Service Provider Agreement (SPA).
MR007	The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.
MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).
MR009	The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described In Appendix 5: List of Requested Documents.
MR010	The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the Department's fee-for-service (FSS) Medicaid program.
MR011	The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department.
MR012	The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements for all applicable members, as outlined in the Service Provider Agreement (SPA).
MR013	The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.

MR014	The Vendor must provide 24-hour access to a provider or service in emergency situations.
MR015	The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs.
MR016	The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis.
MR017	The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations.
MR018	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting Instructions in the Service Provider Agreement (SPA).
MR019	The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.
MR020	The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.
MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.
MR022	The Vendor must participate in public meetings and other events at the request of the Department.
MR023	The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department.
MR024	The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department.
MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.
MR026	The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.

MR027	The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation.
MR028	The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following link:http://www.wvdhhr.org/mis/pollcies.asphttps://technology. wv.gov/security /Pages/policies-issued-by-the-cto.aspx.
MR029	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.
MR030	The Vendor must provide a plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.
MR031	The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply.
MR032	The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new Requirements reporting requirements.
MR033	The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing.
MR034	The Vendor must ensure that all applications inclusive of internet, Intranet, and extranet applications associated with this contract are compliant with Section 508 Requirements of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.
MR035	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements.
MR036	The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.
MR037	The Vendor must employ Key Staff assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within 30 calendar days of the contract award.
MR038	The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.

MR039	The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department.
MR040	The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above.
MR041	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with Vendor on the project.
MR042	The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information).
MR043	The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.
MR043	The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.
MR044	The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.
MR045	The Vendor must provide a drug-free workplace for employees and all applicable agents, including, but not limited to, subcontractors. All agents of the Vendor Requirements must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.
MR046	The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer.
MR047	The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance.In this context, ""data"" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.
MR048	The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, Access to State hardware, software, network infrastructure, and any licensing costs.

MR049	The Vendor must make available to the Department the results of any third-party audit conducted, including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.
MR050	The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.

MR001	The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.

UniCare will comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, State, or federal laws and regulations, waiver amendments, or State Plan amendments, as well as continue to comply with all applicable requirements of our current West Virginia Medicaid SPA. We have carefully reviewed and will comply with relevant sections of the SPA, including Section 9.1.3, Internal Compliance Plan.

We are committed to maintaining high performance and compliance with the State's expectations and requirements, both under the West Virginia Foster Care Specialized Managed Care for Children and Youth Program (the Program) and our current West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) SFY 2020 contract.

Our local leadership and our national Implementation Management Office (IMO), a national project management team dedicated to implementing new contracts, significant contract amendments, and regulatory mandates, closely monitors compliance during contract implementation. When we receive a new contract, UniCare's leadership works closely with the dedicated, cross-functional team of IMO project managers to create a scope document with all changes to implement, develop a project plan, and track all required compliance activities through completion. The IMO also supports UniCare with implementing amendments or when incorporating new populations or services.

Compliance 360 and Project Management Support Compliance

UniCare maintains high performance standards in order to meet the West Virginia Department of Health and Human Resources' (DHHR's) expectations and requirements under our current contracts. To augment our compliance program and activities, we maintain a systematic approach to assessing, tracking, and reporting adherence to our contractual obligations, assisted by our Compliance 360 tool.

We use the Compliance 360 application to promote and verify compliance with contractual requirements within the SPA and its modifications, state or federal laws or regulations, waiver amendments, and State Plan amendments. Whenever there is a new or revised requirement, such as a contract amendment, policy update, or fee schedule change, our Compliance Manager creates an alert and disseminates it to a wide range of employees and stakeholders. Leads from each functional area, designated as Assessors, evaluate alerts to determine whether the regulatory content affects their units. If it does, Assessors must list planned tasks to meet Contract requirements and document their completion. Our Compliance Officer monitors timely assessments and task completion. In 2018, UniCare issued 117 alerts, and in 2019, through July, has issued 48 alerts.

For example, when DHHR sends a notification of a rate or fee schedule change, the Compliance Manager distributes through Compliance 360 to a set distribution list of Assessors and Reviewers from Operations, Encounters, Program Integrity, and Finance. Most often, the West Virginia Operations team then records a task to submit a request for the Pricing Team to update the rates or fee schedule, as well as a task to reprocess claims impacted by the changes once the system update is live. The Task Owner is responsible for updating the tasks in Compliance 360 through completion and uses the tool to ensure compliance with the Contract requirements to implement rate changes within 30 days and to adjust impacted paid claims.

MR002	The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.

UniCare will accept the per member per month rate established by DHHR for managed care physical health and behavioral health services.

MR003	The Vendor must have all requirements operational as agreed upon with the Department, by January 1, 2020.

UniCare will have all requirements operational by January 1, 2020, as agreed upon with the DHHR. As an incumbent West Virginia Medicaid managed care organization (MCO), serving West Virginia since 2003, ***we have the benefit of having nearly all the required functionality and implementation for this Contract already in place*** and the ability to successfully scale new requirements. Throughout our 16-year incumbency serving Medicaid members in West Virginia, we have implemented numerous service requirements and are well prepared to meet all readiness review and implementation requirements. We will adhere to DHHR's expectations and requirements as described throughout this RFP.

As proud West Virginians, our local knowledge, expertise, network, and community relationships provide a solid foundation for implementing Fostering Healthy Lives offering for the Program. Fostering Healthy Lives is our care coordination model developed specifically to support safety, permanency, and well-being through a comprehensive and integrated care coordination approach for children and youth in the child welfare system. Our West Virginia leadership team will direct and oversee the implementation process while strategically drawing on support resources from our national IMO as further described in MR001.

Including our current West Virginia Medicaid contract, our national IMO team has ***successfully executed more than 250 projects on time, including 14 Medicaid contracts covering child welfare populations.*** We have successfully implemented contracts covering child welfare system populations, Expansion/ACA populations, behavioral health (BH) benefits, pharmacy benefits, Supplemental Security Income/Aged, Blind, or Disabled populations, delivered publicly funded health care programs, service area expansions, and program enhancements, including those that support populations with significant health care and support needs. During the implementation process, our local, accessible, and responsive leadership team will meet in-person with DHHR to identify and address issues to minimize stakeholder abrasion and complaints and promote a seamless implementation and readiness review. Along with our affiliates, ***we have passed all readiness reviews, and have always met operational start dates to begin successfully serving members.***

Dedicated Implementation Resources

We have already begun thoroughly analyzing Contract requirements to create a Program Implementation Plan that supports the requisite milestones and timelines to demonstrate our readiness to serve West Virginia's youth.

Our award-winning IMO will establish a dedicated and comprehensive project team of functional subject matter experts (SMEs) to oversee each deliverable of the West Virginia Foster Care Specialized Managed Care for Children and Youth program implementation.

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Our Infrastructure Supports Readiness

As an experienced and trusted partner in West Virginia's Medicaid landscape, UniCare has established flexible infrastructure that will quickly respond to the requirements of this Contract and the needs of children and youth, including:

- Dedicated, local, experienced staff, including key personnel positions and Executive leadership, clinical, and care coordination staffing that meets or exceeds required ratios, member and provider support, and administrative and operational support
- Statewide provider network, including primary care providers (PCPs), specialists, BH providers, and other non-traditional providers
- Established relationships and partnerships with DHHR and other agencies
- Established partnerships and collaboration with a statewide network of community-based organizations and stakeholders
- Fully functional Management Information System (MIS), including sophisticated technologies to support data and information transfers, claims management, care coordination, regulatory compliance, and reporting
- Rigorous regulatory compliance program, including fraud, waste, and abuse (FWA) processes
- Comprehensive policies and procedures that define operational and functional requirements, care coordination processes, and quality management

We provide an overview of our existing infrastructure throughout this proposal and note initiatives that are underway or planned for future implementation.

MR004	The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located.

UniCare will comply with W.Va. Code §9-5-27 requirements, including, but not limited to: reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located. We will fully support our members and their families or caregivers.

We share the State's goal of implementing a transition from fee-for-service (FFS) to managed care with minimal disruption for the children and youth involved in the child welfare system, and we support the State's intent in establishing these statutory requirements. Our Georgia affiliate's experience operating a local foster care model gives us insight into how to connect with our West Virginia members' families, caregivers, and community stakeholders.

We currently submit reports to DHHR under our West Virginia Medicaid SFY 2020 contract. We will use the same processes to continue to report to DHHR according to the established schedule, including quality reports, claims, appeals, advisory group reports, and ad hoc reports as requested for this Contract.

Engaging the child's support system to achieve improved health and social outcomes is of utmost importance. Families — foster parents, adoptive parents, natural parents, and kinship caregivers — are among a child's most important supports. UniCare has the framework of a voluntary advisory group of this support system already in place. ***Our already-established community advisory group includes foster parents, adoptive parents, natural parents, and kinship caregivers.*** In June 2019, we held a community advisory group meeting with stakeholder attendees including foster care parents; West Virginia Foster, Adoptive & Kinship Parents Network; representatives from socially necessary services (SNS) providers; placing agencies; and group homes. The advisory group's work alerted us to possible issues and recommended solutions to help us continuously improve, and we used what we learned to inform our Fostering Healthy Lives care coordination model.

Our West Virginia Presence

UniCare is proud of our strong presence in West Virginia. West Virginia is our community, and our local staff understands West Virginia's unique foster care and health care systems. Consequently, we know how to navigate these systems to promote the best possible outcomes for the youth we serve. We are already meeting the Contract requirement with more than 80% of all our current full-time equivalent (FTE) positions located in state and will continue to meet this requirement as we hire additional staff.

MR005	The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate.

UniCare will adhere to the case management decisions we receive from the Department caseworker, multidisciplinary treatment team (MDT), or court, and will authorize services for the scope and duration of the request. We will incorporate these decisions into the child's Fostering Healthy Lives Care Plan (Care Plan), developed through our child and family-centered Fostering Healthy Lives interdisciplinary care team (ICT) and Intensive Care Management (ICM) team process described in detail in CM030 of the proposal. We will authorize services within specified timeframes through our collaborative utilization management (UM) and care coordination process, promoting timely access to these services for Program members.

The ICT/ICM team, led by the child's Care Coordinator, will engage internal and relevant external parties to address the child and caregiver's needs. The Care Coordinator will have access to internal subject matter experts, such as our pharmacist, UM clinicians, Social Services Director, SNS Liaison, Medical Directors, and BH staff, to support development and deployment of the most effective Care Plan and treatment and linkage to community resources. They will work closely with providers, the member's Department caseworker, and others as determined necessary.

The Care Coordinator, supported by the ICT/ICM team, will make recommendations supporting the member's goals in the individualized service plan (ISP), family service plan (FSP), case plan developed by the Department caseworker, and other applicable care or treatment plans and identify complementary services, Value-Added Services (VAS), and community resources that support the established goals. The Care Coordinator will also identify services that may be potentially duplicative of services already authorized for the member and work with the Department caseworker, MDT, and others as needed to assure non-duplication.

We will document and provide our recommendations for case management and services that support the child's placement stability, caregiver's needs, and improved child and youth outcomes to DHHR, the Bureau for Children and Families (BCF), and the judiciary, as

appropriate in the child's Care Plan. In all cases, the Department caseworker decision will prevail, however, if our recommendations differ from those received from the Department caseworker and MDT, or ordered by the court, we will be available to discuss them with the Department.

MR006	The Vendor must comply with requirements for qualified residential treatment program (QRTP) placements as described in the Service Provider Agreement (SPA).

UniCare understands the State is currently reviewing qualified residential treatment program (QRTP) applications and using this process to determine which residential treatment facilities and/or emergency shelters meet the requirements as a QRTP, based upon alignment with the Family First Prevention Services Act (FFPSA) for members ages 12 to 21 years. We also understand the State has recently approved its first QRTP providers and are ready to contract with these providers upon Contract award. We will comply with the requirements for QRTP placements as described in the SPA Section 13.2.

We will collaborate with DHHR and QRTPs to assure completion of the required QRTP placement assessment by a qualified individual of the youth within 30 days of their placement as defined in the SPA, Section 13.2.1. We will incorporate requirements unique to QRTP placements into our discharge planning and transition of care process, working with DHHR and QRTP providers, and as applicable other stakeholders, to support medically necessary stays and timely discharge to lower levels of care. We will also work with the court system as needed to support the QRTP court review and participate, as invited, in any treatment meetings or status review and permanency hearings.

MR007	The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.

Already available to Program members is UniCare's already well-established, comprehensive Medicaid network ***of more than 14,000 unique Medicaid-enrolled physical and BH providers and facilities*** serving all 55 West Virginia counties. Our network, which contains providers currently providing services to members in child welfare, includes:

- 500 pediatricians
- More than 2,200 PCPs
- More than 680 BH providers
- All three in-state West Virginia psychiatric residential treatment facility (PRTF) providers
- All 75 West Virginia Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- 12 of 13 West Virginia comprehensive BH centers
- All West Virginia acute care and tertiary hospitals, including children's hospitals

Our network provides access to the full range of specialty and facility service providers for members in applicable populations with complex needs.

UniCare brings a strong record of developing and maintaining a provider network that meets and often exceeds adequacy standards. We currently comply with access standards established for the West Virginia Medicaid programs (with the exception a limited number of deficiencies where there are no or limited providers available for contracting as noted in our response to ND007).

Maintaining a robust provider network assures members have timely access to quality care from qualified providers. For the Program, our network will include not only the right number, but also

the right mix, of providers to meet the needs of children, youth, and young adults in child welfare. For example, as described throughout our response, our network for the Program includes BH providers with experience in recognizing and treating Adverse Childhood Experiences (ACEs), as well as providers trained in Parent-child interaction therapy (PCIT) and Trauma-focused Cognitive Behavioral Therapy (TF-CBT) services.

To meet the needs of the population, we will look to identify and contract with additional residential services providers who currently provide services for children and youth in child welfare.

While our network currently serves all 55 West Virginia counties, we recognize access in rural areas with limited providers can be challenging for our members. Strategies we will deploy to assure member access, especially in rural areas, include:

- Educating and incentivizing providers to expand capacity through the use of physician extenders such as nurse practitioners and physicians assistants
- A comprehensive and multi-faceted telemedicine approach focusing on expanding access in rural and underserved geographic areas
- Facilitating member transportation to available providers and educating providers about non-emergency medical transportation
- Using financial and non-financial incentives to expand capacity and access

Please see our response to Attachment E, Section 5, Establishing a Statewide Network (ND001, ND002, ND003, ND004, ND005, and ND006), and Provider Recruitment Strategies (ND010, ND016, ND018, ND019, ND020, ND021, ND022, ND023, ND024, ND025, ND026, ND027, ND028, ND029, ND030, and ND031) for additional information on our provider network and network development strategies.

MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).

UniCare proudly holds NCQA accreditation. ***Since 2006, our more than 12-year span of continuous NCQA accreditation demonstrates our ability to comply with the most comprehensive evaluation in the industry, assessing our results on clinical performance and consumer experience.*** UniCare has never experienced a suspension, denial, or revocation of an NCQA accreditation, nor has our ultimate parent company, Anthem, Inc. (Anthem), its subsidiaries, nor our affiliates.

Award-winning NCQA Accreditation

UniCare was most recently re-accredited by NCQA in 2018 and this certification is valid until September 2021. We diligently work to sustain our NCQA accreditation as part of our commitment to adhering to industry best practices. UniCare will ensure that DHHR is routinely updated regarding sustained accreditation status by the beginning of each Contract year and upon completion of each survey conducted. Our organization-wide adoption of best practices and adherence to NCQA standards is evident in our affiliates' widespread accreditations, with Medicaid affiliates in 19 states currently accredited by NCQA.

UniCare is proud of achieving a 66% gain in the HEDIS component of our NCQA accreditation score between 2016 and 2018, reflecting improved clinical quality outcomes for our members.

WV_FC2019_E.7_GainHEDIS_56_COB_01

UniCare is the only Medicaid MCO in West Virginia to obtain Multicultural Health Care Distinction.
WV_FC2019_E7_MCHDistinction_56_COB_01

In 2017, ***UniCare received NCQA's Multicultural Health Care Distinction,*** which is awarded to organizations engaged in efforts to improve quality by adhering to a collection standard for race/ethnicity and language data, facilitating language assistance, cultural responsiveness, quality improvement of culturally and linguistically appropriate services, and reducing health care disparities. Each year, we analyze HEDIS® measures to detect racial and ethnic disparities in key indicators and determine if our strategies to achieve health equity are successful. UniCare is pleased to note ***no statistically significant disparities are currently present in our Medicaid membership in West Virginia***.

We have the organizational support of Anthem's BH program, which is accredited nationally as a Managed Behavioral Healthcare Organization (MBHO) by NCQA, demonstrating a commitment to following evidence-based practices for providing high-quality care, access, and member protections for BH. ***Anthem's MBHO scored 100% on the associated five standards*** used to demonstrate proficiency: Quality Management and Improvement, Care Coordination, UM, Credentialing, and Members' Rights and Responsibilities.

UniCare shared the top ranking in West Virginia in the NCQA Medicaid Health Insurance Plan Ratings for the past two years.
WV_FC2019_E7_TopRanking_56_COB_01

UniCare will continue to maintain NCQA accreditation and receive support from a seasoned team that includes multiple senior staff who each have more than a decade of NCQA experience. We use a standard approach to prepare for each NCQA survey and continually evaluate compliance with current and new requirements. We document our approach in an Accreditation Playbook for easy reference by our staff. Our internal experts educate staff on best practices through ongoing educational summits, quarterly meetings, and multi-level review of UniCare's applicable documentation. This support has demonstrated the following successes:

- **Core Standards Approved for Medicaid.** NCQA reviewed and approved corporate-wide Medicaid policies, procedures, reports, and materials, which expedite UniCare's reaccreditation process on 30% of NCQA's core standards.
- **Disease Management Accreditation.** Since 2006, UniCare has deployed NCQA accredited disease management programs for the following conditions: chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, depression, diabetes, asthma, HIV/AIDS, and schizophrenia. In 2018, we were accredited in the management of child/adolescent depression. These programs help our members self-manage their chronic conditions and complex needs.
- **Nurse Advice Line.** Our 24/7 nurse advice line is certified by NCQA as a Health Information Product.

Where State and federal regulations or accreditation standards are not consistent, we adopt the most rigorous requirements to ensure the best possible outcomes for our members.

MR009	The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described In Appendix 5: List of Requested Documents.

UniCare will provide all requested supporting documentation upon notification of award or at a later date according to the requirements described in Appendix 4: List of Requested Documents. We have an outstanding record of providing the types of documentation listed in Appendix 4 as well as an excellent record of successful contract implementations.

We will continue to deliver accurate, timely, and complete documentation — contracts, procedures, reports, member ID cards, trainings, member material project plans, and any other

requested documentation — to DHHR. Our reporting resources, processes, and systems are already in place, and we will continue to provide scheduled and ad hoc reports to DHHR at the frequency, format, and level of detail required.

MR010	The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the Department's fee-for-service (FSS) Medicaid program.

In accordance with DHHR's response to Bidder's Question Q017 per Addendum 6 of the RFP, UniCare will provide DHHR with evidence of efforts to contract with all Medicaid-enrolled providers as a future action upon request. ***Our current West Virginia provider network includes more than 14,000 Medicaid-enrolled providers.*** UniCare maintains an open network policy regarding provider participation in our network. As long as a provider is West Virginia Medicaid-enrolled and in good standing, we will offer contracts to them for participation in our network, subject to meeting UniCare's participation and credentialing requirements.

UniCare continually reviews the State Medicaid provider website to look for any new and recently enrolled West Virginia Medicaid providers. This allows us to target newly Medicaid-enrolled providers for contracting. We compare the file to our network to identify potential new providers and initiate recruitment activities.

As we become aware through provider and community outreach of new providers entering the market, we will outreach to them to engage in contracting discussions. If a potential new network provider is not currently West Virginia Medicaid-enrolled, we will educate and assist them in becoming Medicaid-enrolled to allow them to meet DHHR and UniCare requirements for participation in our network. We maintain a database to track our provider recruitment and communications and document our contracting efforts with specific providers.

MR011	The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department.

Provider credentialing and re-credentialing is a critical component of our Quality Management (QM) program. UniCare will continue to credential and re-credential all new and existing physical health and BH network providers in accordance with federal and State requirements.

Consistent with our Provider Pledge, as further described in our response to Attachment E.6 Provider Services, we encourage a capacity for efficient care by contracting with an appropriate mix of providers and resources capable of delivering a culturally sensitive, effective model of care. Our provider credentialing and re-credentialing processes help ensure our members have a selection of physicians and other health care professionals who have demonstrated backgrounds consistent with the delivery of high-quality, cost-effective health care.

Credentialing Process

UniCare maintains credentialing policies and procedures for selection and retention of physical and BH practitioners, facilities, agencies, and health delivery organizations (HDOs) consistent with recognized managed care industry standards, and comply with NCQA and relevant State and federal regulations. Our credentialing process involves verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims through the appropriate state licensing boards.

Each practitioner and/or HDO must complete a standard, UniCare-approved application form. UniCare verifies those elements related to an applicants' legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the

credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the Credentialing Committee making its credentialing recommendation or as otherwise required by applicable accreditation standards.

We meet or exceed all credentialing standards and protocols, including NCQA standards. Our current provider site visit process also meets NCQA and West Virginia standards. To become a participating provider, providers must meet all requirements, including eligibility, safety, medical record documentation, liability insurance, and all other standards, including handicap accessibility in accordance with the Americans with Disabilities Act (ADA).

Re-credentialing Process

We re-credential all contracted practitioners and facilities within three years of the previous credentialing decision. Our re-credentialing requirements include those used for initial credentialing: identifies changes in providers' licensure, sanctions, board certification, clinical privileges, competence, or health status that may affect their ability to serve members. Re-credentialing also considers performance indicators such as those collected through the Quality Assurance and Performance Improvement (QAPI) program, the UM system, the grievance system, member satisfaction surveys, member complaints, and other data UniCare tracks.

Please see our response to ND010 and ND044 respectively for additional information on our credentialing and re-credentialing processes.

MR012	The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements for all applicable members, as outlined in the Service Provider Agreement (SPA).

UniCare successfully coordinates EPSDT services in West Virginia, known as HealthCheck, under the Medicaid program, and has done so for the past 16 years. UniCare will comply with access to and coordination of EPSDT services in accordance with applicable federal and State requirements, as defined by DHHR. We will cover EPSDT services for Medicaid eligible child and adolescent members in the amount, duration, and scope necessary to comply with the requirements of 42 CFR 441.56 and SPA, Article III, Sections 2.2.1 and 2.2.2.

Our approach to EPSDT supports the state's goals for enhancing coordination of care and access to services. See the detailed description of our approach to EPSDT in response to BA009, BA010, BA011, BA012, BA013, and BA014.

Our EPSDT outreach and coordination strategy for members in foster care under age 21 years old is designed to promote easy, timely access to: newborn physical exams; well-child visits; dental exams; immunizations; treatments that result from EPSDT screens and other EPSDT services; and to services not covered by UniCare that arise from an EPSDT screening. New members, their caregivers, and new providers receive information about the EPSDT benefit upon joining UniCare and throughout the year. We determine with DHHR the most effective modes of communication to engage with members, families, and caregivers about EPSDT services to maintain their understanding of, and assure active participation in, the EPSDT program. All member materials and outreach by our staff consider West Virginia's cultural diversity, languages spoken at home, health literacy, and educational level. We understand the challenges associated with obtaining accurate contact information for these members so will develop new processes to send EPSDT-related communications to the right address.

Our Fostering Healthy Lives Concierge Line is a dedicated call line for youth members, their families, and their providers. The Concierge team will initiate outreach by phone to every new member within five business days, with the goal of contacting members within two business days, of enrollment to welcome them to UniCare, conduct a Fostering Healthy Lives Health Risk

Screener (HRS) to identify any unmet EPSDT service needs, and inform them about the need to have an initial EPSDT visit within 30 days of enrollment. Each member will be assigned to a Fostering Healthy Lives Care Coordinator (Care Coordinator) under our high contact model. The Care Coordinator will also reach out to conduct the HRS if the Concierge team was unable to reach the member. The Care Coordinator uses HRS information to coordinate referrals, assist members with timely access to providers, and conduct a comprehensive health risk assessment (HRA) with members who have been stratified into the complex level of care coordination. Care Coordinators proactively educate members and caregivers about EPSDT services, timetables, the importance of making appointments to receive timely EPSDT services, and how to navigate barriers to staying up-to-date on age-appropriate services. Our Care Coordinators partner with the state's HealthCheck Liaison, Department caseworker, the member's PCP, and family to help schedule and complete EPSDT assessments, immunizations, examinations, and follow-up appointments. To encourage EPSDT adherence we educate members about our Healthy Rewards Program, offered as a VAS, which rewards them for completing preventive screenings and other EPSDT-related examinations and align our alternative payment model provider programs with annual HEDIS goals for well-child visits.

Our Provider Relations team conducts initial orientations with new providers with information about EPSDT requirements; our QM Practice Consultants conduct targeted EPSDT education with high-volume PCPs using many resources, including our EPSDT Toolkit.

We regularly analyze data, develop EPSDT compliance targets, and take steps to address any gaps in care for members with missed EPSDT appointments. We also use gaps in care information to initiate provider interventions and our Care Coordinators remind members in child welfare and their caregivers of upcoming preventive health visits. We will continue to submit EPSDT reports as required by DHHR and in accordance with state and federal monitoring requirements.

We invest resources to minimize barriers to care. We review PCPs' proximity to a member's current residence, provider appointment availability, transportation needs, and other root causes of barriers to care. Our efforts to address barriers to EPSDT services are possible through the coordinated efforts of our Care Coordinator, coordination with the state's HealthCheck Liaisons, providers, and partnerships with transportation and dental vendors, Department caseworker, and school-based health clinics.

MR013	The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.

UniCare will comply with post-stabilization care in accordance with applicable federal and State requirements, as defined by DHHR. We cover and reimburse post-stabilization care, including care from an out-of-network (OON) provider, in the amount, duration, and scope necessary to comply with the requirements of 42 CFR 438.114 and 42 CFR 422.113(c). We understand the critical importance to the member and caregiver of connecting the child to, and reimbursing, post-stabilization care to support placement stability following an emergency room (ER) or crisis stabilization unit visit. The ER provider, child's PCP, and Care Coordinator each play an important role in making sure each child is connected to appropriate post-stabilization services and follow-up treatment and care coordination needs are met.

To support coordinated care, we require the ER physician to contact the PCP noted on the member's ID card for authorization of post-stabilization care once the member is stabilized. We also require the ER to send the PCP a copy of the member's ER record within 24 hours of the visit. If the ER cannot reach the child's PCP or the PCP does not respond within one hour of the outreach, including after-hours and during holidays, we consider the post-stabilization services

authorized. We also require the PCP to contact the child and caregiver to schedule a follow-up office visit or make a specialist referral, if appropriate.

We will alert the Care Coordinator to the ER visit through our daily census report and via automated alerts from the hospitals in West Virginia that are implementing PreManage. The Care Coordinator will contact the member and caregiver within two business days of notification to assess the reason for ER use, help resolve any avoidable issues that led to ER use, identify any change in the child's needs, and make adjustments to the Care Plan as needed.

Care Coordinators will also make sure information from the ER visit, the child's post-stabilization care, and any additional follow-up care is available through the Youth Records Access Portal (YouthRAP) that will provide role-based access to the child's health care information, including service use. YouthRAP is described more fully in MS047, MS048, MS049, MS050, and MS051 of our response.

MR014	The Vendor must provide 24-hour access to a provider or service in emergency situations.

UniCare provides 24-hour access to a provider or service in emergency situations. All UniCare-participating PCPs are required to be accessible 24/7, either personally or through covered arrangements with designated network PCPs. We make providers aware of this through our policies and procedures, provider agreement, and provider manual. We monitor PCP compliance with after-hours access standards on a regular basis. We instruct PCPs to advise their answering services to participate in after-hours monitoring as well.

While children and youth in child welfare may experience physical health emergencies, we know that the majority of emergencies that occur with these children are related to BH. ***Our 24/7 nurse advice line and our BH hotline*** are available to assist members around the clock to respond to urgent or emergent needs for assessment of physical symptoms, education, and referrals or to a BH-related crisis situation. Our 24/7 nurse advice line and BH hotline are described in MS024, provide members and their caregivers with evidence-based service recommendations that may prevent an unnecessary ER visit. Through the 24/7 nurse advice line, nurses can assess physical symptoms and severity and address many non-emergent conditions and their treatment with sophisticated decision tree software to support their clinical judgement. Nurses also assess each caller's needs, suggest self-care for non-emergent conditions, recommend next steps for treatment of common ailments, such as upper respiratory infections and urinary tract infections, and direct the member to the most appropriate point of care. On the BH hotline, BH clinicians can engage with members to address emergent issues, suggest referrals for treatment, provide education on BH services, direct the member to emergent care, and coordinate with local crisis response resources.

Upon notification or identification of a member experiencing a potentially life-threatening event, our 24/7 nurse advice line or BH hotline staff will collect information by telephone to assess the status of the crisis and the services required. Depending on the member's acuity, our response will include contacting emergency services. Our BH hotline staff will also contact the member's assigned Care Coordinator for involvement and follow-up with the member, caregiver, medical consenter, providers, and other involved parties.

Please see our response to ND017 and MS024 for additional information on UniCare's crisis response protocols and Emergency Hotline service.

MR015	The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs.

As described in our MR007 response, UniCare already has a well-established, comprehensive Medicaid network serving all 55 West Virginia counties. We currently comply with access standards established for the West Virginia Medicaid programs (with the exception a limited number of situations in which there are no or limited providers available for contracting as noted in our response to ND007).

We offer a mix of specialists and facilities that includes ***more than 3,200 specialty care providers, with more than 180 pediatric/child/adolescent specialists and all West Virginia acute care and tertiary hospitals, including children's hospitals***. Our provider network allows access to the full range of specialty and facility service providers for members in applicable populations with complex needs so members' needs can be substantially met within our network of providers.

Our network provides access to certified pediatric or family nurse practitioners and certified nurse midwives, even if such providers are not designated as PCPs. We will add additional provider types such as residential providers, to our network to meet the needs of the Program. We will continue to develop innovative programs that expand access for conditions prevalent in this member population, such as expansion of training in evidence-based practices including PCIT, trauma-focused cognitive behavioral therapy (TF-CBT), as well as telehealth and telemedicine.

Please see our response to MR007, ND007, and ND016 for additional information on specialty service providers and facilities.

MR016	The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis.

UniCare will allow a specialist or BH provider to serve as a member's PCP in circumstances in which the member has underlying health conditions best managed by a specialist. This would be applicable for members with a chronic or life-threatening behavioral health condition or illness that requires multiple hospitalizations, or in instances where the specialist renders the majority of the member's care.

All members will be assigned to a Care Coordinator who has responsibility for assuring the member's primary care needs are met. To accomplish this, and as part of ongoing care coordination, the Care Coordinator will review utilization records, claims data, EPSDT periodicity schedules, and gaps in care reports to make sure primary care services are being provided by the specialist on an ongoing basis. The Care Coordinator will also outreach to the caregiver/member to obtain information about specific services the member is receiving, and assure any identified barriers to care are addressed and resolved. Additionally, our Network Relations Consultant will work with applicable specialists to assure they understand exactly what is required to serve as the member's PCP and directly address any issues.

We discuss guidelines for which specialists and BH providers will be able to serve as a member's PCP, and the criteria, circumstances, and processes involved in ND032, ND033, ND034, and ND035.

MR017	The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations.

UniCare currently monitors, and will continue to actively monitor PCP panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations. In accordance with Section 3.2.2.1 of the SPA, UniCare limits the number of members who can be assigned to an individual PCP to no more than 2,000 members, and recognizes that any requests for exceptions must meet DHHR criteria for exceptions and have the consent of both the PCP and DHHR.

In order to ensure that maximum PCP capacity limits are not exceeded, each PCP is assigned a panel size of no more than 2,000 members at the time they are initially set up in UniCare's provider data management system. Some providers choose to have a lower capacity limit. As long as the PCP's panel size remains below the established capacity limit, additional members may be auto-assigned to the PCP, and UniCare staff have the ability to manually assign additional members to the PCP at the member's request.

Once the PCP panel size has reached the capacity limit, we deem the panel closed and no additional members can be assigned to the PCP. Our Concierge Line staff will assist members in choosing another appropriate in-network PCP with available capacity to meet their needs unless the PCP requests and/or consents to an exception that complies with DHHR's valid exception criteria, including continuation of established care, such as a new UniCare member who is an existing patient of the PCP; assignment of a member to the same PCP as other members of a family unit; availability of mid-level clinicians in the practice; or inadequate numbers of providers in the geographic area. DHHR must also approve the exception request.

For scenarios where members are assigned to a PCP Group or PCP Team, the panel size is set based on the number of PCPs in the practice times the established capacity limit per individual PCP, and is managed using the same process outlined above.

Upon notice from DHHR that a network PCP's total Medicaid enrollee panel exceeds the 2,000 Medicaid enrollee limit, we will close that PCP's panel and evaluate the specific circumstances of that PCP's caseload. If appropriate, we will submit an exception request to DHHR in accordance with DHHR's exception criteria. If appropriate, we will adjust the PCP's caseload by reducing that PCP's capacity limit to sufficiently offset the overage, as well as work to reassign members who do not meet the criteria for a valid exception request to other available PCPs until the PCP's caseload is within acceptable panel capacity limits.

MR018	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting Instructions in the Service Provider Agreement (SPA).

UniCare currently complies with DHHR reporting requirements for submission of network standards documentation and geographic mapping reports. UniCare will continue to submit network standards documentation and geographic mapping reports to DHHR related to our compliance with the Provider Network Standards in Appendix K and the MCO Reporting Requirements in Appendix D of the SPA. Following these standards, we will submit the full network annually by October 31, all network changes quarterly within 45 days after the end of the quarter, PCP changes within 14 days after the change, immediately for hospital changes, and 14 days following mateiral changes in the network for other providers affecting service delivery.

At least annually, or more often in instances of the loss of a significant provider, using data analytic tools, we conduct a full network assessment against DHHR time and distance standards to verify our network (including hospitals, groups, PCPs, specialty providers, and BH providers) meets adequacy and accessibility standards to deliver covered services to our members. On a periodic basis, we generate and review GeoAccess® reports to determine network gaps based on where our members live. Based on this ongoing network accessibility evaluation process, we are able to identify areas of focus for ongoing network development activities to further assure we address gaps proactively.

MR019	The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.

UniCare has established and incorporated screening processes (per applicable federal and State requirements, as defined by DHHR) into our provider credentialing and re-credentialing and single case agreement processes designed to ensure we do not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs. Our credentialing staff review provider-based sanctions and related reports from various sources such as: Office of Inspector General (OIG), OIG's List of Excluded Individuals/Entities, the General Services Administration's System for Award Management, applicable State and federal agencies, the Office of Personnel Management, State and federal agencies, State licensing boards and agencies, and our own internal data (for example, we review adverse incidents, member complaints, and satisfaction data). We also consider any other verified information received from other appropriate sources.

Please see our responses to ND010, ND044, and BA067 for additional information related to screening for prohibited entities.

MR020	The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.

UniCare already has an existing records retention process that is in accordance with applicable federal and State requirements as defined by DHHR. We will continue to adhere to all applicable records retention requirements throughout our current contracts with DHHR as well as throughout the life of the new Contract.

UniCare's approach to maintaining records that fully disclose the extent of services provided to our members consists of our comprehensive MIS that stores electronic data and a set of detailed policies and procedures that govern the maintenance of records, including policies detailing access to our records as outlined in MR035.

Our Records Management program provides each business unit with direction and support for managing the life cycle of its records, including their appropriate retention, storage, retrieval, and disposal. The Records Management Policy applies to all employees, as well as subcontractors and consultants.

Upon hire and annually, all employees receive training on the Records Management program. Training includes modules about:

- Their need to comply with policies, requirements, and laws related to the retention, destruction, storage, and maintenance of information
- Local desktop procedures, including following the Record Retention Schedule for their department

- Where to go and who to contact for additional information

We also send out periodic operational reminders about records and information management to all employees via blast email, facility posters, screen savers, and interactive online activities.

MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.

As a current West Virginia Medicaid MCO, UniCare has consistently managed our QAPI program in accordance with DHHR's regulations. Our Quality Director, Victoria Warner, will lead our QAPI program and expand it with tailored activities to account for the needs of the population. We designed our QAPI program to achieve and sustain improvements in clinical and non-clinical areas of care through robust quality measurements and interventions. Our QAPI ultimately benefits members' health outcomes and satisfaction with our health plan by deploying strategies that include:

- Periodic measurement of performance against specified targets, including HEDIS and CAHPS® metrics and national benchmarks
- Multi-year performance improvement projects addressing clinical and non-clinical areas, which will be expanded for this population to new targeted areas
- Defined policies and procedures for addressing systematic problems and critical incidents, including reviews of SNS providers
- A health information system, featuring an NCQA-certified HEDIS engine and enhanced for this program with YouthRAP on the member website
- QM expertise and experience that has been developed in concert with the evolving needs of DHHR and members in West Virginia, supporting proper administration of all QAPI activities

We will continue to submit QAPI documents, reports, and performance information to DHHR in accordance with the specified schedule. Table D.1-1 demonstrates UniCare key performance indicators for 2018 related to QAPI program strategies.

Table D.1-1. UniCare's Key Performance Indicators for Medicaid

Category	Results
HEDIS	• 19 of the 39 NCQA-scored metrics showed improvement in percentile ranking • Five metrics met or exceeded the 90th percentile ranking according to the 2018 NCQA Quality Compass levels and eight metrics met or exceeded the 75th percentile • Large increases in 7-Day and 30-Day Follow-up After Hospitalization for Mental Illness

Member Experience	• Member Appeals and Appeals/1000 decreased by 36% from 2017 to 2018
	• 2018 Child Medicaid CAHPS
	  •Getting Needed Care Composite = 90.26%
	  •Getting Care Quickly Composite = 95.06%
	  •Health plan forms were easy to fill out = 97.38%

Provider Availability and Satisfaction	• All 55 West Virginia counties met the current Mountain Health Trust Program overall PCP provider-to-member ratio of one provider to 500 members. • 81% of providers are very or somewhat satisfied with UniCare overall
Clinical Metrics and Outcomes	• Significant reduction in Days/1000 for non-BH admissions • Significant reduction in opioid overdoses from 2017 to 2018

A full description of UniCare's QAPI program is included in QU005.

MR022	The Vendor must participate in public meetings and other events at the request of the Department.

UniCare will continue to participate in public meetings and other events at the request of DHHR, both during the implementation phase and through the life of the contract. We understand that to be a successful program partner, we must listen to, understand the priorities and concerns of, and barriers faced by, all key stakeholder groups. We understand moving children from fee-for-service to managed care will require significant communication and engagement with numerous stakeholders. We are willing to work with key stakeholders — Department caseworkers, providers, caregivers, justice system partners, child welfare agencies, educators, other MCOs, community organizations serving West Virginia's youth, and others — in order to best serve our members and to minimize stakeholder abrasion.

We use public meetings as opportunities to connect community organizations so we can efficiently collaborate with them. Through implementation and beyond, participating in public meetings helps us address issues, share updates about the program, gain input on how to improve and strengthen relationships, and establish partnerships. We have actively participated in public meetings at the request of DHHR. We have also both initiated and been active participants in public meetings with a variety of community organizations. As such, ***we have extensive experience adapting our training and messaging to a variety of audiences***.

Groups and events we have met with at DHHR's request include Medicaid provider workshops, which take place twice annually at multiple locations throughout the state. At these events, UniCare's Provider Relations team members present updated information on topics critical to continued success for West Virginia's sponsored health care programs. Another example of UniCare's active participation in public meetings at DHHR's request is our involvement in the Perinatal Partnership since its inception in 2006. We have participated in meetings established by the Partnership including those around topics such as Tobacco Free Pregnancy through Help2Quit and Substance Use in Pregnancy. In addition, our Medical Director, Tracy Dlott, has been a participant in the Perinatal Partnership since 2015. Dr. Dlott not only participates in the Partnership, but she also identified a need to promote long-acting reversible contraceptives (LARC) in West Virginia to reduce unintended pregnancies in the state, improve the health of women of childbearing age, and reduce incidence of neonatal abstinence syndrome. In response to these needs, Dr. Dlott established and continues to chair the LARC subcommittee, focused on:

- Assuring access to LARC in all 55 West Virginia counties
- Drafting provider and member education materials (both written and through social media) to increase utilization
- Problem solving billing and reimbursement issues for immediate postpartum LARC issues
- Increasing awareness and utilization of immediate postpartum LARC utilization
- Partnering with correctional facilities to increase awareness and non-coercive utilization of LARC

As an example of our participation in public meetings and our responsiveness to information garnered through them, UniCare attended the Kinship Caregiver Forum hosted by the Children's Home Society in the fall of 2017. During this meeting, we learned of the Healthy Grandfamilies grant at West Virginia State University, and subsequently reached out to this organization to identify ways we could partner with them to support their mission. We have provided support for a number of their training sessions, have offered our expertise in teaching the health literacy section of their curriculum, and have provided them with a $25,000 grant to support their statewide expansion.

Other examples of our participation in public meetings include our participation in 2019 in a panel discussion on School-based Health at the Kid Strong Conference. Most recently in June 2019, we held a community advisory group meeting, as well as participated in a payers' forum hosted by the West Virginia Primary Care Association. Additionally, we sent a representative to sit on the statewide roundtable meetings conducted by the Kids Health Forum of the West Virginians for Affordable Health Care in the fall of 2017 and 2018.

Going forward, we will continue to be proactive in looking for opportunities to participate in events with DHHR, and we will host our own public events where we would welcome DHHR's participation. We will continue to engage with members, their families and caregivers, local community stakeholders, and our government partners through a variety of means as described earlier in item MR004 and throughout this proposal.

MR023	The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department.

UniCare understands the importance of communication and collaboration with our State and provider partners; working with child welfare members requires a unique approach. The first year of implementation is especially important, as the Program is structured and infrastructure is developed. It is important the Vendor selected to manage the Program have the right experience and solutions. We are ready to continue collaborating with State and provider partners to help make sure members have the best possible transition experience and their needs are closely coordinated across the care continuum.

We understand some topics are more dynamic than others, and solutions in these areas will benefit from more frequent check-ins. We would like to suggest as topics for these monthly meetings, continuity of care, timeliness of claims payment, claims submission, provider payment, member services, benefit structure, communication challenges, collaboration and relationship building opportunities, and key child welfare principles. Monthly meetings could serve as forums for rapid issue resolution on these topics, helping DHHR, provider groups, and us to quickly share and understand any pressure points or disruptions within the system of care. As such, we will meet with DHHR and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by DHHR. ***UniCare is a state leader in communicating with and supporting provider councils***, as evidenced by our participation over the past 16 years in conferences, summits, and workshops with the following groups: the West Virginia Primary Care Association, West Virginia State Medical Association, West Virginia Rural Health Conference, West Virginia Behavioral Healthcare Provider Association, West Virginia Association of Alcoholism and Drug Abuse Counselors, West Virginia Chiropractic Society, West Virginia Dental Association, and BMS.

UniCare is consistently an active participant in biweekly and monthly meetings between DHHR and the MCOs and values these sessions as opportunities for the managed care companies to partner with BMS to promote the success of the Medicaid Managed Care Program.

MR024	The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department.

UniCare will meet with DHHR and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by DHHR.

We currently and regularly meet with industry-specific providers and stakeholders, making a concentrated effort to connect with groups with expertise in foster care. Recently, we participated in a series of quarterly meetings with the Oral Health Advisory Committee, which included discussion of access to dental care for pregnant women.

Our experience serving TANF members shows us that in an environment serving youth, some subject areas change more dynamically than others. As described in our response to MR023, more rapidly developing areas may benefit from continued monthly meetings beyond the first year. The big-picture view in quarterly meetings could provide an opportunity to collaborate and build closer relationships. Topic discussions that we would suggest for quarterly meetings would include updates to administrative processes, state policies, State Plan amendments, discussions around benefit structure, review or adjustment of co-location, system gaps, SNS service gaps or needs, trends in grievances and appeals, marketing plan updates, and both member and provider communications. We envision joint training and communication presentations presented between UniCare and DHHR for providers at these meetings, which could also include panel discussion and provider question and answer sessions.

MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.

UniCare maintains an excellent relationship with DHHR's current External Quality Review Organization (EQRO), Qlarant Quality Solutions, Inc., and will continue to do so for this Contract. To maintain this positive relationship, we will continue to comply with all EQRO requirements, activities, and audits. As a strong DHHR partner, we willingly collaborate on these and any other initiatives aimed at improving program performance. We will continue working with Qlarant Quality Solutions, Inc. annually to complete the three external quality review mandatory activities, including:

- Systems Performance Review (SPR)
- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)

Our Quality Director, Victoria Warner, will have local responsibility for coordinating successful completion of EQRO activities and will be supported in this role by others on our QM team. UniCare is experienced in preparing for EQRO reviews and producing system reports, medical records, and any other documentation to be audited as part of the process. In its 2018 Annual Technical Report, the EQRO noted numerous UniCare strengths, including:

- We appropriately coordinate services for members with specialized health care needs
- We consistently apply review criteria for authorization decisions, conduct interrater reliability testing, and use clinical practice guidelines
- We achieved full compliance with all credentialing and re-credentialing timeliness and delegation requirements
- Our delegated credentialing policies and procedures are comprehensive — all delegated entities received an annual audit
- Clinical practice guidelines and criteria are in place and appropriately used to make authorization decisions
- We maintain a quality and health information system that collects, analyzes, integrates, and reports data — all required performance measures were reported to BMS on time
- Our Health Education Plan creates opportunities to engage members and their communities in preventive and wellness programs
- Collaboration between quality-related committees and subcommittees is clear and documented in meeting minutes/reports, reflecting our health plan's culture of quality

MR026	The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.

UniCare will be pleased to participate in the oral presentations as scheduled by DHHR during the proposal scoring period. Our proposed key staff with local knowledge of the membership and our operations will attend and be the primary participants.

MR027	The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation.

UniCare's health plan leadership team will manage all implementation details for the Program and will work with DHHR to implement all the systems, processes, and data exchanges necessary to support an on-time start to Program operations. We will provide all requested information according to the specified timelines and participate in a readiness review as defined by DHHR.

Our local West Virginia leadership will receive support from, and leverage, the experience, processes, and best practices of our national IMO. The IMO has executed more than 250 implementations, 14 of which are Medicaid contracts covering child welfare populations — including Georgia Families 360°$_{SM}$, a statewide single source program — never missing a readiness review or member go-live date. We describe the IMO in full in our response to MR003.

MR028	The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following link:http://www.wvdhhr.org/mis/pollcies.asphttps://technology. wv.gov/security /Pages/policies-issued-by-the-cto.aspx

UniCare will comply with all current and future security policies and procedures of DHHR and the West Virginia Office of Technology (WVOT).

To protect the confidentiality, integrity, and availability of all data and information assets, we employ the defense-in-depth security strategy developed and successfully implemented by our organization over the past 28 years, including our over 16 years in West Virginia. Based on long-standing Medicaid managed care systems experience in 22 markets, including West Virginia, we have established security safeguards to prevent unauthorized entry into technology centers, access to data and data files, software modifications, and divulgence of confidential information. Our policies, systems, and processes already comply with DHHR's security policies and procedures, including those regarding:

- Information security
- Facility and workstation security
- Data backup and retention
- Security and privacy training
- Account access and management
- Email guidelines and advanced protections
- Acceptable use of wireless and mobile devices
- Incident reporting and response

MR029	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.

UniCare's current operations, as well as our future operations, are supported by systems compatible with the current versions and standards supported by WVOT. As an incumbent MCO, we have worked with DHHR and WVOT to establish all required data and system interfaces for the West Virginia Medicaid Programs and will continue to support all required technology standards and interfaces for the Program.

MR030	The Vendor must provide a plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.

UniCare currently maintains full Health Insurance Portability and Accountability Act (HIPAA) compliance, and we will maintain this compliance throughout the life of the contract at no additional cost to DHHR. Upon award, we will continue to do so under the Program. We have thoroughly read and reviewed the HIPAA Business Associate Addendum that DHHR has provided as part of this RFP, and we will adhere to its requirements.

HIPAA Compliance

We require our staff, providers, and subcontractors serving the West Virginia Medicaid programs to adhere to HIPAA guidelines and will require the same for the Program. As with our current programs, we will maintain our HIPAA compliance plan and procedures at no cost to DHHR.

Our HIPAA training includes details on information exchange, which outline strict verification and authentication processes for medically sensitive information, caller authority to receive the member's Protected Health Information (PHI), the types of PHI we may release, the types of PHI we can request (for example, related to medical records, authorization determinations, and resolution of payment appeal), the types of information we cannot share (such as psychotherapy notes, sensitive HIV/STD information, and genetic testing), and documentation of those not permitted to access PHI. In addition, we provide education on access restrictions and special requirements for fax machines/faxes, email, and voicemail systems/processes.

UniCare employees must complete extensive online compliance training within the first 30 days of employment and annually thereafter. For subcontractor services, such as dental, we require staff to complete HIPAA training upon hire and annually. The subcontractor submits the information to us as part of our Subcontractor Agreement. As part of their signed and binding contractual agreement with UniCare, we require providers to adhere to HIPAA guidelines.

We have provided more complete detail regarding our HIPAA compliance plan as part of MR031.

MR031	The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply.

UniCare will continue to comply with all applicable State and federal law regarding confidentiality/privacy.

Our Technology Services team has expertise regarding laws and regulations governing data exchange and protected health care information privacy and confidentiality, including HIPAA regulations, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy). In accordance with these and other applicable State and federal requirements, our Technology Services team uses well-established data exchange systems and

protocols. We recognize the complexity of data sharing for foster care, and we will adhere to guidance provided by the State regarding the sharing of information.

To help us maintain data security, we employ the Anthem Workforce Information Security Program (WISP) of our parent company, Anthem, Inc. The overarching objective of the WISP is to establish effective corporate-wide policies, standards, procedures, guidelines, and strategies that address the security of Anthem computer resources, infrastructure, data and information assets regardless of the party responsible for use or management, the physical location or the medium in which such information assets reside (for example, electronic, digital, or paper). The WISP is based in part on Anthem's risk assessment processes and reflects the application of relevant IT controls including:

- Regulatory requirements, such as HIPAA, HITECH, and PCI
- Industry frameworks and standards, such as HITRUST
- Anthem Information Security policies and standards

The WISP includes the following elements:

- The basic protection requirements for all stored information and data, and the requirements that must be followed by anyone who utilizes our computer systems
- Internal publication of policies, programs, standards, procedures, and guidelines that address the technical implementation, control, management, auditing, and administration of computer security and information asset protection
- The development of baseline requirements for the physical protection of our technology infrastructure
- The implementation of an information security awareness program to educate corporate associates and help reduce risk associated with electronic data processing and computer system usage
- The implementation of an information security administration function responsible for coordinating and administering requests for user access to Anthem computer systems and data resources, removing access to these resources when no longer required and performing routine audits to validate that security protection mechanisms are functioning properly
- The implementation of a security risk management function to assess, manage, and communicate risks to Anthem assets and the actions to be taken to mitigate these risks
- The establishment of mechanisms to monitor, analyze, and report on the effectiveness of the WISP
- The appropriate controls that allow us to adhere to applicable federal and state regulations, international law, legal requirements, and best practices
- The maintenance of liaison relationships with internal and external organizations and departments

The WISP is reviewed on at least an annual basis and as new vulnerabilities and threats become known, as well as when new business, technology, and regulatory requirements are identified.

MR032	The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new Requirements reporting requirements.

UniCare agrees to incorporate all requirements mandated through federal and State regulations and legislation, including but not limited to new reporting requirements.

UniCare is supported by the IMO, as further detailed in MR001 and MR003, who assists us in overseeing implementation of new contract requirements, including new or modified reporting,

as well as new state or federal mandates. Our team has supported projects to become compliant with a number of changes in the CMS federal rule governing Medicaid managed care, and we have assisted the state in, and we are currently managing a project to, implement the requirements of West Virginia Prior Authorization House Bill 2351.

Once operational under the new contract, as described in item MR001, we will use the Compliance 360 tool to support our efforts incorporating and complying with any new mandatory requirements enacted through federal or State regulations or legislation, including new reporting requirements. Our organization has recently launched a dedicated Regulatory Reporting Center of Expertise (Reporting COE) for regulatory reporting whose mission is ensuring proactive regulatory compliance through timely and comprehensive identification, communication, collection, and submission of required reporting to our State partners. This team, and its comprehensive repositories of report templates and state issued reporting guides, liaises with our Compliance Manager and senior leaders to facilitate additional internal reviews and approvals (as necessary) prior to submission to verify report format and content accuracy. Supported by powerful tracking tools and systems, the Reporting COE is able to generate automated business owner reminders of upcoming reports and track report timeliness and quality metrics so we can meet our reporting commitments.

Additionally, in January 2019, UniCare participated in a Reporting Task Force created by BMS in partnership with the Medicaid MCO. The Task Force's objective was to review the state-provided quarterly report template, known as the MHT/WVHB/SSI Quarterly Reports, and eliminate elements from the reports that may be unnecessary or duplicative of data that BMS receives from other sources, such as an external quality review. As a result of the Task Force's work, the State decommissioned multiple reports from the prior reporting template, and BMS issued a new quarterly reporting template, consisting of 10 individual reports, to the managed care organizations in May 2019. Within these individual reports, UniCare provides data and information to BMS on enrollment and membership, provider network status, claims processing, grievances and appeals, and finances. UniCare utilized this new reporting template for the submission of the Q2 2019 reports to BMS.

We further demonstrate our commitment to all current and new reporting requirements under our current contract by our consistent, on-time reporting to the state, consisting of 607 reports between 1/1/18 and 7/31/19 with timeliness of submission over 99%.

MR033	The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing.

UniCare will provide compliance support services that include providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing. UniCare assigns a primary point of contact for each audit request to manage the data, documentation, due dates, and other required elements to ensure compliance is achieved for all audit requirements. In addition, this primary point of contact, along with other subject matter experts, performs an internal quality review before submission. Our Compliance Officer and Compliance Manager are an integral part of this process aiding in organization of the on-site audit review and communicating with, and providing documentation as appropriate, to DHHR.

As described in MR032, the Reporting COE is dedicated to the identification, documentation, and communication of new/revised required regulatory reporting deliverables and our compliance with applicable format and submission deadlines. As described in MR001 and elsewhere, we use our Compliance 360 tool to aid in maintaining compliant operations. In

addition to the Compliance 360 tool, we support our compliance efforts with the National Executive Dashboard.

National Executive Dashboard

For transparency and accountability, we monitor, track, and evaluate performance using the National Executive Dashboard (NED), a Tableau-based reporting tool that assembles key metrics from functional areas visualizing performance against defined targets, both internally developed and State-contracted. All functional areas are represented in NED, including, but not limited to, Claims Operations, Call Center, UM, and Enrollment.

Metric goals range from monthly to annually, and each has a clearly identified business owner responsible for the functions' performance and for entering an action plan for missed targets. NED provides leadership with a comprehensive status of operational performance by tracking and assimilating data that can be used to inform mitigation strategies, if necessary, to help us meet our commitments to members, providers, and State partners.

MR034	The Vendor must ensure that all applications inclusive of internet, Intranet, and extranet applications associated with this contract are compliant with Section 508 Requirements of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.

All our internally managed internet and Intranet sites and applications are compliant with Section 508 of the Rehabilitation Act. We do not currently maintain any extranet sites, but if developed, these sites would also be built to comply with Section 508. Our internet websites are based on industry standard Web accessibility design and meet the requirements of the Web Content Accessibility Guidelines (WCAG) 2.0 Level AA Accessibility standards. PDFs on our member website are tagged for accessibility and we test our websites for accessibility compliance quarterly and after every code change for new or modified functionality.

Serving Our Members with Enhanced Accessible Website Design

Our West Virginia members have 24/7/365 access to information about their care through our easy-to-navigate and mobile-friendly, 508-compliant website designed to minimize download and wait times. UniCare's member website is developed by the Anthem Digital Solutions team with navigation and content designed to meet the needs of the covered populations and compliant with all regulatory requirements. This team develops and maintains websites in 22 managed care markets, collectively representing 70 years of digital and web experience and with a proven record of creating award-winning 508-compliant websites — notably for excellence in design and user experience. Awards include the 2017 eHealthcare Leadership Award of Distinction for Best Overall Internet Site for HMOs/PPOs (Georgia), a 2017 ClearMark Award of Distinction from The Center for Plain Language (Indiana), and a 2017 Digital Health Bronze Award for responsive design (Georgia).

We will leverage this technology for YouthRAP, a new member portal built specifically to support Program members, their Authorized Representatives, and caregivers, providing the current functionality plus additional items geared specifically to the Program while maintaining compliance with Section 508 and WCAG 2.0 standards.

MR035	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements.

UniCare follows strict records retention policies and schedules in accordance with 45 CFR Part 75 and in compliance with Program RFP, Contract, State, and federal requirements. Our records retention process is outlined in MR020.

The retention periods set forth in our records retention schedule are minimum requirements based upon legal, tax, administrative, and contractual requirements. Legal hold directives will supersede and suspend the destruction of records covered by the legal hold directive when the retention period would call for their destruction. All records subject to a legal hold will be preserved until our Legal department has lifted the legal hold. Records that have fulfilled their official retention period are required to be reviewed for legal holds by the Legal department and the Records Manager prior to destruction. Upon award, we will apply these same stringent policies to ensure that data entered, maintained, or generated in relation to the Program will be retained in accordance with 45 CFR Part 75 and the requirements of this RFP and other applicable State and federal regulations.

We, and our subcontractors, agree that authorized federal and State representatives will have access to and the right to examine our records and access our or our subcontractors' physical premises during the contract period and during the 10 years post contract period or 10 years from the date of completion of any audit, whichever is later. All employees receive training, upon hire and annually, regarding the appropriate handling, storage, and disposal of confidential records.

In the event the Contract terminates, UniCare will retain, or to the extent applicable and practicable, deliver to the State for retention purposes, all records, and books of accounting related to the provision of the services and professional services required for retention by the State. All records will be kept in a timely, accurate, and complete manner, and written in English and in accordance with applicable laws. All applicable records will adhere to consistently applied generally accepted accounting principles. Upon the expiration of the record retention period, we will properly, permanently, and securely destroy all confidential records.

MR036	The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.

UniCare will obtain DHHR's approval for all key staff and all personnel assigned to administer this Contract. As a health plan already serving Medicaid members in West Virginia, we are accustomed to obtaining approval from DHHR and will continue to comply with this requirement.

We recognize key personnel are critical in providing guidance and leadership that permeate through all areas of our organization. We base our process for identifying key personnel on a comprehensive, well-structured recruitment and selection process. When we need to identify key personnel replacements, we use a structured talent acquisition model of recruiters and sourcing specialists who work with our current leadership to identify the best candidates for a position. We replace key staff with top-level candidates who have the same (or greater) experience and qualifications. Our current designated key personnel bring more than 200 years of relevant experience.

We designed our succession planning strategies so that we can recruit from within and use behavioral interviewing techniques to assess how internal and external candidates have handled employment-related situations in their current or previous positions. These techniques allow us to better assess the candidates' ability to handle similar situations going forward. We also use a wide, multi-channel recruitment approach of traditional advertising, social media, word-of-mouth, and public events to help locate top-level talent when we need it. We know success depends on qualified stable staffing at all levels of the organization, and flexible policies and procedures that enable us to scale resources as circumstances dictate and to replace key management personnel and other management staff with qualified staff quickly and efficiently, all in accordance with DHHR requirements.

MR037	The Vendor must employ Key Staff assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within 30 calendar days of the contract award.

UniCare will employ all designated key staff on a full-time basis to serve the Specialized Managed Care for Children and Youth Program. Each key staff position will be filled by one staff member, unless otherwise approved by DHHR. We will use an Initial Staffing Plan with well-defined strategies to recruit, interview, and hire sufficient and qualified candidates within a short period to fulfill requirements as specified in the RFP. We have already designated permanent hires for many of our key staff positions, and recruitment efforts are underway, so that all key staff members will be in place within 30 calendar days of the Contract award.

We have always been able to recruit and retain sufficient numbers of adequately trained employees to meet our Contract obligations. UniCare, nor our affiliates, have ever had an implementation delay because of inability to recruit staff.

Our screening tools and processes help us identify, attract, and retain a top-tier workforce representative of the views, perspectives, experiences, and health care needs of the individuals and communities we serve. For the Program, we will recruit and hire experienced, qualified key staff and leadership who have personal and professional experience and knowledge of child welfare and the system of care. In addition to the permanent key staff we have already designated, we also have interim key staff in place to oversee initial operations, including recruitment and training of qualified staff for any vacant key staff positions. We provide a full list of identified interim and permanent key personnel in our response to Attachment C: Project Organization and Staffing Approach, Table C.1-1 UniCare's Designated Full-Time Key Staff, Timelines for Hiring and Contact Information.

MR038	The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.

UniCare will provide prompt notification (at minimum 10 business days' notice) to DHHR when staffing changes occur, including changes in key staff. In addition to ensuring we have strong leadership through our key staff, our Initial Staffing Plan will assure we have the ability to modify the projected number of staff as staffing assumptions change. We adjust staffing levels based on changes in volume and service delivery. Each manager and department routinely review their specific responsibilities and determine the capacity of the current department by monitoring any changes in volume, membership, program updates, and service delivery to adjust staffing levels to meet our members' needs. Management works closely with their counterparts in our affiliate health plans to share best practices, review new processes and programs, and determine whether global or systemic changes may be required to enhance service delivery. Managers refine existing staffing plans, identify additional resources that can be rapidly

mobilized, continue to provide required training, and work with other departments to identify operational efficiencies. As these staffing changes occur, we will provide as much notice as possible to DHHR, and will comply with this requirement.

MR039	The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department.

When a key staff member departs, we will use all best efforts to replace them within 30 business days after the position is vacant. Our leadership are highly qualified and understand the nuances of our Fostering Healthy Lives model to serve children and families in the child welfare system, and they can easily step in on an interim basis to prevent disruption to our operations. Further, we maintain strong ties within the health care community, and are able to attract highly qualified individuals, who are often eager to join an organization with a stellar reputation for quality care. We maintain a list of eligible individuals who we can expeditiously recruit for any of the key positions. This list includes individuals we have interviewed, local experts in specific areas, qualified employees of UniCare interested in taking on new responsibilities, and individuals referred to us by our stakeholders.

As soon as any key employee submits a resignation, we mobilize and review this list and begin recruiting those who are most qualified. Our succession planning strategies enable us to provide any needed training or mentorship to increase successor competencies and make sure they are ready to assume vacated roles as quickly as possible (and within the required timeframes). In the unlikely event UniCare is not able to fill a vacant key staff position within 30 days, we will communicate and coordinate our efforts with DHHR to keep them aware of our progress and obtain approval for a longer period. Our Initial Staffing Plan (Attachment C: Project Organization and Staffing and Approach, Replacing Key Staff) provides additional detail on our approach to replacing key personnel, when necessary.

MR040	The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above.

UniCare understands DHHR's interest in ensuring its operations are appropriately carried out in an efficient, professional, legal, and secure manner. To support the State's interest in a successful foster care program, we will only recruit, hire, and maintain staff who share our common desire for a successful program. Additionally, we will remove any staff involved in the project if DHHR determines that any such staff has interfered or may interfere with its interests.

Employee Hiring Processes, Conflicts of Interest Reporting, and Remedies

Upon hire and throughout employment, our employees must report any potential or actual conflicts of interest. To supplement these efforts, ***we perform thorough background checks as part of the hiring process***, making sure we only hire staff who would securely care for West Virginia's youth, and we are sensitive to the background of staff working in foster care.

Upon hire, we identify and remedy any potential conflict of interest situations such as:

- Personal or working relationships with practitioners, members, or institutions who might be involved in or have an interest in the Program
- Financial interests or investments in direct conflict with any part of the Program
- Secondary employment with any entities involved in the Program

- Past employment that might preclude staff from working on projects for specific periods of time
- Presence on exclusion lists for work on Medicaid
- Receipt of any gifts, gratuities, or entertainment offered to reviewers as an incentive for a requested outcome

We maintain a culture of compliance throughout our organization, designing our programs and workflows so that we support the State's goals while also holding our team members accountable towards achieving those goals. All UniCare and Anthem staff, including those who are assigned to help work with our team, are required to self-disclose conflict of interest information annually and if they start a secondary job. We also require all UniCare and Anthem staff to complete Ethics and Compliance training upon hire and annually thereafter. This training includes a segment on Living with Integrity and an attestation regarding compensation. By completing the full Ethics and Compliance training, staff agree to the terms of this statement. Our policies and procedures require any clinical reviewer identified as having a conflict of interest or receiving any incentive that may affect review decisions be terminated. Our staff will have completed this training requirement prior to implementation.

Corrective Action Processes to Address Employee Performance or DHHR Interests' Interference

Corrective action, up to and including staff removal from projects and termination from our organization, may be initiated for various performance and/or conduct issues. These issues may, include but not be limited to, DHHR determination of staff interference or potential interference with Departmental interests, as well as violations of the company's policies, procedures, practices, work standards, values, health and safety rules, attendance standards, unsatisfactory job performance, insubordination or other acts of misconduct.

As noted here, and as outlined above in MR036, MR037, MR038 and MR039, to further DHHR interests, our organization ensures experienced staff are hired, vetted for potential conflicts, succession management strategies are utilized to optimize operational efficiency, and corrective action processes are in place to remove staff if found to have interfered with DHHR interests.

MR041	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with Vendor on the project.

UniCare accepts financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting UniCare or working with us on the Program. As we understand our business partners' conduct reflects both on us and on the State, we employ a robust oversight and compliance process to identify, monitor, and mitigate potential issues. We describe our oversight and compliance processes more fully in Attachment C: Project Organization and Staff Approach, Subcontractor Selection and Oversight Program Activities.

Anthem's Standards of Ethical Business Conduct (the Code) provides guidance to all employees, affiliates and subsidiaries on how to conduct business and all our employees must acknowledge and agree to comply with the Code as a condition of employment. This Code applies to UniCare, Anthem, and all our affiliates. Our Code promotes ethical conduct and obligates us to comply with all applicable policies, laws, and regulations, as well as our company values. UniCare and all Anthem staff attest to their commitment to the Code each year, which is updated annually by Anthem.

As a condition of doing business with UniCare, all entities must agree to our Supplier Code of Conduct. The Supplier Code of Conduct is similar to our internal Code, and all entities must adhere to it while conducting business on our behalf. ***UniCare retains sole responsibility for fulfilling Contract requirements***. We are fully accountable for our subcontractors' performance through processes implemented to monitor, supervise, and enforce Contract compliance.

We continually monitor our subcontractors' performance through processes that include an annual formal review, frequent meetings, review of performance data, and confirmation that our subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements as necessary. Both UniCare and Anthem consistently apply subcontracting policies, procedures, and processes to all subcontractors, and we adjust them as appropriate as we onboard new subcontractors or implement new programs.

MR042	The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information).

We use established and tested controls to make sure unauthorized staff and users do not have the capability to access, edit, or share personal information and data, including PHI, Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data.

UniCare fosters a culture of security and compliance and maintains strict security policies and procedures regarding facility and system access and data use. All employees must complete training on security policies upon hire and annually thereafter. Compliance with security policies is managed internally through combined health plan accountability and support from Anthem's Privacy, Information Security, and Technology Services teams.

Securing Personal Information

UniCare actively shares responsibility with DHHR to meet HIPAA, federal, and State enterprise information security policies, standards, regulations, and requirements related to the protection of PHI, PII, FTI, and SSA data. To protect confidentiality, integrity, and availability of data, our Information Security and Privacy teams have established a multi-faceted security management plan based on more than 28 years of experience in Medicaid managed care systems. We employ security safeguards to prevent unauthorized entry into our technology centers, access to data and data files, software modifications, and divulgence of confidential information. These systems and processes already comply with the WVOT's current security policies and procedures.

Identity and Access Management

We use the following Identity and Access Management protocols to protect our West Virginia Medicaid member data and minimize the risk of data breaches, and will use the same protocols to support the Contract:

- Facility access controlled with proximity-based electronic security badges.
  - All UniCare employees and visitors must complete a security access request form and obtain approval signatures for unsupervised access.
  - Each employee must present her/his own access badge when entering a building or controlled area. Inappropriate use of an approved access badge or privilege may result in disciplinary action.

  - After-hours access requires use of specially coded security badges, and data center access is limited to staff responsible for network engineering, system administration, and network security.
  - All servers and data storage devices are located within secure areas accessible only with additional electronic lock/PIN access.
- Access to workstations or systems requires a unique user identifier and password (complex and changed at regular intervals).
  - Remote system access requires two-factor authentication that verifies the identity of the individual, using "something they know" (user identifier and password) with "something they have" (such as a key card or token).
  - Access to privileged administrator accounts requires complex, three-factor authentication.
- Role-based security enables us to limit user access and application functionality based on role.
  - Users can only view information that is relevant to their role.
  - Users with inquiry-only privileges are unable to modify or update information.
  - We use a workflow management system to enforce rules pertaining to PHI, collect required information, and route requests for appropriate approval and tracking.
- Enforcing verification rules assures that only appropriate external users are provided access to PHI and PII, and then only the information that they are permitted to see (for example, limiting access to historical information prior to an adoption.)
- Network security is managed and monitored using a number of technologies and security management systems that provide 24/7/365 real-time security event monitoring and reporting capabilities.
  - A Vulnerability Management program identifies vulnerabilities, reports them for remediation, and tracks and reports remediation efforts.
  - On a regular basis, managers receive requests to review and affirm staff's need for continued access to specific systems and databases and approve the level of access required.

MR043	The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.

UniCare will implement processes to monitor and ensure all our project staff serving the Program complete the OMIS Vendor Employee Confidentiality Statement prior to beginning work on the project.

MR044	The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.

UniCare complies with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.

MR045	The Vendor must provide a drug-free workplace for employees and all applicable agents, including, but not limited to, subcontractors. All agents of the Vendor Requirements must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.

UniCare provides an alcohol and drug-free workplace for employees and all applicable agents, including but not limited to subcontractors, as demonstrated through our compliance with the Drug-Free Workplace Act of 1988. We will continue to comply with this requirement and will prohibit employees, temporary employees, agents, and subcontractors from the unlawful

manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of this Contract or while representing UniCare at any time.

MR046	The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer.

Leslie Caluya will serve as UniCare's designated HIPAA Compliance Officer. Since 2014, Ms. Caluya has been our Information Technology Director for West Virginia and has deep experience and knowledge of overseeing HIPAA Privacy and Security Rules. She stays abreast of the latest developments related to regulatory compliance, including when new or updated privacy and security requirements are introduced, so that UniCare remains fully compliant with all related requirements.

MR047	The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance.In this context, ""data"" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.

UniCare does not publish or copyright data using DHHR's name without prior written approval by DHHR for every instance.

We understand and agree that except with respect to any commercial software, DHHR will be and remain the owner of all data provided to DHHR by UniCare or its agents, subcontractors, or representatives pursuant to the contract other than UniCare's internal administrative procedure records.

To make certain the content and form of our published materials comply with SPA requirements, we will continue to use our well-established, structured, and rigorous review process known as our Collateral Materials Approval Process (CMAP). Through the CMAP process, all marketing materials for external distribution (verbally, in written form, or by electronic means) are reviewed by a multidisciplinary team of subject matter experts (SMEs), regulatory and compliance staff, and legal counsel prior to submission to DHHR for approval.

For more details on our CMAP process, please see our response to MS011.

MR048	The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, Access to State hardware, software, network infrastructure, and any licensing costs.

UniCare will continue to be responsible for all expenses required to obtain and maintain access to DHHR systems as we have done under our current and previous contracts with the State. We understand and agree that such expenses include, but are not limited to, access to State hardware, software, network infrastructure, any licensing costs, and SNS as indicated.

MR049	The Vendor must make available to the Department the results of any third-party audit conducted, including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.

UniCare will make available to DHHR all third-party audit results, including the results from the annual EQRO and Service Organization Control (SOC) 1 and 2 audits.

Sharing Audit Results

In addition to the annual EQRO and SOC 1 audits, our security team has established audit and accountability programs to identify potential security risks and will provide DHHR with all security related deliverables as required, including a copy of the SOC 2, Type 2 attestation report as directed by DHHR.

We understand DHHR may require security assurance for functional, technical, and infrastructure components to verify systems meet all information security requirements throughout the life of the Contract. We will provide DHHR and their security team with our security assessment scenarios and strategies as required and will perform security assessments for key applicable milestones, providing appropriate evidentiary artifacts as required by DHHR.

MR050	The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.

UniCare provides, as specified in Supplemental Document D, authorization from our ultimate parent company and subcontractor, Anthem, Inc., for the State to have access to its records if such a relationship exists that impacts UniCare's performance under the proposed contract. The authorization extends to any Anthem, Inc. affiliated or subsidiary entity, which may provide services under the contract.

Access to Records Guarantee

UniCare Health Plan of West Virginia, Inc.'s ultimate parent organization, Anthem, Inc., guarantees and authorizes that the State of West Virginia shall have access to records specifically concerning the performance of UniCare Health Plan of West Virginia, Inc. or that impacts the performance of UniCare Health Plan of West Virginia, Inc. under the proposed state contract to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance (the "WV Contract"). This authorization extends to any Anthem, Inc. affiliated or subsidiary entity which may provide services under the WV Contract.

Any such records of Anthem, Inc. or of its affiliated or subsidiary entities are considered confidential and proprietary information and shall not be used, commercialized, or disclosed to any person or entity, except to the State of West Virginia's authorized employees, contractor personnel, or to its attorneys, accountants, consultants, and other professional advisors having a "need to know." Such confidential and proprietary information of Anthem, Inc. or of its affiliated or subsidiary entities shall be used with at least the same degree of care that the State of West Virginia uses in safeguarding its own confidential information.

In the event that the State of West Virginia accesses any records of UniCare Health Plan of West Virginia, Inc. or of Anthem, Inc. or its affiliates or subsidiaries, the State of West Virginia will comply with applicable state and federal law regarding confidentiality/privacy including the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431, Subpart F (42 CFR 431 F); Title 45, Parts 160, 162, and 164; and the Federal Information Security Management Act (FISMA), to the extent they apply. Such records, whether verbal, written, recorded magnetic media, cards or otherwise will be regarded as confidential information and all necessary steps must be taken by the State of West Virginia to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations.
The State of West Virginia agrees not to release any information provided by UniCare Health Plan of West Virginia, Inc. or of Anthem, Inc. or its affiliates or subsidiaries, without the express consent of UniCare Health Plan of West Virginia, Inc. except as otherwise specified otherwise provided in the WV Contract.

Kathleen S. Kiefer, Corporate Secretary, Anthem, Inc.

Date: 7/29/19

Access to Records Guarantee

UniCare Health Plan of West Virginia, Inc.'s ultimate parent organization, Anthem, Inc., guarantees and authorizes that the State of West Virginia shall have access to records specifically concerning the performance of UniCare Health Plan of West Virginia, Inc. or that impacts the performance of UniCare Health Plan of West Virginia, Inc. under the proposed state contract to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance (the "WV Contract"). This authorization extends to any Anthem, Inc. affiliated or subsidiary entity which may provide services under the WV Contract.

Any such records of Anthem, Inc. or of its affiliated or subsidiary entities are considered confidential and proprietary information and shall not be used, commercialized, or disclosed to any person or entity, except to the State of West Virginia's authorized employees, contractor personnel, or to its attorneys, accountants, consultants, and other professional advisors having a "need to know." Such confidential and proprietary information of Anthem, Inc. or of its affiliated or subsidiary entities shall be used with at least the same degree of care that the State of West Virginia uses in safeguarding its own confidential information.

In the event that the State of West Virginia accesses any records of UniCare Health Plan of West Virginia, Inc. or of Anthem, Inc. or its affiliates or subsidiaries, the State of West Virginia will comply with applicable state and federal law regarding confidentiality/privacy including the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431, Subpart F (42 CFR 431 F); Title 45, Parts 160, 162, and 164; and the Federal Information Security Management Act (FISMA), to the extent they apply. Such records, whether verbal, written, recorded magnetic media, cards or otherwise will be regarded as confidential information and all necessary steps must be taken by the State of West Virginia to safeguard the confidentiality of such material or information in conformance with federal and state statutes and regulations.
The State of West Virginia agrees not to release any information provided by UniCare Health Plan of West Virginia, Inc. or of Anthem, Inc. or its affiliates or subsidiaries, without the express consent of UniCare Health Plan of West Virginia, Inc. except as otherwise specified otherwise provided in the WV Contract.

Kathleen S. Kiefer, Corporate Secretary, Anthem, Inc.

Date: 7/29/19

WEST VIRGINIA Department of Health & Human Resources

Vendor's Responses to Mandatory Requirements

Instructions for Completion of Attachment D - Mandatory Requirements

1. The Vendor must note compliance with each mandatory requirement listed in the ***Vendor's Disposition*** column of *Tab 3 - Mandatory Req Responses*, using only the values that appear in the drop-down list.
2. *Vendor's Disposition* values are outlined below:
    1. "Will Meet": Vendor agrees to the mandatory requirement.
    2. "Will Not Meet": Vendor declines to meet the mandatory requirement.
3. All mandatory requirements must contain one of the values identified above. Any mandatory requirement without a ***Vendor's Disposition*** response value will be considered to be "Will Not Meet."
4. If appropriate, the Vendor must provide the ***Attachment***, ***Section***, and ***Page Number(s)*** where their detailed narrative response for each mandatory requirement resides, providing the Department with a crosswalk, and ensuring that each mandatory requirement is addressed. Be advised that the ***Attachment*** column has been pre-populated with the location that the Department anticipates the narrative response to reside; however, it is up to the Vendor to update that column accordingly, should the Vendor respond to a mandatory requirement in a different location.

WEST VIRGINIA Department of Health & Human Resources

Vendor's Responses to Mandatory Requirements

Tabs in this spreadsheet	
1. Worksheet Instructions	Instructions for completion of this RFP supplement.
2. Worksheet Information	This tab including information about the contents of this workbook.
3. Mandatory Req Responses	Contains the mandatory requirements and all related data.
4. Code Values	Contains coded values for use in the mandatory requirements tab, and explanations as appropriate.

Columns on the Mandatory Req Responses Tab			
Section	**Column(s)**	**Description**	**Corresponding Code Values**
Mandatory Requirements	*Req ID #*	The unique ID of the mandatory requirement.	N/A
	Requirement Text	The text of the mandatory requirement.	N/A
	Type	How the mandatory requirement is categorized.	N/A
Vendor Response	*Vendor's Disposition*	Vendor is expected to indicate its compliance with the mandatory requirement using one of the supplied values.	Vendor Response - Disposition
	Attachment	Vendor is expected to provide a reference to the appropriate RFP attachment where more detailed information about the mandatory requirement can be found. The expected attachment is identified for Vendor convenience.	Response Templates
	Section and Page Reference	Vendor is expected to provide a reference to the appropriate section and page number within the specified attachment where more detailed information about the mandatory requirement can be found.	N/A

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR001	The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	5
MR002	The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.	Capitation Rate	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	6
MR003	The Vendor must have all requirements operational, as agreed upon with the Department, by January 1, 2020.	Implementation	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	6
MR004	The Vendor must comply with W.Va. Code §9-5-27 requirements, including, but not limited to, reporting; establishing a voluntary advisory group of foster, adoptive, and kinship parents; and maintaining a primary workplace in the State where at least 80% of the full-time equivalent positions are located.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	7
MR005	The Vendor must adhere to the case management decisions of the Department caseworker, multidisciplinary team (MDT), or court, but must document and provide all recommendations for case management, as appropriate.	Care Coordination	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	8
MR006	The Vendor must comply with requirements for qualified residential treatment program (QRTP) placements as described in the Service Provider Agreement (SPA).	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	9
MR007	The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.	Network Standards	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	9
MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).	Accreditation	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	10
MR009	The Vendor must provide all requested supporting documentation upon notification of award, or a later date as specified by the Department, according to the requirements described in Appendix 5: List of Requested Documents.	Readiness Review	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	11

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR010	The Vendor must provide evidence of efforts to contract with all currently enrolled providers under the Department's fee-for-service (FFS) Medicaid program.	Network Standards	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	12
MR011	The Vendor must credential and re-credential new physical health and behavioral health providers in accordance with federal and State requirements, as defined by the Department.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	12
MR012	The Vendor must ensure compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements for applicable members, as outlined in the Service Provider Agreement (SPA).	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	13
MR013	The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	14
MR014	The Vendor must provide 24-hour access to a provider or service in emergency situations.	Access to Care	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	15
MR015	The Vendor must, based on Department provider access to care requirements, ensure access to the full range of specialty and facility service providers for members in applicable populations with complex needs.	Access to Care	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	16
MR016	The Vendor must ensure that individuals in applicable populations who have specialists as primary care providers (PCPs) are receiving primary care services on an ongoing basis.	Benefit Administration	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	16
MR017	The Vendor must monitor primary care provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) limit of Medicaid members assigned per PCP, for applicable populations.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	17
MR018	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).	Network Standards	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	17
MR019	The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	18

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR020	The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.	Data Retention and Accessibility	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	18
MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	QU005	19
MR022	The Vendor must participate in public meetings and other events at the request of the Department.	Stakeholder Engagement	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	20
MR023	The Vendor must meet with the Department and industry-specific provider councils on a monthly basis during the first year of implementation, as requested by the Department.	Stakeholder Engagement	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	21
MR024	The Vendor must meet with the Department and industry-specific provider councils on a quarterly basis after the first year of implementation, as requested by the Department.	Stakeholder Engagement	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	21
MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.	External Quality Reviews	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	22
MR026	The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.	Orals	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	23
MR027	The Vendor must provide all requested information prior to and participate in a readiness review, which will be defined by the Department, prior to implementation.	Readiness Review	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	23
MR028	The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following link: http://www.wvdhhr.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx	Security	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	23
MR029	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.	Compatibility	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	23

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR030	The Vendor must provide a plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.	Security	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	24
MR031	The Vendor must comply with applicable State and federal law regarding confidentiality/privacy, including, but not limited to, the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act; the information safeguarding requirements of Title 42, Part 431 (Safeguarding Information on Applicants and Beneficiaries), Subpart F (42 CFR 431 F); and Title 45, Parts 160 (General Administrative Requirements), 162 (Federal Information Security Management Act [FISMA]), and 164 (Security and Privacy), to the extent they apply.	Security	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	24
MR032	The Vendor must agree to incorporate all requirements mandated through federal and State regulations and legislation, which will include, but not be limited to, new reporting requirements.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	25
MR033	The Vendor must provide compliance support services to include, but not be limited to, providing up-to-date, accurate, and thorough documentation and reporting for regulatory and State compliance auditing.	Audit Compliance	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	26
MR034	The Vendor must ensure that all applications inclusive of internet, intranet, and extranet applications associated with this contract are compliant with Section 508 of the Rehabilitation Act of 1973, as amended by 29 United States Code (USC) §794d, and 36 Code of Federal Regulation (CFR) 1194.21 and 36 CFR 1194.22.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	27
MR035	The Vendor must ensure that data entered, maintained, or generated to meet the requirements of this Request for Proposal (RFP) are retained and/or accessible according to the federal requirements in 45 Code of Federal Regulations (CFR) Part 75 and/or applicable State and/or federal requirements.	Data Retention and Accessibility	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	28

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR036	The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	28
MR037	The Vendor must employ Key Staff assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within 30 calendar days of the contract award.	Staffing	Will Meet	Attachment C - Project Organization and Staffing	Table C.1-1	29
MR038	The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	29
MR039	The Vendor must replace key staff within 30 business days after the position is vacant, unless a longer period is approved by the Department.	Staffing	Will Meet	Attachment C - Project Organization and Staffing	Replacing Key Staff	30
MR040	The Department has an interest in ensuring that its operations are carried out in an efficient, professional, legal, and secure manner. The Vendor must remove any staff involved in the project, if the Department determines that any such staff has interfered or may interfere with the Department's interests identified above.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	30
MR041	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with Vendor on the project.	Staffing	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	31
MR042	The Vendor must have controls in place to ensure that unauthorized staff and other users do not have the capability to access, edit, or share personal information data. Personal information data includes, but is not limited to, Protected Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), and Social Security Administration (SSA) data (including, but not limited to, family, friends, and acquaintance information).	Security	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	32

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR043	The Vendor must ensure that all project staff have completed a Department Office of Management Systems (OMIS) Vendor Employee Confidentiality Statement (VECS) before beginning work on the project.	Security	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	33
MR044	The Vendor must comply with Federal Executive Order 11246 related to Equal Employment Opportunity, the Clean Air Act, and the Clean Water Act.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	33
MR045	The Vendor must provide a drug free workplace for employees and all applicable agents, including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	33
MR046	The Vendor must designate one named individual in its proposal as the Vendor Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance officer.	Security	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	34
MR047	The Vendor must not publish or copyright any data using the Department's name without prior written approval by the Department for every instance. In this context, "data" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to: all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder. Except with respect to any commercial software, the Department will be and remain the owner of all data provided to the Department by the Vendor or its agents, subcontractors, or representatives pursuant to the contract other than the Vendor's internal administrative procedure records.	Publication and Copyright of State Data	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	34

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR048	The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.	Cost of Maintaining Access to State Systems	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	34
MR049	The Vendor must make available to the Department the results of any third-party audit conducted, including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.	Audit Compliance	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	35
MR050	The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.	CMS RFP Checklist	Will Meet	Attachment D - Mandatory Requirements	Attachment D: Mandatory Requirements	35

Vendor's Responses to Mandatory Requirements

Vendors should not edit this worksheet.

Vendor Response - Disposition	
Vendor's Disposition	Description
Will Meet	Mandatory requirement will be met by the Vendor.
Will Not Meet	Mandatory requirement will not be met by the Vendor.

Response Templates	
Response Template	Description
Attachment A	Cost Proposal
Attachment B	Vendor Qualifications and Experience
Attachment C	Project Organization and Staffing
Attachment D	Mandatory Requirements
Attachment E	Detailed Specifications Approach
Attachment F	Sample Case Scenario
Attachment G	Terms and Conditions Response Template

ATTACHMENT E: DETAILED SPECIFICATIONS APPROACH

1. BENEFIT ADMINISTRATION

The Vendor should refer to the relevant specifications located in **Appendix 1: Detailed Specifications** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in **Section 4: Project Specifications** in this RFP, and then describe its approach to Benefit Administration below.

BA001	The Vendor should establish and implement authorization criteria for socially necessary services (SNS).	The Vendor should provide proposed authorization criteria for these services.
BA002	The Vendor should establish and implement a process for providers to request authorization for socially necessary services (SNS).	The Vendor should describe the provider authorization request process for these services.
BA003	The Vendor should establish and implement a process to review authorization requests for socially necessary services (SNS).	The Vendor should describe the provider authorization request process for these services.
BA004	The Vendor should apply utilization management guidelines to retroactively review socially necessary services (SNS).	The Vendor should describe its process to retroactively review socially necessary services (SNS).
BA005	The Vendor should coordinate socially necessary services (SNS) for the member and/or their family.	The Vendor should describe in detail the process to coordinate these services for the member and/or their family.
BA006	The Vendor should verify the most appropriate provider of socially necessary services (SNS) Is used to meet the member's needs.	The Vendor should describe both the verification process and how the Vendor proposes to define "most appropriate" for the purposes of verification.
BA007	The Vendor should support the Department caseworker in the development of the member individualized service plan (ISP).	The Vendor should describe the procedures and protocols for how will meet this specification.
BA008	The vendor should use family service plan (FSP) and individualized service plan (ISP) information, as applicable from the Department caseworker, to authorize socially necessary services (SNS).	The Vendor should describe the procedures and protocols for using the family service plan (FSP) and individualized service plan (ISP) to authorize socially necessary services (SNS). *Note: Link to additional information: https://dhhr.wv.gov/bcf/Reports/Documents/West%20Virginia%20Child%20and%20Family%20Services%20Plan%20%28CFS%29%202015-2019.pdf*
BA009	The Vendor should establish medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for applicable populations.	The Vendor should demonstrate its understanding of medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, according to the Vendor's experience and the policies, procedures, and

		requirements outlines in the Services Provider Agreement (SPA).
BA010	The Vendor should establish processes specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in all geographic areas, for applicable populations.	1) The Vendor should specify activities that will be performed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and responsible staff/departments. 2) The Vendor should demonstrate its understanding of American Academy of Pediatrics (AAP) EPSDT standards, including, but not limited to, timeframes for a child placed within foster care to receive the initial health assessment and comprehensive EPSDT exam. 3) The Vendor should demonstrate its understanding of the Department Foster Care Child Welfare Policy and the HealthCheck program, including, but not limited to, evaluation timeframes and periodicity schedules. 4) The Vendor should detail how its plan will be accomplished in all geographic areas.
BA011	The Vendor should develop and distribute materials to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for applicable populations.	1) The Vendor should explain what materials it will develop to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. 2) The Vendor should explain how it will emphasize EPSDT services to children receiving primary care from a specialist.
BA012	The Vendor should use reports to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.	The Vendor should describe reports, and other tools if applicable, that will be used to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.
BA013	The Vendor should work with caregivers and families to help track appointments members are scheduled for and may miss without further reminders or assistance.	The Vendor should describe how it will work with caregivers and families to meet this specification.
BA014	The Vendor should assist in rescheduling appointments and removing potential obstacles to care, including, but not limited to, transportation.	1) The Vendor should describe how it will work with caregivers and families to meet this specification. 2) The Vendor should give an example of an obstacle of care and how the Vendor would work to remove it. The Vendor may use

		transportation as this example but is not required to do so.
BA015	The Vendor should develop and review utilization management guidelines for physical health and behavioral health services.	The Vendor should describe its process to develop and revise physical health and behavioral health services utilization management guidelines.
BA016	The Vendor should apply utilization management guidelines to authorize payments or services for physical and behavioral health.	The Vendor should provide proposed physical and behavioral health utilization management guidelines that reflect an understanding of this contract's population, services, and stakeholders.
BA017	The Vendor should apply utilization management guidelines to retroactively review payments or services for physical and behavioral health.	The Vendor should describe its process to retroactively review payments or services for physical and behavioral health.
BA018	The Vendor should help expedite the submission and return of service authorization data from providers.	The Vendor should describe its process to help expedite the submission and return of service authorization data.
BA019	The Vendor should leverage a utilization management system with the ability to include text fields, including, but not limited to, the following:	The Vendor should: 1) Describe the system it would leverage for utilization management services. 2) Describe that system's ability to include the requested text fields.
BA020	Clinical notes	See the parent specification.
BA021	Inpatient request	See the parent specification.
BA022	Review Criteria	See the parent specification.
BA023	Case history	See the parent specification.
BA024	The Vendor should leverage a utilization management system with the ability to support claims payment for physical and behavioral health services by interfacing with other Vendor systems, as applicable, and Department enterprise systems, including, but not limited to, the following:	The Vendor should: 1) Describe its utilization management system's ability to support claims payment for physical and behavioral health services. 2) Identify necessary interfaces.
BA025	Medicaid Management Information System (MMIS)	See the parent specification.
BA026	Call Center	See the parent specification.
BA027	The Vendor should leverage a utilization management system with the ability to support inbound member and provider inquiries by interfacing with other Vendor systems, as applicable, and Department enterprise systems, Including, but not limited to, the following:	The Vendor should: 1) Describe its utilization management system's ability to support inbound member and provider inquiries. 2) Identify necessary interfaces.

BA028	Medicaid Management Information System (MMIS)	See the parent specification.
BA029	Call Center	See the parent specification.
BA030	The Vendor should establish interface(s) and conduct testing that meets all Department-specified interface requirements, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
BA031	Medicaid Management Information System (MMIS)	See the parent specification.
BA032	Families and Children Tracking System (FACTS)	See the parent specification.
BA033	Integrated Eligibility Solution (IES), when applicable	See the parent specification.
BA034	The Vendor should leverage a system with the ability to maintain case history.	The Vendor should describe how it will meet this specification.
BA035	The Vendor should establish utilization management processes for members, including, but not limited to, the following:	The Vendor should describe how its utilization management processes support members, both for the processes listed and any other processes the Vendor identifies as supporting members.
BA036	Medical necessity review	See the parent specification.
BA037	Social necessity review	See the parent specification.
BA038	Approvals	See the parent specification.
BA039	Denials	See the parent specification.
BA040	The Vendor should operate utilization management monitoring activities m conjunction with fraud and abuse detection activities.	The Vendor should describe how it will meet this specification.
BA041	The Vendor should prevent and detect fraud and abuse related to pharmacy services.	The Vendor should describe how it will meet this specification, if the Department chooses to carve in pharmacy services at a later date.
BA042	The Vendor should modify its standard utilization management protocols when reviewing referral and treatment requests for members with special healthcare needs, including, but not limited to, the following:	The Vendor should: 1) Identify factors that may require modification of its standard utilization management protocols. 2) Give at least one example of each factor and describe how the standard protocols would be changed as a result.
BA043	Standing referrals	See the parent specification.
BA044	Expedited utilization review processes	See the parent specification.
BA045	The Vendor should establish condition-specific protocols or standards that will be used to manage members with special healthcare needs.	The Vendor should describe how it will meet this specification.

BA046	The Vendor should update and share condition-specific protocols or standards with primary and specialty care providers.	The Vendor should describe how it will meet this specification.
BA047	The Vendor should establish, implement, and update guidelines for the services or types of services that require prior authorization (PA) by the Vendor.	The Vendor should list the services or types of services that require prior authorization by the Vendor.
BA048	The Vendor should establish, implement, and update guidelines for the services or types of services that can be approved by the member's primary care provider (PCP) for physical and behavioral health services.	The Vendor should list the services or types of services that can be approved by the member's primary care provider (PCP).
BA049	The Vendor should establish, implement, and update guidelines for the services or types of services to which the member can self-refer.	The Vendor should list the services or types of services to which the member can self-refer.
BA050	The Vendor should establish and implement a required length of time for providers to request prior authorizations (PAs) for services.	1) The Vendor should provide its proposed required length of time for providers to request prior authorizations (PAs) for services. 2) If this varies by service or circumstance, the Vendor should provide the applicable length of time for each service/situation.
BA051	The Vendor should establish and implement levels of authority for prior authorizations (PAs).	The Vendor should provide its proposed levels of authority for prior authorizations (PAs).
BA052	The Vendor should provide prior authorization (PA) approval/denial letters to members, providers, and caseworkers, as appropriate.	1) The Vendor should explain which elements would be included in prior authorization (PA) approval/denial letters to members, providers, and caseworkers, and how the Vendor would define "as appropriate." 2) The Vendor should provide sample letter(s).
BA053	The Vendor should develop and use clinical guidelines for prior authorizations (PAs) for physical and behavioral health services.	1) The Vendor should provide proposed clinical guidelines for physical and behavioral health services. 2) The Vendor should describe how it develops and uses guidelines. 3) The Vendor should provide a specific example that follows a prior authorization (PA) through the process.
BA054	The Vendor should honor medical, behavioral health, pharmacy, and social necessary services (SNS) authorization	The Vendor should describe how it will meet this specification.

	approvals from previous coverage during the transition period.	
BA055	The Vendor should notify providers and/or members regarding expiration of existing medical, pharmacy, and socially necessary services (SNS) authorizations.	The Vendor should describe how it will meet this specification.
BA056	The Vendor should authorize out-of-network services, including, but not limited to, the following:	The Vendor should describe how it will meet these specifications.
BA057	Emergency situations	See the parent specification.
BA058	Non-emergency situations, including, but not limited to, both medically necessary and non-medically-necessary services	See the parent specification.
BA059	The Vendor should grant members a standing referral to a specialist provider according to guidelines that the Vendor develops and the Department approves, including but not limited to, the duration and/or number of visits usually granted or maximally allowed.	1) The Vendor should describe the circumstances under which a member might be granted a standing referral to a specialist provider. 2) The Vendor should propose durations and/or number of visits usually granted or maximally allowed.
BA060	The Vendor should develop and implement physical health and behavioral health guidelines for the extent to which a specialist provider may:	The Vendor should provide proposed guidelines.
BA061	Admit patients for inpatient care	See the parent specification.
BA062	Choose the hospital of admission	See the parent specification.
BA063	Determine that the patient must remain hospitalized	See the parent specification.
BA064	Schedule or provide ancillary services, such as laboratory testing	See the parent specification.
BA065	Refer patients to sub-specialists or other providers	See the parent specification.
BA066	The Vendor should refer members to out-of-network providers using guidelines that the Vendor develops and the Department approves.	The Vendor should describe circumstances in which members might be referred to out-of-network providers.
BA067	The Vendor should establish and Implement a process through which members and/or providers can request out-of-network referrals.	The Vendor should describe the process for members and/or providers to request out-of-network referrals.
BA068	The Vendor should ensure that information from non-network providers is shared with the member's primary care provider (PCP).	The Vendor should explain the procedures for ensuring that information from non-network providers is shared with the member's primary care provider (PCP).

BA069	The Vendor should review and process medical referrals according to guidelines that the Vendor develops and the Department approves.	The Vendor should: 1) Provide proposed timeframes for reviewing and processing medical referrals. 2) Describe the average duration of medical referrals.
BA070	The Vendor should develop and implement guidelines under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the Vendor's network) If it is considered to be in the best medical Interest of the member, as determined by the member's primary care provider (PCP) and/or the Medical Director.	The Vendor should: 1) Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the managed care organization's (MCO's) network) if it considered to be in the best medical interest of the member. 2) Specify how long it will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days.
BA071	The Vendor should perform ongoing monitoring of emergency room (ER) usage.	The Vendor should separately describe ongoing monitoring of emergency room (ER) usage.
BA072	The Vendor should apply the "prudent layperson" standard for all emergency room (ER) visits.	The Vendor should explain: 1) Application of the "prudent layperson" standard for all emergency room (ER) visits. 2) If it would not require prior authorization (PA) for screening and stabilization of members.
BA073	The Vendor should transition the member from an out-of- network provider to an appropriate in-network provider if the member is currently seeing a provider that does not participate in the network.	The Vendor should: 1) Describe the process by which the Vendor will work to meet these specifications. 2) Explain how the Vendor would propose to define an "appropriate" in-network provider.
BA074	The Vendor should assist in transferring necessary clinical information to the foster care member's new in-network physical health or behavioral health provider.	The Vendor should describe how it will meet this specification.
BA075	The Vendor should inform members of their choices in Family Planning services, for applicable populations.	The Vendor should describe how it will meet this specification.
BA076	The Vendor should facilitate timely payment for Family Planning services for In-network and out-of-network providers, for applicable populations.	The Vendor should describe how it will meet this specification.

BA077	The Vendor should identify pregnant members at enrollment and on an ongoing basis.	The Vendor should describe the mechanisms it will employ to identify pregnant women, both at enrollment and on an ongoing basis.
BA078	The Vendor should promote "early and often" prenatal care for members who are identified as being pregnant, for applicable populations.	The Vendor should describe how it will meet this specification.
BA079	The Vendor should identify individuals with complex or serious medical conditions on an ongoing basis, for applicable populations.	The Vendor should describe how it will meet this specification.
BA080	The Vendor should use information systems to identify members with special needs.	The Vendor should describe how it will meet this specification.
BA081	The Vendor should use Information systems to isolate data specific to eligibility category or diagnosis.	The Vendor should describe how it will meet this specification.
BA082	The Vendor should ensure timely access to crisis stabilization services.	1) The Vendor should indicate if crisis stabilization services are subject to medical necessity review criteria. If so, the Vendor should describe how it will ensure timely access to these services and state what it considers as timely access to such services. 2) The Vendor should address an approach to these services when they are provided out of network.
BA083	The Vendor should manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.	The Vendor should describe how it will meet this specification, if the Department chooses to carve in pharmacy services at a later date.
BA084	The Vendor should develop and Implement prescription limits, including, but not limited to, limitations on brand name and generic prescriptions.	1) The Vendor should describe how it would meet this specification, if pharmacy benefits are carved in at a future date. 2) If applicable, the Vendor should provide the policies and procedures for how limits would be managed and how cases of medical necessity would be handled.
BA085	The Vendor should identify and manage polypharmacy utilization.	The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date.
BA086	The Vendor should monitor potential abuse or inappropriate utilization of controlled prescription medications.	The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date.
BA087	The Vendor should manage members with a history of prescription drug abuse, including, but not limited to, lock-in.	1) The Vendor should describe how it would meet this specification, if pharmacy benefits are carved in at a future date.

		2) The Vendor should escribe any data that would be needed from the Department to facilitate this transaction.
BA088	The Vendor should ensure that primary care providers (PCPs) maintain information shared by behavioral health providers as to the outcome including, but not limited to, in a patient's medical record.	The Vendor should describe the process for how it will meet this application.
BA089	The Vendor should inform primary care providers (PCPs) about changes In a member's behavioral health, including, but not limited to:	The Vendor should: 1) Describe how it will meet this specification. 2) Explain how it proposes to define what constitutes a change in behavioral health status.
BA090	Hospitalization	See the parent specification.
BA091	Emergency room (ER) usage	See the parent specification.
BA092	Change of medication	See the parent specification.
BA093	The Vendor should assist members in accessing additional services as a result of change in behavioral health status, including, but not limited to, the care coordinator's assistance in making appointments for members.	The Vendor should describe how it will meet this specification.
BA094	The Vendor should provide dental services for individuals under 21 years of age as covered services in an amount, duration, and scope to achieve the purpose for which the services are furnished, for applicable populations.	The Vendor should describe how it will meet this specification.
BA095	The Vendor should remind members of upcoming initial and periodic dental screenings, for applicable populations.	The Vendor should describe the mechanisms it will use to meet this specification.
BA096	The Vendor should make arrangements with inpatient and outpatient facilities for the provision of dental services to members with special needs, for applicable populations.	The Vendor should describe the arrangements it will make to meet this specification.
BA097	The Vendor should monitor dental screening utilization on an ongoing basis, for applicable populations.	The Vendor should describe the process and mechanisms it will use to meet this specification.
BA098	The Vendor should intervene if a member has not had a dental screening in over one year, for applicable populations.	The Vendor should describe how it will meet this specification.

UM and Coordination of Services Guidelines

Utilization management (UM) is a key component of UniCare Health Plan of West Virginia, Inc.'s (UniCare's) successfully integrated Fostering Healthy Lives model. Our approach to UM will assure that members receive timely, appropriate care through individualized, innovative programs and coordination of services and community resources.

Our UM program is guided by a written UM Program Description, as well as nationally recognized medical policy and clinical guidelines. ***The UM program features a local perspective based on 16 years of experience serving West Virginia's Medicaid population.*** We follow an evidence-based hierarchy of established medical necessity criteria, supported by policies and procedures when applying medical necessity criteria to service authorization requests based on individual member needs. UniCare makes sure that decisions with respect to UM, member education, coverage of services, and other areas to which the guidelines are applicable are consistent with our UM and clinical guidelines.



Our Fostering Healthy Lives UM Clinicians will work closely with Care Coordinators to make sure members receive needed services in relation to their care planning. Care Coordinators will support families and help identify and prioritize their service needs based on articulated goals and results of our screening and assessments as well as provider assessment information, physical health (PH), behavioral health (BH), and social determinants of health (SDOH) data. Working with the member and caregiver in collaboration with the Department caseworker and treating providers, the Care Coordinator will identify the Medicaid-covered services, social necessary services (SNS), community-based supports, and our Value-Added Services (VAS) that can meet the member's holistic needs.

Anonymous UniCare Associate

Paige has been in foster care for over a year because her biological parents are not fit to care for her, and the family member that had custody of her became very ill and unable to care for her. She has been in different homes and shelter placements over the last 12 months. I met Paige while I was volunteering at one of the shelters. We instantly grew a bond and I continued to look for her each time I visited. In May, UniCare sponsored a baseball game and gave tickets for the game to the shelter residents. I was able to spend time with Paige at the game and introduce her to my husband and kids.

That weekend, we decided we needed to do more as a family to help Paige. I contacted her social workers and was approved to be her mentor. We have talked on the phone every day since, and have formed a wonderful friendship. My husband and I have started the process of fostering Paige. We have filled out the application and are waiting for the home visits and to take the classes. We plan to have everything completed so that once Paige gets out of the long term program, she will be ready to come home with us.

I have never fostered before, so this process is new to me. But, it has always been a burden on my heart. One of my biggest worries about Paige is getting her the continued therapy she will need. Excellent healthcare is absolutely necessary and I want to make sure she has the right coverage and tools needed to stay healthy and thrive through the transition and in the future. Knowing that my company, UniCare, is so involved eases my mind as we enter this journey. I know that I will have support outside of work as well as support and resources every day in my office. Knowing first-hand that our company is kind, caring, and equipped to lessen the burden on the children and families currently in state custody helps lighten the load. Paige is just one of MANY kids in our state in this situation. **I may be able to personally help only one, but all of us working together can make a huge impact. Paige is MY WHY.**

WV_FC2019_MyWhy_Anonymous_COB_1

UM and Clinical Guidelines (BA015 and BA053)

Our NCQA- and Managed Behavioral Healthcare Organization (MBHO)- accredited UM program is guided by West Virginia-specific policy and nationally recognized medical policy and clinical guidelines, including:

- Milliman® Care Guidelines (MCG) (including levels of care for residential services)
- American Society of Addiction Medicine (ASAM®) criteria for substance use Disorder (SUD) services
- CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver
- State and federal standards for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

We also use West Virginia policies and guidelines, including Chapter 503 Licensed Behavioral Health Center Services for crisis stabilization. We will leverage these listed clinical utilization guidelines for management of members in the Specialized Managed Care for Children and Youth Program (the Program). In addition, we will leverage Department of Health and Human Resources' (DHHR's) SNS UM Manual during the first year of the Contract. After this time, we will develop and leverage guidelines informed by the state manual for SNS criteria that will inform guidelines specifically developed for SNS. We will use SNS guidelines to expeditiously connect youth and children and their caregivers and/or Authorized Representatives with appropriate SNS that reflect the needs and preferences of the member and their caregivers to promote stability and strengthen families.

When necessary, we will adapt guidelines to align all requirements established by DHHR for administering covered Medicaid benefits, including State and federal EPSDT standards. UniCare will confirm with DHHR that our UM program assures fee-for-service (FFS) and Managed Care are aligned under Federal Mental Health Parity, as required by federal regulations.

UniCare also adopts nationally recognized clinical guidelines from organizations such as the American Academy of Family Physicians (AAFP), the AAP, American Academy of Child and Adolescent Psychiatry, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the United States Preventive Services Task Force (USPSTF). These guidelines keep us and providers informed about scientific advances, support consistent delivery of care, and positively impact health outcomes. Clinical guidelines support our prior authorization (PA) requirements, and also serve as a resource to help providers identify where to send patients who are positively screened and need additional clinical intervention. Guidelines also help providers identify supports and services that may be offered in the community and be of benefit to the child or youth.

Our current comprehensive portfolio of evidence-based clinical guidelines span more than 43 conditions and diseases, including diabetes and the following pediatric/adolescent clinical guidelines:

- Autism
- Hypertension in children and adolescents
- Celiac disease
- Obesity
- ADHD
- Depression
- Oppositional defiant disorder
- Substance use disorder

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We will support providers with the tools to care for children and youth who may have been exposed to Adverse Childhood Experiences (ACEs), resulting in early stress and trauma, and who may require specialized care coordination to address their complex needs. In addition to the current applicable clinical guidelines, we will support providers offering services to our child welfare members by incorporating additional guidelines and adding these to ongoing provider training and education programs. These guidelines will include but are not limited to trauma-fcused care, high fidelity wraparound practices, ACEs, parent-child interactive therapy (PCIT), and trauma-focused cognitive behavioral therapy (TF-CBT).

Both the MCG and ASAM guidelines are proprietary and are used via licensure directly from the entities. Since these guidelines are proprietary in nature, adding full guidelines to the response is precluded by strict licensure agreements. We have attached overview documents of the MCG as well as a listing that indicates the specific guidelines we have modified in partnership with MCG to customize these guidelines to meet the needs of the members we serve, in Supplemental Document E.1-3. State guidelines we have used are not attached because they are directly accessible from the State site. As we continue to work with DHHR on developing the SNS guidelines, we will make sure these guidelines are on websites and available to members and providers.

Approach to Development, Review, and Revision of Guidelines

Our UM policies and clinical guidelines are based on the national criteria adopted by our ultimate parent company, Anthem Inc.'s, Medical Policy and Technology Assessment Committee (MPTAC). UniCare's Medical Director, Dr. Tracy Dlott, is the liaison for MPTAC, a multidisciplinary group that includes network physicians from various specialties, clinical practices, and geographies including physicians from West Virginia. Our UM policies and clinical guidelines, endorsed by the MPTAC, include a comprehensive range of level of care alternatives sensitive to the differing needs of youth and children, and are based on valid and reliable medical evidence from professional organizations and up-to-date clinical research.

These endorsed policies and clinical guidelines will undergo a rigorous review process to assure appropriateness in administering Program benefits for all covered services, and alignment with the Families First Prevention Services Act, as applicable. UniCare Medical Directors will review the clinical practice guidelines, and adopt based on the health care needs of Program members and identified opportunities for improvement.



Our Medical Director oversees the development and review of all UM and medical policies and clinical guidelines. Local providers on our Medical Advisory Committee (MAC) review, provide input, and approve the criteria before use. The MAC, led by Dr. Dlott and comprised of local physicians and a psychiatrist, will bring knowledge and perspective of the local delivery system to help us make sure our UM criteria, including levels of care, is appropriate and will meet the needs of Program members. ***To make sure that we are responsive to the unique needs of this Program's population, we will also adjust the types of providers participating in our MAC as appropriate and include other provider types, such as SNS providers.*** The role of our MAC is further discussed in our response to BA046.

Our adopted medical policies and clinical guidelines become an essential tool in our network providers' toolkits that helps to define the most appropriate treatment and setting and assure consistency of care for all our members. In the review of medical policies and clinical guidelines through our MAC, we gather and listen to feedback from network providers to make sure our UM criteria is clinically strong while also taking into account individual member needs and clinical and environmental factors.

We review and update UM clinical guidelines and practices at least semi-annually and more often when State requirements or utilization trends require revisions. Through a formal scheduled process, MPTAC reviews for development of medical necessity, clinical indications for new medical services, technology or procedures, or new uses of existing services, technology, or procedures. Clinical guidelines and UM processes are adjusted accordingly.

UM and Clinical Guidelines Support Service Authorization (BA053)

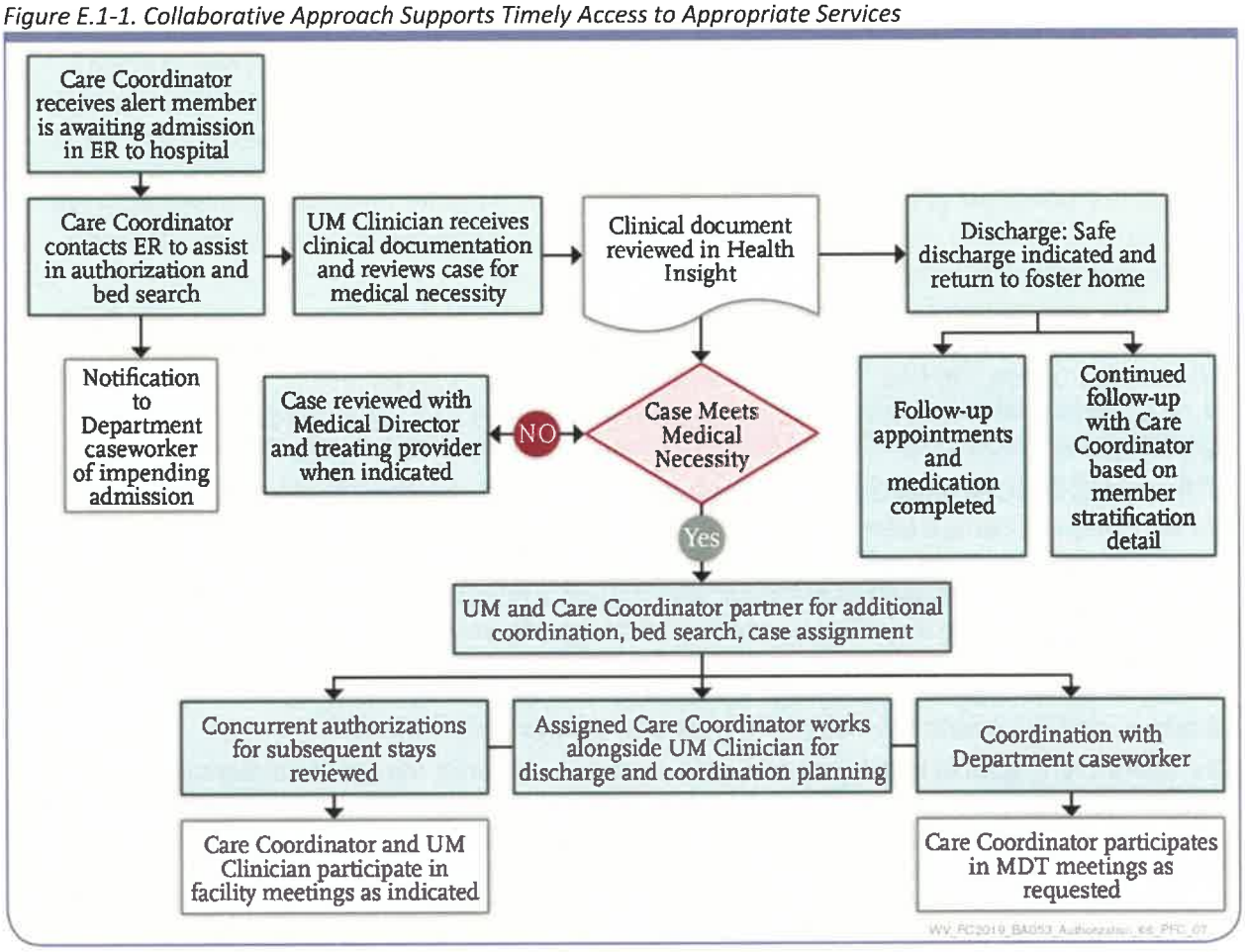
We will apply our current best practice medical policies and clinical guidelines to provide a rules-based system for screening PH, BH, and SUD services for the Program. Our policies and clinical guidelines are objective, evidence-based, and include a comprehensive range of level of care alternatives sensitive to the differing needs of children and youth. We match the level of care to the member's current condition, considering individual member needs and circumstances, the severity of illness, treatment progress, comorbidities, home environment, episode-specific variables, and the characteristics of the local delivery system.

Our overarching goal is to view members in a person-centered manner to make sure they receive the ***right services, at the right time, in the right place.*** We know that children in the child welfare system often have complex health and social support needs, including significant PH, BH, and SUD needs, all of which may be compounded by exposure to trauma and ACEs. Together our UM and care coordination team will work to make sure that we respond to the unique needs and situation of each member through incorporating the clinical, psychosocial, and SDOH information into the review process. We consider members' home environments, family and caregiver supports and resources, cultural and linguistic needs, social circumstances, characteristics of the local health care system, and court orders in making medical necessity decisions.

This collaborative process assures that we consider whole-person care when completing authorization reviews. UM Clinicians will also identify and address each members' unique needs, strengths, and goals in consultation with the member and their caregiver, and the members' treating providers and assigned Care Coordinator. UM Clinicians coordinate and authorize services, facilitate discharge planning, and in collaboration with the Care Coordination team, follows the member through treatment. Daily integrated (PH and BH) rounds include discussion of the member's treatment in addition to staffing for placement and pending transitions, and identifying supports to promote safe discharge and transitions of care. This coordinated approach assures members receive the ***care to holistically address their health needs***.

Our approach to PA and concurrent review for covered services promotes appropriate care to our members through reinforcement of the applicable evidence-based clinical guidelines. We use clinical guidelines for PAs as a tool to be applied judiciously and selectively to procedures that have demonstrated significant variability in utilization both locally and nationally, as well as excessive utilization in lieu of more appropriate approaches, in addition to other considerations. Figure E.1-1 provides a specific authorization example that illustrates our PA process.

Figure E.1-1. Collaborative Approach Supports Timely Access to Appropriate Services



UM Processes Support Member Access to Services (BA035, BA036, BA037, BA038, and BA039)

Our UM program uses a person-centered approach, combined with evidence-based clinical guidelines, to facilitate appropriate and timely access to quality services for our members. Each review is customized to individual members and focused on determining the appropriate level and site of services based on their specific situations and benefits. Integration of our UM and care coordination teams as well as our clinical system Health Insight will reinforce our comprehensive approach to providing for member health needs and allows for regular communication and coordination between both functions to better support person-centered care planning. This comprehensive approach will also prevent further trauma by assuring our members and caregivers receive the right care and supports in the right intensity that promote our members' safety, well-being, permanency, and quality of life — overarching goals that result from the members' progress in meeting their individual goals.

To facilitate members' care and streamline provider processes, we provide and post listings of the services requiring PA. These are outlined in our response to BA047. We focus our PA efforts on inpatient admissions, outpatient surgeries and procedures, out-of-network services, home care, durable medical equipment, rehabilitation services, select medications, diagnostic procedures, and SNS as required by DHHR. We disseminate changes in authorization requirements by posting on member websites, updating the member handbook, and updating providers through the provider portal, provider handbooks, and sending out provider notices. We are evaluating opportunities to support members through simplifying our UM processes, and we will make sure that our processes support continuity of care for our members and continue to be in compliance with Service Provider Agreement (SPA), Article III, Section 6.4.1.

Flexible and Collaborative Processes Help Us Meet Member Needs



We recognize our members' needs may change frequently, our workflow, policies, and processes are designed for timely UM decisions that support their needs and accommodate the clinical urgency and necessity of any situation for members. While authorization requests may typically begin with a treating provider, we also accept authorization requests directly from our members and caregivers. UniCare has a "no wrong door" policy for accepting authorization requests; we receive authorization requests via telephone, facsimile, and our provider portal.

Our UM Clinicians are available 24/7 to assist members and caregivers and their providers with urgent or emergent requests. UM Clinicians will integrate information gathered by Care Coordinators to further support the clinical information received from providers by UM Clinicians as well as help incorporate a trauma-informed approach to service-level decisions. Working collaboratively helps to assure members receive needed services in relation to their individualized Care Plan goals. Each Care Coordinator has in-depth knowledge of how their member and UM decisions are integrated and supported by the care coordination process.

Consideration of Complex Variables in Applying UM Criteria

We always consider multiple factors in authorizing services. Because every member will be assigned a Care Coordinator with the expertise most closely aligned with their needs and conditions and who has close and continual contact with the member, caregiver, Authorized Representative, and child welfare workers as applicable, we will be positioned to know immediately when our members have complex service needs or are admitted to a higher level of care. By working together with facility staff and the care team, our Care Coordinators will have direct knowledge of the treatment provided while the member is admitted as well as near real-time information as the member stabilizes.

Our interdisciplinary approach will provide Care Coordinators access to multiple avenues of expertise in addressing the needs of the child, including UM. Care Coordinators can add details to the clinical information received from providers by UM Clinicians as well as help incorporate a trauma-informed approach to service-level decisions. UM Clinicians, as well as UniCare employees who will be working with the Fostering Healthy Lives model, will be trained in TIC, ACEs, PCIT, and TF-CBT. Our approach to employee training is discussed in more detail in our response to MS033.



In particular, when we receive requests for BH inpatient services, we consider suicidal risk or danger to others, presence of acute psychotic symptoms, level of functional impairment, self-injury, or uncontrolled risk-taking behaviors. For example, if a member goes to the emergency room (ER) experiencing a BH crisis, the UM Manager will contact the Care Coordinator to confer on the case as soon as UM is notified. The Care Coordinator contacts the hospital representative to identify the best placement option, and works alongside the Department

caseworker to engage with the caregiver and/or Authorized Representative to give them their name and contact information to begin transitioning the child to the best care setting.

Medical Necessity Review Process (BA036)

Our goal is to be a clinical resource, not a roadblock to accessing medically necessary services and supports. Our medical necessity review process assures that each request is reviewed on a case-by-case basis, considering the specific needs of each member at the time of the request. Our dedicated team of UM Clinicians will review the request in a manner that is most expedited for the needs of the member, and within the required time frame for the request type (standard or expedited). UM Clinicians will also check whether the service is a covered benefit or subject to any limitations or exclusions. UM Clinicians will work closely with the care coordination staff and providers to obtain minimum necessary clinical information to support quality and informed decision-making and confirm that decisions consider all member needs and unique circumstances. As UM Clinicians review the request and information, they will have access to our decision support system that includes medical necessity criteria. If the requested service is not a covered benefit, or if limitations or exclusions apply, the UM Clinician will determine whether it should include review for medical necessity EPSDT requirements.

Guidelines Incorporate Non-medical Factors

We also account for non-medical factors through our knowledgeable and trained Care Coordinators who have the expertise and compassion to collaborate with our members and their multidisciplinary treatment teams (MDT) to do what is right and in the member's best interest — in a manner that addresses the member's whole health needs in the safest and least restrictive setting. We see these situations as an opportunity to address and prevent recurring inappropriate utilization of medical resources and improve our delivery approach by applying what we learn to our practices, processes, and systems for the following:

- Adhering to evidence-based best practices for early engagement, care coordination, health care service planning, safety crisis contingency planning, discharge planning, medical necessity determinations, and monitoring for gaps in care and member goal-achievement and progress
- Enhancing or developing traditional and non-traditional community-based services, supports, and resources such as peer and family support
- Collaborating with our State partners to improve early engagement, intervention, and communication
- Improving timely sharing of information through our robust Health Insight platform, our care management system, that supports provider access to our members' holistic electronic health record that contains information that supports informed decision-making

Thorough Review of Information and Provider Consultation Informs Medical Necessity

When medical necessity is not clear, or when clinical information needed to make a decision has been requested but not received, the UM Clinician may request additional documentation and refer the case to our Medical Director for medical necessity review and determination. In reviewing cases for medical necessity, our Medical Director balances the objective of supporting providers in exercising professional judgement and making informed decisions with the objective of promoting consistent use of evidence-based guidelines that have been established to be the most effective for each member's condition. The Medical Director will review all relevant clinical information, including factors that may require special consideration such as age, comorbidities, complications, progress of treatment, psychosocial issues, home

> In all UM decisions, our staff act as advocates to make sure members and caregivers obtain what they need, when they need it.
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environment, support structure, acute versus chronic condition, or life-threatening illness. Prior to issuing a denial, the Medical Director may offer an opportunity for peer-to-peer consultation to discuss the case and potential care alternatives. If it meets a lower level of care, that care is offered for the member.

UM Processes Support Admission and Discharge Planning

We designed our UM program to reduce the likelihood of avoidable hospital stays and readmissions to facility-based care by initiating discharge planning at admission to services to verify that each member transitions safely to outpatient services. For example, during times of transition, our Care Coordinators will work in collaboration with the Fostering Healthy Lives interdisciplinary care team (ICT) or Intensive Care Management (ICM) team as applicable, including UM, to provide one-on-one member and caregiver support, coaching, and education on strategies for successful transitions. This is especially important during discharge from inpatient to a lower level of care or back into the community, and helps UM Clinicians have a more complete clinical picture when making authorization decisions.

> Our daily processes and workflows integrate UM/care coordination functions to address whole-person care, and our medical necessity review process assures that each request is reviewed on a case-by-case basis, considering the specific needs of each member at the time of the request.

Our goal is to make sure the member is sustained in the most integrated setting and avoids placement disruption or unnecessary ER use (BA071), as well as disruptions or interruptions in their care. Our full transition and discharge process is described in CM011, CM012, and CM013.

Social Necessity Review Process (BA037)

Emphasizing integration, our UM and Care Coordination teams will collaborate to ensure members, their caregivers and/or Authorized Representatives are linked with appropriate SNS that reflect the overall needs of the child or youth and their family. While we will use the State's SNS criteria as a guide to verify that requested services are appropriate, our UM processes prioritize our ability to evaluate and address the holistic needs of the member and their family.

When an SNS authorization request is received, the UM Clinician will alert the member's Care Coordinator who ensures SNS are included into the member's Care Plan and contact the member and caregiver to discuss the SNS, family's goals, provider preferences, and priorities.

Our UM process to coordinate and authorize SNS is discussed in further detail throughout our response to BA001 through BA006 and BA008.

UM Approval and Denial Process (BA038 and BA039)

If the requested service and supporting information meets medical necessity criteria, the UM Clinician will authorize the service in Health Insight and notify the requesting practitioner and Department caseworker in a manner which assures expedited service delivery to the member. UM Clinicians verbally notify the provider and give written notification of the decision to the member, provider, the attending health professional, and hospital of any review decisions. Each type of review request adheres to the requisite time frames specified by DHHR for that request type. All time frames begin with the request for review and end with issuance of the determination.

As described in our response to BA036, the UM Clinician may request additional documentation and, prior to issuing a denial, may offer an opportunity for peer-to-peer consultation with the Medical Director to discuss the case and potential care alternatives. The Medical Director will consider the medical necessity of the service without regard to whether it is a covered benefit or if limitations or exclusions apply such as In Lieu of Services. Where medically appropriate and

cost-effective alternatives to covered services are available, the PA process may approve such ILOS (42 CFR 438.3(e)(2)) as permitted by DHHR. If the service is deemed medically necessary, the Medical Director will notify UM staff, who will notify the provider.

Any adverse determination regarding medical necessity, including a denial or authorization of service in an amount, frequency, and duration less than was requested, will only be made by our Medical Director, who will also offer a peer-to-peer consultation upon a denial to discuss the case and potential treatment or service alternatives. We take advantage of this educational opportunity to reinforce applicable, evidence-based guidelines and appropriate care settings with the provider, and send the provider a copy of the medical policy or clinical guideline for their future reference upon request. The member, practitioner, or hospital may appeal a denial decision.

As part of our appeal procedures, we include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. At the time of any adverse determination or partial adverse determination, we advise the member and provider in writing, detailing the specific reasons for the determination, the factors considered, and any additional information or actions available to the member or provider. Additional information about our PA approval/denial letters is provided in our response to BA052.

Authorization for Physical and Behavioral Health Services (BA016)

Certain procedures and services may require authorization, such as:

- Inpatient admissions
- Outpatient surgeries and procedures
- Out-of-network services
- Home care
- Durable medical equipment
- Rehabilitation services
- Select medications
- Diagnostic procedures

When authorization is required, UniCare provides written notice to the requesting provider and member as expeditiously as required by the member's health condition, no later than seven calendar days of receiving a standard authorization request for service, and no later than two business days for an expedited request. We will only extend these timeframes upon request of the member or provider, or if we justify to DHHR in advance and in writing on our belief that additional information and time will benefit the member. Our response to BA047 provides additional details about our authorization requirements.

Utilization Management Before, During, or After Services

UniCare's UM processes include initial authorizations (as already described in our response to BA036) and concurrent and retrospective reviews (as will be described in BA017).

Application of UM Guidelines

When we receive an authorization request, our UM Clinician enters the clinical information into our integrated Health Insight platform, our care management system, and evaluates the clinical information against appropriate medical necessity guidelines. Health Insight allows for the UM Clinician and the Care Coordinator to have access to the member notes and records and work in tandem to assist the member and coordinate care. The UM Clinician may discuss with the treating provider the services being requested, additional clinical information if needed, clarify services being delivered, and when indicated, may also discuss potential alternatives to the requested services. When the information provided for

We conduct annual Inter-Rater Reliability (IRR) reviews of our clinical teams to verify consistency and accuracy in application of medical necessity criteria. Overall, our UM team scored a total of 95% on the 2018 IRR review. Results are reported to the Medical Directors, UM Committee, Quality Management Committee, and Medical Advisory Committee annually.

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services meets medical necessity, the authorization is completed, documented in our system, and notification is sent to the provider. If criteria are not met for continued services, we will consult our Medical Director. When the service does not meet medical necessity criteria, our Medical Director will contact the provider to discuss necessity for the service and obtain additional information. We provide UM guidelines in Supplemental Document E.1-1.

Concurrent Reviews

We conduct concurrent review for all inpatient and residential services if the provider and member determine that treatment should continue beyond initial authorization. In performing concurrent reviews, UM Clinicians assess individual member progress and needs during treatment and coordinate such needs before discharge to facilitate the member's smooth transition between levels of care or home, and to avoid delays in discharge due to unanticipated care needs. UM Clinicians apply clinical UM guidelines to compare requested services and the member's assessed needs to the established criteria to determine the necessity for the service and continued length of stay.

Retrospective Review (BA017)

We initiate retrospective review when services were provided without obtaining authorization due to circumstances that prevented timely authorization, such as member eligibility or a medical emergency, including a request for coverage of an acute inpatient stay after the member's discharge (our retrospective review process for SNS is discussed in our response to BA004). Initiated by the member or provider, retrospective review assesses the medical necessity of requested care based on UM guidelines.

After services are provided, a received claim with imaged medical records is automatically routed for determination if the service qualifies for retrospective review. The claim and relevant medical record information, such as diagnoses, medical treatment, timeliness of services rendered, and any social/environmental factors that impacted the member's medical condition to make a determination of medical necessity, length of stay, and level of care, are reviewed using our approved Medical Policies and Clinical Review Guidelines. The approved services are documented directly in our claims systems for prompt processing. If the UM Clinician is unable to approve the claim with the information provided, it is routed to a Medical Director for further evaluation of the specific clinical issues.

A provider may also appeal any claim that has been denied for lack of PA if they notify us of one of the following:

- The service under review was a true medical emergency
- Provider states they were told by UniCare that no authorization is required
- Provider attempted but was not successful in obtaining a timely pre-authorization and proceeded to provide the necessary service
- Provider was unable to obtain authorization at the time due to the urgency of the member's condition
- Provider initially obtained authorization with another carrier, thinking that the other carrier was primary

Supporting Timely Submission and Service Authorization Data (BA018)

One of the keys to successful UM is a strong relationship with our providers. UniCare is committed to helping West Virginia's Medicaid providers become comfortable with the UM processes, and we design our workflow, policies, and processes for timely utilization decisions that accommodate the clinical urgency and necessity of any situation.

UniCare boasts a strong performance with timely authorizations. In December 2018, we met 100% of our Performance Improvement and Enhancement audit elements, including timeliness of UM review.
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Our UM clinical staff are available 24/7 to assist providers with urgent or emergent requests, and we can receive authorization requests via telephone, facsimile, and our provider portal. We return service authorization determination notices expeditiously, and prioritize based on the member's current condition. Notifications are typically faxed or relayed via a phone call made directly to the provider. UniCare remains committed to maintaining efficient and timely processes to support service authorizations for PH and BH services as well as SNS. ***We are currently achieving 97.5% compliance in pre-service turnaround-time rates for PH and BH services to date in 2019.***

Our Provider Relations and Community Engagement and Training teams partner to provide support training and education, and frequent contact and support to providers. We will leverage previous experience to achieve our goal of maintaining program integrity and developing provider knowledge and experience to assure appropriate service use that promotes member health and outcomes.

Reducing Provider Administrative Burden

Provider Pledge
Engage • Incent
Empower

We leverage and offer access to innovative technology to help expedite submission and return of authorization data while reducing provider administrative burden. Our Interactive Care Reviewer (ICR) tool and Automated Voice Response System (AVRS) are available 24/7 with many self-service options for providers to check eligibility, authorization requirements and status, and claims status.

The ICR tool expedites our authorization process and allows providers to enter a request for PA directly into our systems from their offices. The submission status can be easily accessed and tracked 24/7/365. The process increases administrative efficiency by enabling providers to attach clinical documentation at any time after the case is opened. This information is seamlessly integrated into the Health Insight platform, our care management system that enables data sharing among providers, and our clinical staff including Care Coordinators and UM Clinicians. Health Insight's unique capabilities create efficiencies for providers, such as immediately approving or denying authorization requests for common procedures. Using our medical policy and clinical guidelines, combined with integrated data from the claims system, it will ask providers for the minimum information necessary to process the request and deliver a timely response. The authorization request process will link to the claims system and advise providers if PA is required. While we encourage and educate providers on the use of this tool, they may choose to submit authorization requests by telephone or fax.

Our approach to expediting the submission and return of SNS authorization data is discussed in our response to BA002 and BA003.

Implementing Authorization Criteria for SNS (BA001)

UniCare will adopt State-developed and provided authorization criteria for SNS upon implementation and throughout the first year of the Program. Our Fostering Healthy Lives model consists of a local dedicated team of licensed UM Clinicians who use SNS guidelines to

review service authorization requests. In conjunction with our SNS Liaison and Care Coordinators, they assure SNS interventions are appropriately authorized to maintain or establish safety, permanency, and well-being for targeted populations.

Adopting State-developed criteria for SNS will promote continuity of care for members while simultaneously reducing provider abrasion. We will use these State-developed SNS guidelines to expeditiously connect youth and children and their caregivers and/or Authorized Representatives with appropriate SNS that reflect the needs and preferences of the member and their caregivers to promote stability and strengthen families. As we gain experience administering SNS over time, we will develop and leverage guidelines informed by the State SNS manual.

> Our ultimate goal is to promote services that are easily accessible to youth and families while assuring that there is effective oversight and quality controls.

As we become more familiar with authorizing SNS services, we will pass the State criteria through our MPTAC to formally approve the criteria as UniCare SNS guidelines. We will leverage this rigorous process for developing and adopting medical policies and clinical guidelines that include obtaining input and approval from external providers in community and academic settings. The process also incorporates clinical best practice guidelines from professional organizations, up-to-date clinical research, and input from a practicing licensed multidisciplinary group that includes network physicians from various medical and BH specialties, clinical practices, and geographies, and includes West Virginia providers.

Stronger Together UniCare will review authorization criteria annually and whenever policy or program requirements change. We will review utilization and conduct ongoing monitoring of the SNS guidelines, soliciting feedback from our SNS focus groups. We look forward to collaborative conversations regarding the guidelines with DHHR as a way to improve overall SNS outcomes on an ongoing basis.

Ongoing analysis will allow us to update criteria and assure ease of access to care, promoting our goal of stabilizing and strengthening West Virginia families through continuous improvement. By embracing a collaborative approach, we believe we can partner with DHHR to remove barriers to access to care.

Implementing a Process to Request Authorization for SNS (BA002)

Providers (both SNS and non-SNS) can request SNS via the Care Coordinator. The Care Coordinator will then contact the Department caseworker to discuss SNS needs. The Department caseworker will make the determination of adding SNS and UniCare will authorize the services. Providers can also continue to use the existing provider tool to request additional services. We will collaborate with DHHR to assure we have the most effective process for providers and the delivery of services. UniCare will comply with all requirements in SPA Section 12.5 related to SNS authorization requirements.

The SNS provider will submit authorization request information for validation that it aligns with what was received via FACTS from the Department caseworker. We will then authorize or deny the service, according to UM guidelines, and provide a return file to FACTS that will be used for reconciliation of payment by the Bureau for Children and Families (BCF) for authorized services.

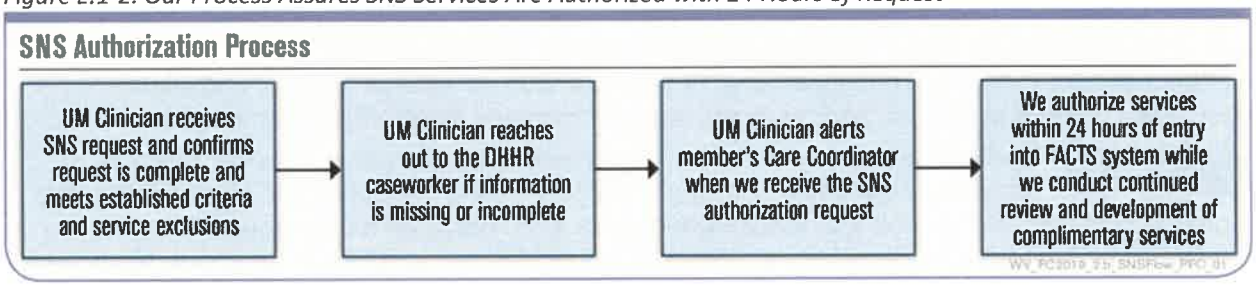
Providers will be able to review their authorizations to determine the scope and duration of services authorized by UniCare through the provider portal. Authorization information will be uploaded within 24 hours of approval. In Contract year one, the provider portal will replicate the elements of the existing provider tool for accessing referrals, requesting additional services, and meeting other provider needs.

Reauthorization of SNS Services. Providers can also reach out directly to UniCare to request reauthorization of expiring authorizations. We require providers to send reauthorization requests five business days in advance of the expiration to allow for processing. UniCare's Care Coordinator will review the request and determine if sufficient progress is being made through a review of monthly reports submitted by the provider, review of the individualized service plan (ISP)/case plan, and coordination with the Department caseworker to determine if SNS continues to be indicated. Authorization by UM staff will occur if continuing stay criteria is indicated and no service exclusions exist.

Process to Review Authorization Requests for SNS (BA003)

Expeditiously connecting youth and children and their families or guardians with appropriate SNS that reflect the needs and preferences of the member promotes stability and strength. Our proposed protocols aim to reduce fragmentation, avoid exacerbation of trauma and re-traumatization, and promote integration. This will improve outcomes while easing the stress on families in the child welfare system. We include a high-level overview of the SNS authorization process in Figure E.1-2.

Figure E.1-2. Our Process Assures SNS Services Are Authorized with 24 Hours of Request



UniCare understands SNS are integral to supporting children and youth in child welfare. We will work with DHHR to establish a process for sharing SNS authorization requests and approval data electronically between FACTS and Health Insight. This will enable Department workers to continue to use FACTS to submit requests and then receive automated authorization data within 24 hours. The establishment of an authorization-share process, through close collaboration between UniCare, BMS, BCF, and other stakeholders, will allow for expedited authorizations and avoid duplicate data entry and its inherent risk of errors.

As stated earlier, our dedicated team of UM Clinicians will be Child and Adolescent Needs and Strengths (CANS)-certified and trained in trauma-informed service delivery. They will also have experience and familiarity with the Department's SNS and the child welfare service delivery system as well as all DHHR-BCF Policies (Child Protective Services, Youth Services, and foster care). Our team has experience managing complex members and services and have established practices that allow for seamless interaction and engagement between those authorizing the services and the Care Coordinator.

To expedite our turnaround, the UM Clinician will alert the member's Care Coordinator when we receive an SNS authorization request. The UM Clinician will make sure the request is complete in amount, frequency, and duration and will verify it meets established criteria and service exclusions, with decision support embedded in our Health Insight system. In the event information is missing or incomplete, the UM Clinician will outreach to the Department caseworker to obtain additional information so that authorization process can be completed.

Services will be authorized within 24 hours of entry into the FACTS system while continued review and development of complementary services is conducted. UniCare will also automate

some authorizations through Health Insight, review requests, and compare the State-provided SNS criteria, enabling auto-authorization.

UM Clinicians will review requests that cannot be automated or requests that Health Insight suggests do not meet criteria.

Reauthorization of SNS Services. For members currently receiving SNS services, the UM Clinician, in conjunction with the Care Coordinator, will review the progress reports submitted by providers to assure ongoing appropriateness of services, review for sufficient goal progress, and to identify other needed services if appropriate. Our Health Insight platform will have established authorization rules that will allow for auto-authorization of requested SNS reauthorization when established criteria and service exclusions have been validated in the system, removing barriers for youth, their families, and providers to continue important SNS in support of permanency and well-being.

Upon request for reauthorization of SNS, the UM Clinician will verify that the SNS meets the Department's continuing stay criteria and coordinate with the member's Care Coordinator to determine if the provider's progress reports indicate sufficient member and family progress. If the criteria are met, the Care Coordinator will continue monitoring through provider progress reports and the UM Clinician electronically submits authorization files for uploading to FACTS.

In accordance with our family-driven model, if the SNS does not meet continuing stay criteria and progress is not being made, UniCare's priority is to evaluate the holistic needs of the member and family to guide authorization decisions. The SNS Liaison and Care Coordinator will work collaboratively with the Department caseworker and the MDT as indicated to determine if the family's needs suggest ongoing SNS of a different type or other Medicaid covered services to support the Individual Service Plan goals.

Throughout the authorization and reauthorization processes, our Fostering Healthy Lives clinical team will remain focused on rapidly connecting children and youth and their families with the SNS that are appropriate for their overall needs, using the State's criteria as a guide.

Applying UM Guidelines to Retroactively Review SNS (BA004)

UniCare will administer retrospective reviews of SNS providers. All reviews will be conducted within three years of the term of the BCF agreement with the provider. Providers must score at least 80% during their retrospective review for each service reviewed. Providers failing to meet 80% will be placed on a probation period for each respective service failing to meet that threshold. Our SNS Liaison will support the administration of retroactive reviews for providers.

We will provide a written notice that the probation period is in effect. At the end of the probation period, we will conduct another assessment. If the provider continues to score less than 80% for that service, the service will be closed for that provider and the provider will no longer be eligible for referrals for that service. If the provider scores a zero on any safety related service during any review, the service will be automatically closed for the provider.

We will provide a report on each provider assessment to BCF outlining:

- Results of each of the services under review
- Methodology by which the provider was reviewed
- Scores for each service area
- Provider strengths and weaknesses (opportunities for improvement)
- Documentation that all staff have met background check, licensure, and educational requirements as applicable
- Recommendations for next steps to improve provider processes

We will provide our reports to BCF within 30 calendar days of completion of the assessment and will coordinate with BCF throughout the process to expedite any necessary action. We will additionally conduct SNS provider rounds to promote quality monitoring of SNS services. Meetings will be led by the SNS Liaison and held regularly to review and oversee the retrospective reviews, SNS coordination activities, access to SNS, and engagement with BCF to continually monitor and enhance SNS service provision. Attendees will include the SNS Liaison, Social Services Director (when available), all SNS UM Clinicians, Quality Management staff, and Care Coordinators as needed.

Issues brought up in regards to provider patterns related, but not limited to:

- Overall concern regarding quality of care provided
- Red flags of fraud, waste, and abuse
- Access to care standards by county, region, and SNS service type

Our Health Insight system has the ability to keep an inventory of all SNS that are available by provider, by county, and by service. Using reports and analytics from our Health Insight, we will have near real time understanding of the SNS network capacity and access for services.

Monthly Monitoring. UniCare will monitor utilization of services and provide monthly reports that indicate geographic areas in which there is a high utilization of services required with low provider enrollment (for example, providers must travel greater than 45 minutes to render services) or the use of providers that are not most geographically appropriate in the requested service area.

Based on data and analytics from our Health Insight system, we will offer recommendations to BCF on how to address such service gaps and mis-utilization of providers. In addition, we will collaborate with providers on a regular basis to understand challenges in the delivery of services and work on mitigating those issues while sharing quality and access results.

Coordinating SNS for the Member and/or Their Family (BA005)

Our Fostering Healthy Lives model is committed to stabilizing and strengthening West Virginia families engaged with the child welfare system. Emphasizing integration, our UM and Care Coordination teams, supported by the SNS Liaison, will collaborate to verify that the requested services are appropriate. In accordance with our family-driven and youth-guided care coordination model, we will also engage members and their families, Department caseworkers, providers, and the MDT as appropriate to assure that SNS services are accessible and well-coordinated with other Medicaid, FFS, or community services included in the member's Care Plan.

Care Coordinators will participate in MDT meetings as requested by the Department caseworker or courts, to provide input regarding outcomes of screenings and assessments, potential needs identified, and available Medicaid or other community-based services that would benefit the child and family and support the goals of the MDT. This will help inform and coordinate the delivery of SNS services with the array of other services that will be included in their Care Plan.

When SNS services are identified, the Care Coordinator works collaboratively as described earlier in BA003 with UM Clinicians to make sure services are authorized expeditiously and in consideration of the member, family and caregiver, preferences, and needs. The Care Coordinator will add all SNS to the Care Plan and will conduct ongoing coordination and monitoring, including review of monthly reports of SNS providers and ongoing outreach to the member and caregiver, to make sure that the services continue to meet their needs, that there are no barriers to accessing services, and, if barriers arise, to work with the Department caseworker and the SNS Liaison to develop action plans to resolve the barriers.

In the event that additional services or differing services should be determined necessary, the Care Coordinator will inform the Department caseworker of the recommendations and will document recommendations in the Care Plan for consideration by the MDT. Additionally, Care Coordinators will directly engage with the MDT if so requested. Throughout the process, the Care Coordinator will serve as an advocate to establish timely SNS authorizations while identifying complementary and alternative services that will further support the goals of the ISP, promoting our commitment to optimizing health outcomes and improving quality of life for the youth we will serve.

Continual Enhancement of SNS Delivery

Throughout the Contract, UniCare will continually evaluate the effectiveness of our SNS authorization and coordination process. In collaboration with DHHR, we will capitalize on the SNS focus groups to verify that youth, families, and foster parents who receive SNS are satisfied with the process. We will also seek their feedback about opportunities for process improvement. In addition, as part of our gaps in care review, we will include evaluation of SNS delivery, providers, and needs to assure seamless delivery of care.



Seeking improvements to the child welfare system overall, we will collaborate with DHHR to discuss our experience with SNS coordination to identify opportunities for improvement as the program matures. For example, if we identify locations where access to specific SNS is limited, we will work with DHHR and community stakeholders to identify barriers and potential strategies or providers to increase access.



UniCare will also work with DHHR, as well as SNS and Medicaid providers, to identify opportunities to strengthen integration. For example, educating high-volume Medicaid providers about available SNS so they may identify emerging family issues and engage with our Care Coordinators or BCF for SNS before the issue escalates to a crisis where the child or youth needs to be removed from their home or placement. This will help prevent additional cases from being opened by capitalizing on community supports.

Verifying the Most Appropriate Provider of SNS is Used (BA006)

UniCare understands the Department caseworker retains the authority to select the vendor to be used for SNS. In this case, we will authorize the service based on the scope and duration of the request; However, UniCare will be available to assist the Department caseworker with identification of a provider if needed. UniCare will incorporate all SNS provider data provided by the Department into our system, enabling our teams to rapidly search for available providers and any performance data. Our Provider Services department will maintain the data, working with DHHR to verify its completeness and accuracy.

Upon receipt of an authorization request, the UM Clinician will enter authorization information in our Health Insight system. Our authorization system has sophisticated algorithms to identify available providers for the service requested, taking into account known geographic or language preferences. For some authorizations, the provider selection will be automated based on the request and available providers.

For those SNS authorizations that are not automated, the UM Clinician will inform the Care Coordinator of the SNS request and available identified providers who will promote person-centered planning and contact the youth and family to discuss the SNS and the family's goals and provider preferences. These may include geographic location, gender, or cultural preferences.

We will also obtain youth or family feedback on any SNS already in place or that they have utilized in the past. For example, if the member or family has used these SNS before and has an established relationship with a SNS provider, we will facilitate referral to that SNS provider to promote stability and continuity.

After reviewing the member's prior utilization, authorizations, and demographics, the Care Coordinator will then identify available SNS providers for the requested service who meet the member or family's preferences (whenever possible) and confirm geographic convenience and their ability to quickly initiate services. They will also review all SNS to identify opportunities to locate a single provider who can deliver multiple authorized SNS. Consolidating SNS with one provider whenever possible eases the family's burden and reduces fragmentation. While reviewing available providers, the Care Coordinator will prioritize selection of SNS providers whose performance data (determined by DHHR provided information, ongoing monthly report reviews, and retrospective review processes and incorporated into our system) indicates positive results or performance.

They will then contact the first choice of providers to confirm their capacity and acceptance of the referral. If they do not have the immediate capacity or are unwilling to accept the referral, the Care Coordinator will continue to contact alternate SNS providers until they locate one who will accept the referral.

If the member or family expresses no preferences, we will rotate referrals among available providers based on geographic location, positive performance data, and immediate availability. Building volume across multiple SNS providers will enable UniCare to gather sufficient outcomes data for quality improvement initiatives. The Care Coordinator will update the member's Care Plan to reflect the new SNS and provider. During periodic Care Plan reviews, the Care Coordinator will review all Care Plan services, including SNS, to verify they continue to be appropriate and achieving goals.

Using FSP and ISP Information to Authorize SNS (BA008)

We will support the Department caseworker, member, family, and caregivers in meeting the goals developed in the ISP or family service plan (FSP) through authorization of SNS services and identification of other necessary supports and services.

As part of establishing a process for sharing information between FACTS and Health Insight, we propose developing an electronic interface to allow our Care Coordinators and UM Clinicians access to information in the ISP and FSP. This will streamline data sharing processes while simultaneously reducing the administrative burden on the Department caseworker. Should an occasion arise where we do not have access to this information, we will work with the Department caseworker and the provider to confirm SNS services are appropriate and align to FSP and ISP goals and obtain the information necessary to authorize SNS.

Our Care Coordinator and UM Clinician, using our integrated Health Insight platform, will collaboratively review the member's FSP and ISP for key information needed to authorize the requested SNS services. The ISP and FSP provide integral information required to authorize SNS services and will be used to expedite requests and ease the authorization process for SNS providers, members, caregivers, and Department caseworkers, which include:

- The child's living arrangement
- DHHR County of jurisdiction
- Education status
- Presence of an individualized education plan (IEP)
- Specific areas of concern related to the SNS service
- Service plan summary components

Care Coordinators will additionally identify the goals for the family, other potential services where providers could align with SNS services, and identify opportunities for supporting the goals contained with the ISP or FSP when authorizing SNS.

UM and Coordination of Services – Integrating Care Delivery

Our integrated approach assures that our members, their families, caregivers, and providers receive the level of support they need across the full spectrum of health care and social services (physical, behavioral, pharmaceutical, and socially necessary), with connections, as necessary, to organizations that can assist with SDOH.

Maintaining an Accurate and Complete System of Record (BA088)

Maintaining an accurate, complete electronic health record (EHR) is not only a regulatory requirement, but also a best practice that allows primary care providers (PCPs) to integrate BH information into informed recommendations and decisions regarding our members' care. UniCare's provider contracts require network providers to maintain accurate, timely, and complete information on the care they deliver. Our Quality Management Practice Consultants periodically conduct internal audits of provider compliance with the requirements. For the Program, our PCPs will ultimately be responsible for ensuring each member's personal health record contains accurate and complete information about all encounters with support from the Fostering Healthy Lives Care Coordinator.

Maintaining Up-to-date Information Through Our Care Coordinators

Our Care Coordinators conduct ongoing care coordination activities with each member, collaborating with PCPs and BH providers and engaging them in care planning activities. A critical function of the Care Coordinator is to integrate treatment plans from PCPs, BH providers, and other providers and specialists into our Care Plan, so it can be shared across all stakeholders. Additionally, Care Coordinators will obtain specific treatment and outcomes information from BH providers to share with the PCP directly and incorporate into Health Insight, our care management technology platform. They play a key role in making sure the information is accurate and up-to-date, as well as entering manual information on encounters and discussions with the member, the family, caregivers, Department caseworkers, and others involved with the placement and care of the member.

Gathering Organized Data in One Place Through Health Insight

We understand that access to current and historical member health information is crucial to coordinated, targeted, and expedient communication, care coordination, and service delivery. Improved data sharing can lead to identification of gaps in care as well as improved continuity of care and reduction in duplication and fragmentation of care. Providers are able to access the most up-to-date medical and clinical records through the Health Insight platform. Details facilitate access to a single view of member data in an easy-to-navigate dashboard that shows HEDIS® care alerts, authorizations, prescriptions, and claims. It enables sharing of member care coordination information, including screenings, assessments, and Care Plans. The Health Insight platform includes available data from:

- UniCare's care coordination and claims processing systems
- Public health systems
- Continuity of care data, such as claims history or other information provided by DHHR or other MCOs
- Other payers and providers (including pharmacy, lab, and diagnostic data)
- Providers' electronic medical records

Health Insight provides access to all clinical disciplines, including care coordination and UM, and integrates seamlessly with our other Management Information System (MIS) modules, as discussed in BA019 through BA023. Health Insight aggregates patient data from all available sources to provide a complete picture of a patient's medical history to all internal and external stakeholders and will help members and their caregivers to engage in their health care. Member utilization data, such as claims history, authorizations, immunization records, lab results, and care and chronic condition management data, are readily available in an organized format, delivering a holistic picture of each individual's service utilization and Care Plan. Health Insight is fully compliant with all applicable State and federal laws, including HIPAA and HITECH Act, and supports role-based access to essential information and functionality. Through Health Insight and the Youth Records Access Portal (YouthRAP), DHHR, the Department caseworker, and providers can readily access the member's complete health information, which is especially vital during placement transitions. A longitudinal health and service record that travels with children over time and across placements can improve communication, avoid redundant assessment processes, and reduce service duplication and fragmentation.

YouthRAP is a standalone portal that will be used to foster collaboration, inform our UM decision-making efforts, and coordinate care, involving:

- Our child and family-centered ICT
- Our ICM teams
- Department caseworkers
- Local BCF teams
- Other community providers
- Members and caregivers
- Other authorized stakeholders

Roles-based security will enable Department caseworkers, caregivers, child placement agencies, and other authorized users to easily and securely access the information needed to effectively coordinate care, providing access to the child's ID card and electronic health records. This solution will link caregivers to their assigned members and will provide designated stakeholders with access to the Care Plan and medical record data, including notifications and alerts, limiting access to member information based on assignment. Additional information regarding the functionality of YouthRAP that will be available upon implementation is discussed in detail under MS048 through MS051.

Notifying PCPs of Changes in Member BH Status (BA089, BA090, BA091, BA092)

It is important to UniCare that changes in the BH status of our members are communicated efficiently to those involved in providing care. We define changes in BH status to include events such as crisis calls, hospitalizations, ER visits, and changes in medication related to BH conditions. Health Insight will allow UniCare to keep providers and Care Coordinators aware of changes in BH status that may affect care decisions or require follow-up.

Anytime a member has a change in BH status the PCP will be notified. We will promote rapid notification to PCPs, as we currently do through our West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) programs through monitoring of daily census reports by Care Coordinators, alerts from the ER through PreManage (a data sharing solution being implemented by hospitals across West Virginia), data from pending service authorizations, and pending discharge plans and dates. Health Insight will house the information and push notifications to PCPs via email and the Health Insight alerts. Care Coordinators will have access to the information via alerts on Health Insight and will conduct necessary post-discharge management or post-stabilization outreach needed in coordination with the member's PCP.

To support our goal of providing effective integrated care we will add a dedicated Pharmacist position to assist in reviewing overall medication utilization and changes. This role, above and beyond the required positions will be responsible for reviewing medication regimens, additions, or adjustments to assess potential drug-to-drug interactions or side effect implications. This role will also be available answer questions regarding implications on current Care Plans.

Accessing Additional Services to Support BH Needs (BA093)

Care Coordinators will play a pivotal role in making sure our members, their families, and caregivers have what they need to thrive. They will be trained on the resources available and our 22 VAS. They will have access to Community Resource Link, which provides up-to-date information regarding programs and services available to support members in reaching their health status goals. Care Coordinators will be the key point of contact for members, caregivers, and families. The Care Coordinator responsibilities include:

- Identifying services and supports to meet BH and other member needs, when members, caregivers, or providers seek them or during discharge planning and care transitions
- Suggesting services and supports to meet BH and other member needs, when they identify a gap in care or a resource they believe may support ongoing care needs
- Making connections, scheduling appointments, tracking referrals, arranging for transportation, and otherwise facilitating the member's access to additional services

We expect requests for assistance and additional services will come in through many avenues – through our BH hotline, through the 24/7 nurse advice line, through the Fostering Healthy Lives Concierge Line (Concierge Line), from providers, from our Care Coordination team, or from any of our staff who work with members directly. ***There is no wrong door to seek additional services and supports at UniCare.*** The Care Coordinator will retain primary responsibility for ensuring Care Plans are implemented, updated based on emerging needs, and making sure all requests for assistance or additional services are addressed. All our encounters with members, caregivers, and providers are documented in Health Insight, no matter the source. This information is pushed automatically to the Care Coordinators and can be retrieved from Health Insight at any time for follow-up with the member and caregiver.

Care Coordinators and Concierge Representatives play a pivotal role in educating members about the supports available to them. We encourage members, families, and caregivers to become engaged in self-advocacy and well-being, with access to the following VAS:



- **Community Resource Link.** Up-to-date descriptions and contact information on available programs and services to support health and well-being needs
- **Online Well-being program.** Web and mobile online community to help with emotional health issues, incorporating a suite of self-help resources
- **Healthy Rewards.** Incentives to prompt self-directed health care management

Supporting Department Caseworkers in Developing ISPs (BA007)

Coordination and communication with Department caseworkers is critical as members enter the Program, move between placements, show signs of emerging needs, or experience changes in health status. Care Coordinators, providers, and other specialists participate on the MDT as needed and when requested, to provide clinical and utilization information review outcomes, and elaborate on recommendations developed through the assessment of the member and their family. Care Coordinators also engage with the Department caseworker in treatment planning conferences and discharge planning when members move between placements. Care

Coordinators support the Department caseworker in the development and maintenance of the ISP by:

- Providing results of all screenings, assessments, and gathered information
- Making sure the Care Plan is consistent with the ISP
- Identifying past services through the ISP for potential inclusion in the Care Plan
- Notifying when the BH or medical status of the member changes
- Assisting in updating the ISP as member needs change
- Supporting the goals of the ISP through coordination, education, information sharing, and authorization of necessary services needed to meet goals

For full detail on ISP and Care Plan collaboration, see our response to CM001, CM004, CM014, CM023, CM024, and CM030.

Implementing Proactive Fraud and Abuse Detection Activities (BA040)

One key component of our comprehensive quality approach is identifying potential issues of fraud and abuse before they happen. We are committed to simplifying health care and serving as good stewards of state and federal Medicaid dollars. In addition to using UM technology and team to identify concerning trends, we leverage our PA process to help catch potential issues of fraud, waste, and abuse (FWA). We will leverage our UM program for our members in the child welfare system to combat FWA, improve placement stability, and reduce avoidable hospital stays, the length of admissions, and readmissions. Some of the tools we use include:

- **UM team.** This team will use evidence-based, medical necessity criteria to evaluate the appropriateness of services like hospital admissions and initiating discharge planning. Clinicians reviewing PA requests are also tasked with identifying fraud and other activities that could reduce the member's safety or quality of care.
- **UM technology.** Our clinical team uses analytic tools to proactively and retroactively identify overutilization. These tools include predictive modeling, member trending, provider ranking, services from highest to lowest utilization, and data analysis of ER use and rapid hospital readmission.
- **Dedicated Special Investigations Unit (SIU).** The West Virginia based SIU will be fully integrated with our corporate SIU (which brings experience from former law enforcement officers, former federal and State Medicaid regulators, and a variety of other experienced health care investigators), Program Integrity Lead Officer, and the Office of the Inspector General with DHHR and will be responsible for implementing our Program Integrity strategy. Our employees and providers represent the eyes and ears of Program Integrity and produce most of the referrals to the SIU.
- **Employee training.** We recognize every employee can play a role to make sure our members and their caregivers have access to the highest quality services, so we require our employees to be knowledgeable about FWA; to that end we provide training upon hire and annually thereafter on FWA. Training and supplemental documents teach employees how to recognize FWA and give them the tools to act if they see it.

Our UM team reviews both primary care utilization patterns and servicing provider billing patterns in the context of local, regional, and national benchmarks to identify providers whose utilization patterns are atypical. The team also identifies outlier members and providers based on relative distribution of services and then refers to the appropriate UniCare functional area for intervention.

When utilization patterns suggest the need to reach out to members, our interdisciplinary team collaborates to determine an appropriate strategy. We leverage our care coordination, provider engagement, and health education teams where appropriate to perform outreach efforts to intervene and remedy the situation. When indicated, we may seek additional quality of care guidance and identification of potential FWA. If fraud or abuse is suspected, it is referred to UniCare's SIU for further review and determination. Action steps for providers with unacceptable performance are described in greater detail in QU003.

Developing and Sharing Provider Protocols and Standards (BA046)

We have and will continue to refine our general and condition-specific protocols and standards to align with state and federal guidelines as they change and to reflect feedback from our provider relationships. We are proud to have nine disease management (DM) programs with NCQA Patient and Practitioner Oriented accreditation, including for conditions like diabetes, asthma, and child/adolescent depression likely to help members in child welfare and their caregivers. ***Our DM programs are accredited through 2021 and we are working with NCQA to transition to the Population Health Program (PHP) accreditation, scheduled for review in 2020,*** making us one of the first organizations to commit to seeking PHP accreditation and, as such, will be one of the first to go through the review process. UniCare has developed protocols, standards, and materials as part of these accredited programs and are informed by NCQA's model that includes keeping members healthy, managing members with emerging risk, maintaining member safety including outcomes across settings, and managing members' multiple chronic illnesses. We also encourage provider input through our existing MAC (comprised of a Medical Director and local and participating providers, including pediatricians, psychiatrists, and adding child welfare-focused providers like SNS providers) and our proposed Stakeholder Advisory Group (comprised of members, their caregivers, providers, and other advocates and stakeholders) will provide input on appropriate protocols and standards. The MAC uses the provider prospective to speak to clinical guidelines and the Stakeholder Advisory Group will lend a more member- and caregiver-focused perspective. We use the MAC meetings as an opportunity to promote multidisciplinary solutions to address gaps in coverage and service delivery, including perspectives from those individuals.

Dr. Jessica McColley, a member of our MAC, has been instrumental in coordinating LARC services with harm reduction services through an alliance between Kanawha County Health Department and Cabin Creek FQHC.
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The MAC has been instrumental in developing clinical guidelines that promote UniCare performance improvement efforts. We consulted local providers on our current MAC on potential interventions for our Performance Improvement Project (PIP) to improve our HEDIS Follow-Up After Hospitalization for Mental Illness scores. We sought potential solutions on barriers our Quality Management (QM) team had identified, such as lack of transportation, lack of adequate and consistent discharge planning, and members' unwillingness to engage in outpatient care. We worked closely with providers like Dr. Ahmed Faheem (recipient of the Federation of State Medical Boards' John H. Clark, MD Leadership Award) on our MAC to also gain critical perspectives around the challenges in meeting HEDIS measures, such as a seven day follow-up after hospitalization, metabolic screenings for those on antipsychotics, sharing information/coordinating care with medical counterparts, and monitoring individuals taking medications for ADHD. Providers have offered us advice on

Dr. Faheem, a member of our MAC, has advocated for 7-day follow-up after behavioral health inpatient discharge and instructs us in gaps that need to be addressed in this area.
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how to be more successful in partnering with providers to achieve HEDIS goals. ***We acted on their recommendations and launched a program to link outpatient and inpatient BH providers during discharge planning.*** We anticipate continuing to leverage provider perspectives to identify and pursue opportunities to improve care for our child welfare members.

We periodically update criteria when standards of practice and technology change. We involve practicing physicians in these updates and then notify providers of changes through web-posted newsletters, fax communications (such as provider bulletins), and other mailings. To encourage adherence to clinical practice guidelines (CPGs), our QM Practice Consultants help providers interpret quality data, educate them (either in person or telephonically) on expectations for each CPG, and review medical record keeping requirements to make sure they accurately document evidence of compliance. The support we offer providers to improve outcomes through CPG compliance drives positive results in HEDIS scores and other quality-related initiatives.



We will also help providers adopt our standards and protocols by offering training around topics like the dedicated local care coordination team, local and national best practices and evidence-based practices, strategies to be flexible and adaptable to varying member needs, key quality measures, and identifying and addressing members' needs. We will partner with our providers, working towards a common interest to improve access to care, ease provider administrative burden, provide holistic care, and promote healthy lifestyles for our members. Our strategy includes giving providers the tools, resources, and support they need to succeed, while advancing clinical quality outcomes and driving improvement in quality performance measures.

Developing and Implementing Guidelines for PA (BA047)

UniCare establishes PA guidelines based on state and federal requirements, the most up-to-date UM standards from NCQA, provider input through our MAC, our affiliates' experience in other states, and our multidisciplinary approach to meeting the medical, behavioral, dental, and psychosocial needs of our members when we develop our PA guidelines. Additional detail around the clinical guidelines for PA and UM are described at BA015 and BA053.

We are continuously evaluating opportunities to reduce administrative burden and eliminate barriers to medically necessary PH and BH services, while at the same time developing systems to avoid our members accessing unnecessary or inappropriate care. We design our workflow, policies, and processes for timely utilization decisions that accommodate the clinical urgency and necessity of any situation. ***We accept PA requests by telephone, fax, or portal 24/7.*** When we receive a physician request for medical services, the intake representative will verify eligibility and benefits. This information will be forwarded to the UM Clinician for review for medical necessity.

Key types of services requiring PA are listed, but not limited to, those in Figure E.1-3, with the comprehensive list available at implementation. To make sure providers, members, and members' caregivers easily understand and identify which services require PA, we have outlined the services in our member and provider handbooks. We disseminate changes in authorization requirements by immediately sending out provider notices, posting changes at the provider portal and member websites, and updating member and provider handbooks. Network Relation Consultants (NRC) also update providers in person and over the phone. We also offer additional information on our website, member- and provider-specific web portals, Frequently Asked Questions documents, member welcome packets, and on-site provider education.

Our strategies will assure effective and timely communication and include our Provider Services department, supported by our Community Engagement and Training team, which is a hub for all provider support, communications, and problem solving. This will also include our provider website, which offers links to our training and resources including Pre-Certification Lookup Tool, claims status inquiry, eligibility and benefits inquiry, member reports, pharmacy information, provider newsletters, DHHR communications, and provider updates. To deliver information in a timely and efficient manner, we deploy a comprehensive communications strategy that includes email blasts, fax blasts, letter and newsletter mailings, and more. Communication preferences vary from provider to provider, and our many flexible communication methods allow us to provide information in whatever way works best for a particular provider, whether they are a large practice, hospital, or small rural PCP.

Figure E.1-3. Types of Services that Need Prior Authorization

Services that typically require prior authorization:
- Inpatient hospital services, including:
  - Long-term acute care facility
  - Newborn stays beyond federally mandated timeframes
- Advanced radiology services
- Behavioral health initial and continued stay days for:
  - Inpatient
  - Residential treatment, including PRTF
  - Partial Hospital Levels of Care
- Durable medical equipment
- Genetic testing
- Home health care services, including hospice care
- Hysterectomy
- Rehabilitation facility admissions
- All out-of-network services

Services Authorized by Primary Care Providers (BA048)

PCPs or specialists serving as PCPs are authorized to provide certain services without PA from the health plan. Key types of services PCPs can provide without PA are listed but are not limited to those in Figure E.1-4, with the comprehensive list available at implementation.

By not requiring PAs, we strive to make it easy for members to access emergency, crisis, and primary care services and we avoid adding administrative burdens for our providers.

Figure E.1-4. Types of Services Authorized by Primary Care Providers

Services that can be provided or referred to a PCP without prior authorization:
- Behavioral health screening and assessment
- HealthCheck services (age-appropriate preventive care screening and testing during each well-child visit and during an acute illness episode, if appropriate)
- Emergency services (notify UniCare within 24 hours or the next business day of inpatient admission)
- Family planning/well-woman checkups
- Nebulizers
- Obstetrical care, including in-network physician visits and routine testing
- Physician referrals for in-network specialists, consultation or a nonsurgical course of treatment
- Standard X-rays and ultrasounds

The list of services that do not require PA are evaluated periodically using the same standards and recommendations listed in BA047; and the means of notifying providers, members, and their caregivers will generally be the same, relying on updates to the provider and member manuals. A list of some of the most common services that PCPs can provide without PA are listed in the provider manual and the member handbook lists member benefits with a brief description of any limitations, including whether the service requires PA.

We recognize that some of our child welfare members may have more complex health conditions that would be better managed and coordinated by a specialist instead of a general practitioner. Enrollees with a disabling condition, chronic illness, or who are eligible for Supplemental Security Income must have the option to select a specialist provider as the member's PCP. Additional information around which specialists can be designated as PCPs and the process to do so is available in ND032-ND033. Having the specialist designated as the member's PCP will assure the specialist can provide the services listed in Figure E.1-4 without additional approvals.

Member Self-referral Guidelines (BA049)

Members and their caregivers can and will be able to ***access care and services with their provider of choice and do not need a referral to access specialty providers***. Members may self-refer to any BH provider in UniCare's network. We encourage members and their caregivers to use their PCPs as advocates to help them identify and access appropriate specialists, ancillary providers, and community services, based on the member's individual needs. Providers will generally help members and their caregivers identify in-network facilities and providers. When in-network facilities and providers are not available, providers will help members access the appropriate services by following the appropriate process to request out-of-network referrals. Additional detail on out-of-network processes is outlined in BA067.

There are also times members can get a service without any PA from us, including emergency, urgent care, family planning services (as long as they go to a qualified family planning provider), or certain BH services, like routine BH therapy services, psychotherapy, and psychiatric evaluation and treatment. We tell members and their caregivers in plain language that these services will not need any PA from us. We aim to make policies clear, consistent, and easy-to-understand.

Members and their caregivers can also leverage their Care Coordinator as a source of information for the most up-to-date program information and requirements and to request specific services be considered.

Prior Authorization Request Timelines (BA050)

UniCare requires PA for all elective inpatient admissions and other services as identified in our provider and member manuals and BA047. The referring physician identifies the need to schedule a hospital admission and must submit the request to the UniCare UM department.

Routine requests for scheduled, elective admissions should be submitted at least seven days prior to the scheduled admission. We also recognize that our child welfare population may need expedited authorizations. Urgent requests for admission with all supporting documentation must be submitted a minimum of two business days prior to the scheduled admission. An urgent request is any request for authorization of medical care or treatment that cannot be delayed because delay would result in either of the following:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgement.
- Would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. This assessment must be made by a practitioner with knowledge of the member's medical condition.

There is no requirement for PA on emergency/crisis services; however, we do ask that providers notify us within 24 hours or the next business day for inpatient admissions.

Prior Authorization Levels of Authority (BA051)

In general, the treating provider is responsible for contacting the UM department to request PA review for both professional and institutional services; however, a hospital or ancillary provider may contact UniCare to verify PA review status for all non-urgent care before rendering services. Members and their representatives may also contact their providers or call the UniCare Member Services department to prompt a PA review. Members can also work with the Care Coordinator to request and track the PA review.

Once we receive a PA request, determinations will go before our multidisciplinary UM team which will be comprised of physicians, registered nurses, licensed BH clinicians, physical/occupational/speech therapists, and pharmacists. We will hire UM Clinicians with

expertise relevant to child welfare members, such as training and experience in trauma and foster care; children, including those with special health care needs; chronic conditions; mental health and SUD; and comorbid physical and BH conditions.

Our UM Clinicians collaborate with the members' interdisciplinary team of Care Coordinators, nurses, social workers, pharmacists, and BH professionals through integrated rounds to make sure we consider each member's individual needs, situation, preferences, and person-centered goals during decision-making. Through this coordinated and integrated process, we make sure members, including those with ongoing and chronic conditions, have access to alternative services and forms of service delivery to meet their unique needs, and support them in their desired health outcomes. The UM Clinicians can make authorization approvals.

When medical necessity is in question or additional clinical information requested to make a decision has not been received, the UM Clinician refers the case to our Medical Director (or designee) who has the appropriate PH or BH expertise to address member needs. Only a Medical Director or her/his designee can make a decision to deny a request or authorize services in an amount, duration, or scope that is less than requested. If indicated, the UM Clinician will assist the provider in identifying alternatives for health care delivery as supported by the Medical Director. If the Medical Director denies the request, the appropriate denial letter (including the member's appeal rights) will be sent to the requesting provider, the member's PCP and the member or their Authorized Representative. We document and maintain all results, including the reason for the decision or any alternative services approved in lieu of the original request, in our Health Insight platform.

Sending Prior Authorization Approval/Denial Letters (BA052)

UniCare assures compliance with local, State, regulatory requirements and accreditation standards when making UM decisions and sending notifications. Providers receive a decision letter, regardless of whether the PA was approved, denied, or modified, and members (or their Authorized Representative) will receive a written notice within seven calendar days of our receiving the request only if the decision was denied. If the approval was denied, the notice will contain an explanation of why the service was not approved and how the Authorized Representative can appeal the decision. The type of information provided in the denial letter is listed in Figure E.1-5.

Figure E.1-5. Member PA Denial Letter Content

Important information in the Member PA denial letter:
- Diagnosis
- Decision, with reason
- Place of service
- Who to contact with questions about the decision
- Contact information
- Accessibility taglines
- Directions for the appeals process
- Confidentiality statement

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We will also rely heavily on our Care Coordinators and will work closely with DHHR to identify effective strategies to ensure any approval and/or denial letters are going to the appropriate member at the appropriate location.

Our processes for appeals provide all members, their Authorized Representatives, families, parents, guardians, or Department caseworkers with a full and fair process to appeal any adverse medical necessity and benefit decision, either verbally or in writing. We document all appeal processes in our member handbook and include these as attachments to denial and appeal letters. For member appeals, this letter outlines member and caregiver rights to present evidence and allegations of fact or law in person as well as in writing. It also explains the right to examine, free of charge, the case files, including medical records or other documents relevant to the appeal. We provide interpreters, TDD/TTY services, a language line service comprising more than 200 languages, and other assistance described later in in MS043 to members and families or the Department caseworkers as necessary. Sample letters for approvals and denials are attached in Supplemental Document E.1-2.

Continuity of Care Coverage During Transitions (BA054)

Our members are our first priority. UniCare is committed to connecting members with the services they need, when they need them, and in the setting they choose. Our Fostering Healthy Lives model recognizes that our members' needs change frequently and supporting them during critical transitions is one of the most crucial care coordination functions.

We understand that children and youth in child welfare have often experienced a lack of permanency, consistency, and trauma, and we endeavor to minimize further disruption through our established transition processes that promote continuity and reduce the risk of re-traumatization throughout this transition period. We support member voice and choice and help our members prepare for transitions before they occur by providing information on continuity of care, coordination of care, and accessing supports.

During the Program transition, when a new member has an established relationship with a provider and approved authorizations for services, we will approve those services for up to six months, or until reviewed by our team and new services are authorized. We understand that transitions to managed care can be a significant change and we want to make sure the transition is as smooth as possible.

Our Care Coordinator will assist during this transitional period to determine if the member is in an active course of treatment, if the provider is in the UniCare network, and to determine any changes in needs, including urgent needs that will be prioritized. If a provider is out-of-network (OON), and the Care Coordinator is unable to locate a comparable in-network provider, it may be determined the authorization for the OON provider will be continued. We will convey this information in new member welcome calls, welcome packets, and through our ongoing Care Coordination support. We will conduct welcome calls to all new members to review current needs and services and issue necessary authorizations to assure continuity of services.

Our Concierge team identifies existing provider relationships and services that will need to be preserved and reinforced. The assigned Care Coordinator will then work with UniCare's UM team to assure necessary authorizations are entered and community supports are in place. The Care Coordinator will also work directly with the providers and service agencies currently involved with the member's care to educate them on the program and engage them as part of the team supporting the member.

Table E.1-1 describes each of the critical components of our approach to facilitating continuity of care for all members.

Table E.1-1. Components of Effective Continuity of Care

Component	Description
Authorizations	We honor all existing authorizations, including those with providers not currently in our network, and frequency of the service identified on the member's Care Plan for up to six months, or until reviewed by our team, following enrollment. During this time, Care Coordinators complete an assessment as needed and develop a new Care Plan with the same or alternate services and supports based on the member's holistic needs. Care Coordinators continually monitor the member's progress and continued need for authorized services. Our clinicians complete the necessary PA request to prevent disruption in care. There are other instances where UniCare would allow the member to continue with an OON providers such as a member in active course of treatment for late-term pregnancy or cancer treatment.

Component	Description
Dedicated Care Coordinators	We know that many children and youth involved in the child welfare system have experienced numerous disruptions and our model seeks to minimize further disruption by maintaining the same Care Coordinator for a member throughout their enrollment in the Program. During the initial screening, Care Coordinators take the time to get to know members, learning about their preferences, families and supports, and identify and understand their needs, including identification of any emergent needs for prioritization. By proactively obtaining a copy of the members' Care Plans, past assessments, and existing PAs, and through outreach to the providers with established relationships with them, the Care Coordinator lays the foundation for continuity of care.
Care Plans	Care Coordinators review new members' Care Plans for appropriateness of care, arrange for all medically and SNS, and identify any gaps in care. They complete a thorough review and honor new members' existing Care Plans or work with the member, families, caregivers, Department caseworkers, and providers to develop new Care Plans. Care Coordinators identify any gaps in care and refer members for additional services, if needed.
Youth Records Access Portal (YouthRAP)	YouthRAP is a standalone portal that will be used by our child and family-centered ICT and ICM teams supporting members. Role-based security will enable Department caseworkers, caregivers, child placement agencies, and other authorized users to easily and securely access the information needed to effectively coordinate care, providing access to the child's ID card and electronic health records. This solution will link caregivers to their assigned members and will provide designated stakeholders with access to the member's Care Plan and medical record data, including notifications and alerts, limiting access to member information based on assignment.
Non-Contracted Providers	Our Care Coordination team identifies members receiving services from OON providers and contacts our Provider Relations department for outreach and contracting. If we are not able to contract with the provider, we work closely with the member to choose another or, if in the member's best interest, we work with the provider to establish a single-case agreement to continue care. We do not enter into single-case agreements with any providers who have sanctions.
Member Grievance Information	We continuously review member grievances to monitor provider adherence to access and availability standards during transitions to and from UniCare. Our Stakeholder Advisory Group, focus groups, and one-on-one member interactions provide us information on the adequacy and availability of network providers that help shape our focus and management of our network.

Notification Regarding Expiration of Existing Authorizations (BA055)

We will use the Health Insight platform, our care management system, to monitor authorizations on an ongoing basis, supported by specific dashboards that provide alerts for expiring authorizations 60 days prior to expiration. When an expiration date is identified, the Care Coordinator will reach out to the provider and the Department caseworker to discuss the need for ongoing services and determine if reauthorization is necessary or if other services may need to be authorizated in addition to or in lieu of an expiring service. Additionally, the Care Coordinator will conduct outreach to the member and caregiver to discuss Care Plan progress and preferences regarding services that will be shared with the MDT as necessary to determine ongoing service authorizations.

Authorizing Out-of-network Services (BA056)

UniCare procedures support the authorization of OON providers to support continuity of care and to assure members are able to access care during emergency situations. We summarize our procedures for emergency and non-emergency situations below.

Emergency Situations (BA057)

UniCare facilitates access to medically appropriate care for our members. Members needing emergency services can always access them at the nearest facility available, regardless of the provider's status in our network. UniCare does not require service authorization as a condition for payment for emergency care.

Non-emergency Situations (BA058)

Our extensive network minimizes the need for OON services for most Medicaid covered services; however, in the event that an in-network provider is not available or accessible to meet a member's non-emergency, medically necessary need for covered services, we will coordinate services with an OON provider. When services are court ordered, we will cover all OON services even if we determine them to not be medically necessary.

UniCare assures that the care of members is not disrupted or interrupted. We do not require service authorization for family planning services whether rendered by a network or OON provider.

Rural Option

If UniCare is the single MCO contracted to provide services in a rural county as permitted in 42 CFR 438.52, we will permit members to choose from at least two physicians, and to obtain services from an OON provider under any of the following circumstances:

- The service or type of provider, in terms of training, experience, and specialization, is not available within our network
- The member's PCP or other provider determines that the member needs related services that would subject them to unnecessary risk if received separately and not all of the related services are available within the network
- DHHR determines that other circumstances warrant OON treatment

In addition, members may access an OON provider that is the main source of a service to the member for six months, or until reviewed by our team, upon implementation of the Program, exceeding DHHR's standard of the first 60 calendar days of enrollment.

Out-of-network Referrals to Promote Continuity and Access to Appropriate Care (BA066, BA067, BA068, BA073, BA074)

UniCare is committed to continuity and coordination of care as part of providing high-quality health care services for our members. Our Fostering Healthy Lives model optimizes health outcomes by matching members with appropriate providers, including those in and out of network.

Established, Approved Out-of-network Guidelines (BA066)

As a current West Virginia Medicaid MCO, we will use existing, DHHR-approved policies and procedures for referring members to OON providers for specialty and medically necessary services, based on sources including NCQA standards and guidelines and the SPA. We provide access to services from OON providers for varied situations:

- There is no available network provider with the training, experience, or specialization within the applicable GeoAccess® standards

- To maintain continuity of care with an OON provider for new members (beyond the initial Program transition) for the first 90 days of enrollment, or during active course of treatment (for example, including late term pregnancy or cancer treatment)
- The member's PCP or other provider determines that the member needs related services that would subject them to unnecessary risk if received separately and not all of the related services are available within the network
- DHHR determines that circumstances warrant OON treatment
- A member receives emergency or crisis services, post-stabilization services (services subsequent to emergency medical services after a member is stabilized to maintain a stabilized condition, or to improve or resolve the condition, as per federal and state requirements as defined by DHHR), family planning services, or sexually transmitted infection (STI) treatment

Understanding the importance of relationships with providers for some members, UniCare considers extending time periods and authorizations for OON providers based on clinical judgement and member needs.

Referrals to Out-of-network Providers When Needed (BA067)

Providing needed care to our members by a qualified provider is a top priority for UniCare. If we lack an agreement with a specialist or key provider type in a given geographic area, we will coordinate care for the member with an OON provider until a network provider is available, or as long as the member requires care that cannot otherwise be met by network providers.

In the event there is not a participating specialist in West Virginia who is available to provide needed specialized services, we will arrange for the provision of services through an out-of-state provider until a participating provider can fulfill that role. Similarly, if no appropriate network provider is available to offer a member a second opinion, we will arrange for the member to obtain a second opinion from outside the network.

In these instances, our Care Coordinators and UM Clinicians monitor member progress from the time of the OON authorization request through visit or service completion. Our staff will quickly identify the closest, most appropriate OON provider to meet the member's needs and execute a ***single-case agreement*** when appropriate. Single-case agreements solidify payment terms (including protections related to balance billing), authorization requirements, information sharing, and treatment plans to ensure thorough coordination of the member's care.

If a provider preferred by the member or Authorized Representative is not in-network, and if appropriate for continuity of care, we will reach out to the OON provider to try to bring the provider into our network, or secure a single-case agreement until the member can transition to a network provider.

UniCare has the following established processes for providers and members or their Authorized Representatives to request OON referrals, and for coordinating, tracking, and documenting all referrals.

Primary Care Provider Requests for Out-of-network Referrals

UniCare considers the PCP to be the principal coordinator of care when members require medical services from other health care service providers, and the PCP determines when a member needs specialty care. The expectation is that referrals will be made to in-network specialists when available; however, consideration will be made for OON providers under special circumstances including: to maintain continuity of care for members with a pre-established relationship with a provider, to address a lack of providers available in the area where the patients resides, to arrange access to centers of excellence for specialized care, or when DHHR determines OON treatment is warranted.

UniCare's process when a PCP determines that a member needs specialty care from an OON provider involves the following steps:

- The PCP calls/faxes the UM department to request initial PA for OON specialists.
- Requests for referrals to OON specialists are authorized based on medical necessity and availability of in-network specialists.
- Subsequent visits to the OON specialist requires PA as long as the specialist deems the visits medically necessary and the member retains eligibility with UniCare.

Member Requests for Out-of-network Referrals

When a new member (beyond Program implementation/transition) has an established relationship with a provider and approved authorizations for services, we approve those services for 90 calendar days and attempt to contract with that provider or help the member transition to a network provider. We convey this information in new member welcome calls and welcome packets. The member's assigned Care Coordinator, aided by the Concierge team, will review current needs and services and work to issue necessary authorizations to assure continuity of services.

We also notify members and their Authorized Representatives of their right to request OON referrals or assistance transitioning providers through the member handbook and, if their provider terminates their contract, through a notification letter. The member handbook also makes clear that members may access OON providers for emergency services, family planning services, and STI treatment without request for PA.

When we receive a request for a referral for continued access to care, our UM Clinician works with the member's assigned Care Coordinator, informing the member and their Authorized Representative and provider of receipt of request and the continuity of care process, verifying information about the scheduled date of service or delivery, and answering member or provider questions. The UM Clinician examines requests in collaboration with the Care Coordinator and obtains additional medical records if needed. Decisions are based on a holistic review of the member's placement history, individualized needs, clinical condition, medical needs, environmental and other relevant factors.

If the OON request is approved, the UM Clinician informs the member/Authorized Representative, PCP, and OON provider and collaborates with the Care Coordinator to develop a transition plan. If the UM Clinician cannot approve the request for clinical reasons, the request is referred to our Medical Director for determination and recommendations. Only a physician may make a denial determination. If this occurs, UniCare assists in identifying and transitioning to, if applicable, an appropriate network PH or BH provider for needed services.

Non-network Provider Information Sharing with PCPs (BA068)

The Concierge team will document all calls on requests for OON services and transition assistance. Once an intake is created, the UM Clinician will enter the necessary documentation

into Health Insight. Our Care Coordinators will continue to coordinate in- and OON services, tracking member progress and facilitating information sharing.

UniCare will send standard single-case agreement letters to OON providers, that requires ***the provider to forward medical records within 10 working days of UniCare's request and that all member information, records, and data must remain available to UniCare*** (and otherwise remain confidential). The assigned Care Coordinator will incorporate the out-of-network (OON) provider's notes into the member's record in Health Insight, which is available to the PCP, and can directly provide this information to the PCP to further assure that the PCP is apprised of the member's treatment and progress.

Transferring Information to Network Providers (BA073, BA074)

To promote stability, continuity of care, and positive relationships between members and their providers, and reduce potential re-traumatization of youth in the child welfare system, UniCare attempts to bring a member's current OON provider into the network. If we are unable to do so, then we work to identify an appropriate network provider who can meet the member's needs, and begin a transition process to the new provider. The transition process involves the member's assigned Care Coordinator, in collaboration with the UM Clinician, developing a Transition Care Plan that includes at a minimum the following:

- The non-participating provider's treatment plan for the member's active course of treatment, for which continued access to care or OON referral was requested
- The specific treatment goal to be reached prior to transfer to the UniCare contracting provider and the estimated date the transfer can be safely accomplished



The Care Coordinator works with the member and Authorized Representative to select an appropriate in-network provider, based on the individualized needs of the member (for example, a pediatric cardiologist if needed), and the distance to the member's living situation. The Care Coordinator confirms that the provider is still in the service area and is able to perform services required, and coordinates the referral, documenting progress in the Transition Care Plan. The Care Coordinator or Concierge team will assist with scheduling an appointment with the new provider. They will also facilitate the transfer of records and other information to make sure the new provider is well-prepared to engage with and provide trauma-informed care to the member and their caregiver.

For example, we will work with the member or Authorized Representative to sign a release of information and request a transfer of medical records to the new in-network PH or BH provider, and input information to the member's record in Health Insight, which will be made available in our YouthRAP to enhance coordination of care among the MDT and create a lasting and permanent medical record. ***This will allow for shared access to key member information among the Department caseworker, caregiver, and receiving and sending providers during and after the transition, reducing fragmentation and promoting continuity of care.***

Coordination of Services – Emergency Room Oversight

Facilitating the delivery of ***the right care, at the right time, in the right place*** is central to UniCare's philosophy of care. Our clinical care approach is designed to avoid crises and trips to the ER, whenever possible, with a goal to stabilize placements for members, families, and caregivers. But when trips to the ER happen, our approach is to monitor usage, apply the "prudent layperson" standard through our utilization review process, and make sure that adequate resources are available to provide timely, effective crisis stabilization and intervention.

Monitoring Ongoing ER Usage (BA071)

Primary functions of our UM program are maximizing the delivery of appropriate medical, BH, dental, and pharmacy services, while minimizing occurrences of over- and under-utilization. We will identify and address aberrant utilization patterns through a combination of:

- Direct connection and engagement with PCPs
- Enhanced real-time and on-site communication
- Powerful data analytics supported by up-to-date, organized information
- Focused clinical leadership attention, including our newly created Pharmacist role, to examine trends and implement effective improvement strategies

Through our data-informed enhanced care management model and the UM strategies we implement, we will effectively provide each member with holistic, person-centered strategies and interventions in the most appropriate setting, while simultaneously reducing unnecessary ancillary services and potentially preventable ER visits, admissions, and readmissions.

Working Directly with Hospitals and ER Encounters

UniCare currently has facility-based care management resources in several hospitals for the West Virginia Medicaid programs, which will be extended to Program members:

- Beckley Hospital, Appalachian Regional Healthcare in Beckley
- West Virginia University Hospitals, Chestnut Ridge Center in Morgantown
- The Behavioral Health Pavilion of the Virginias in Princeton
- Fairmont Regional Medical Center in Fairmont
- CAMC Memorial Hospital and CAMC General Hospital in Charleston

The Care Coordination team currently provides on-site assistance at these five facilities with discharge planning, follow-up on needed services and supports, medication reconciliation, crisis planning, updates to the Care Plan, and education to members, caregivers, and families. We will extend these practices to cover similar services for members in the Program and may consider placing additional resources in other facilities with significant Program members.

UniCare is also ready to leverage ER and hospital data that we currently use in our Fostering Healthy Lives approach. ***Information made available through PreManage — a data sharing solution being implemented by hospitals across West Virginia — will provide real-time notification to ERs to assist in identifying frequent usage and aberrant patterns.*** As of March 2019, 34 West Virginia hospitals have adopted PreManage and additional hospitals are in process. PreManage will help hospitals:

- Better inform and prepare ER physicians to engage with their patients who are frequent ER users or those with chronic medical or BH issues
- Improve care coordination and outcomes post-discharge by allowing quicker notification and engagement of recommended providers or services
- Improve management of members with complex health issues that present to an ER and, as a result, reduce preventable ER utilization and ER visits
- Share information across facilities, PCPs, and clinical teams to exchange, update, and verify treatment for each individual member, supporting data exchanges including shared member assessment data

Using Information to Prevent, Identify, and Intervene on ER Usage

Information sharing through Health Insight, our care management platform, will help providers, Care Coordinators, and others involved in care decisions to improve performance while assuring continuity, coordination, and the delivery of high-quality integrated care. Access to Health Insight will give our MDTs actionable medical, BH, and pharmacy information in nearly real time. Providers will be able to see a comprehensive view of member utilization, interactions, authorizations, claims, clinical history, assessments, care coordination, and Care Plans in a central, personal health record. This near real-time information will allow providers to intervene when a member has been to the ER to engage the member in appropriate follow-up to avoid a future crisis. ***From January through April 2018 to the same time period in 2019, ER visits per 1,000 UniCare members decreased by 3.5 as a result of coordinated communication efforts.***

Our broad array of tools and resources will identify, predict, and track ER utilization, while our Care Coordinators and care management team engage members with education and supportive relationships. Figure E.1-6 highlights key components of our approach.

Figure E.1-6. Preventing Inappropriate ER Utilization Through Analytics and Member Engagement

✓ PREVENTION	✓ IDENTIFICATION	✓ INTERVENTION
Proactive member education, identification of potential utilization, and specialty programs	**Processes and tools to identify potential and actual ER utilization**	**Outreach and interventions for members with preventable events, complex needs, and high utilization**

• Member education upon enrollment regarding Healthy Rewards incentive program, services, supports, and resources available
• Proactive member incentives regarding proper use of the ER and using alternative services available as appropriate
• Low-intensity ER predictive modeling predicts the likelihood of a member having an ER visit in the next three months for low-intensity conditions such as colds, the flu, skin conditions, medication refills, and minor injuries
• Chronic condition management for chronic conditions such as asthma, diabetes, HIV/AIDS, coronary artery disease, chronic obstructive pulmonary disease, and substance use disorder (SUD)
• Provider-focused initiatives Value-based payment (VBP) programs offer providers participation in shared savings for reduced non-emergent and preventable emergent ER visits
	• Predictive modeling synthesizes member and claims data to identify and stratify member risk such as the likelihood of ER use
	  • CI³ calculates a risk score for each member
	  • LIER predicts the likelihood of an ER visit in the next three months for low-intensity conditions
	  • ER Triage predicts the likelihood of ER visits for ambulatory care sensitive conditions
	• Integrated, person-centered screening, assessment, and care coordination processes support the identification of Children with high-risk/high-needs and Special Health Care Needs (CSHCN)
	• 834 enrollment file review and claims analysis to identify CSHCN, preventable events, and high utilization
		• Integrated care coordination for CSHCN, pregnant women with SUD, members with I/DD diagnosis, or other priority populations
		• Post-discharge follow-up by Care Coordinators upon notification of an ER visit or a hospitalization to support post-stabilization planning
		• Specialized pharmacy management addresses the impact improper medication prescribing or adherence can have on use of the ER
		• Onsite Care Coordination at key facilities for discharge planning and interventions

Using Our Toolbox to Identify Root Causes of High ER Use

We will monitor and analyze ER and other utilization by identifying aberrant utilization patterns through a variety of tools, as shown in Table E.1-2.

Table E.1-2. UniCare's Toolbox for Monitoring ER Usage

UniCare Tool	Contents and Purpose
Daily census reports	• Contains detail by member on utilization of inpatient and outpatient services, pending approvals, and data needed • Used by UM, Care Coordinators, and the care management team to monitor utilization of services and need for follow-up • Alerts Care Coordinators to members who have used the ER for follow-up with PCP and others, as necessary
Utilization management dashboard	• Presents weekly trends for a variety of utilization statistics • Used by UM, Care Coordinators, and the care management team to monitor trends in utilization of services to identify areas of potential improvement • Informs understanding of the impact of interventions to direct members to the most appropriate setting of care
Over- and under-utilization reports	• Provides aggregated member and provider trends in non-emergency service and medication utilization based on claims data supported by our Pharmacist • Shows standard deviation results for the current quarter and year-to-date, as well as year-over-year changes • Used by the Medical Director to identify unusual patterns of utilization suggesting variance against typical practice patterns • Guides peer discussions with the Medical Director and providers whose patient rosters have higher than average ER usage, with additional support from the Provider Relations team

We will approach our analysis from two directions. First, we identify member-specific utilization patterns of high ER usage that can be addressed through targeted interventions with the member and the caregiver. Second we identify potential provider-initiated interactions that may reduce future ER utilization.

Addressing ER Utilization Through Clinical Leadership

Our interdisciplinary clinical leadership team, which will expand to include key leaders from our Fostering Healthy Lives team, meets monthly in the Clinical Operations Workgroup to review key medical trends, including ER trends, and to identify potential hot spots for program development or quality of care improvement opportunities. In addition, our MAC, Quality Management Committee (QMC), and Quality Management team will also gauge the effect of our ER strategies on an ongoing basis by reviewing ER visits and other key utilization and quality metrics. UniCare recently formed a new HEDIS workgroup that meets every two weeks to discuss trends across all HEDIS metrics for our Medicaid programs program, and we anticipate convening a similar workgroup for the Program. The Clinical Operations Workgroup currently supports our Medicaid programs, where they have focused on several key initiatives to make sure that members receive emergency care when they need it, while ensuring care is received in the appropriate setting:

- Providing initial and ongoing education on how to appropriately access care in a crisis
- Assisting with coordination of services that may address issues that have led to ER use
- Following up on ER visits to make sure crisis plans and follow-up are in place
- Focusing specifically on making sure that members with high ER utilization patterns have medical homes and are considered for an increase in care coordination level, as necessary

The Clinical Operations Workgroup, along with our Care Coordinators, specifically assists members with high or increasing ER utilization patterns to plan for and avoid crisis. Members identified with high ER utilization will be linked to appropriate services, resources, and education, and/or care coordination to address unmet needs that may be triggering ER visits.

Applying the Prudent Layperson Standard to ER Visits (BA072)

Emergency services and treatment are considered to be on-demand services and do not require precertification. Members, families, and caregivers are requested to go directly to ERs for services if they are either unsafe or the member's condition is deteriorating. The treating physician in the ER determines the services needed to stabilize the member's emergency medical or BH condition. Notification of any hospitalization must be made the next business day. The medical necessity of the admission will be reviewed upon receipt of the notification.

We will apply the prudent layperson standard to all claims submitted for emergency services used to evaluate or stabilize the emergency BH or medical condition. If care results in an admission to inpatient, the review of the member's presenting symptoms and clinical history, input from the Care Coordinator or the Department caseworker, and other factors that may have prompted the member to seek ER care are used to determine medical necessity.

Ensuring Timely Access to Crisis Stabilization Services (BA082)

UniCare currently contracts for short-term crisis stabilization services such as mobile crisis response services, assertive community treatment teams, and crisis intervention counseling. We also arrange for these services through other community mental health agencies and individual providers who can deliver interventions in the home or in a community-based setting. In addition, we have established contracts with the comprehensive crisis stabilization units, collaborating with these entities to support West Virginia youth in this community-based alternative to acute care. ***In the rare event that crisis stabilization services can only be provided by an OON provider, we will work with that provider to develop a single-case agreement and will consider the provider for inclusion in our network.***

Short-term crisis stabilization provides supportive services, such as medication reconciliation and management and motivational interviewing, to engage Program members in understanding and better managing their BH conditions in the most integrated residential environment. ***Crisis stabilization services that do not involve hospitalization do not require medical necessity reviews for care completed in 72 hours.***

Our primary goal is to achieve the best outcomes for our members in the right settings of care that minimize trauma and disruption, particularly for Program members, their families, and their caregivers. In addition to identifying members with significant needs and who are high-risk for crisis, ER usage, and hospitalization through predictive modeling and other data analytics, we focus on carefully planning for crisis, educating members and caregivers on steps to take in a crisis, providing assistance however members reach out during a crisis, and implementing follow-up.

Mitigating Crisis and Promoting Stability Through Care Plans

At UniCare, we believe the best approach to crisis management is to be proactive, whenever possible, and to have a plan for crises if they do happen. A critical component of our crisis management approach will be the development of safety plans as part of the Care Plan for every Program member. Our Care Coordinators will identify upon enrollment or at any point the need for a safety plan and develop the plan in conjunction with the member, caregivers, family, guardians, PCP, other providers, and Department caseworker as part of the members' holistic Care Plan. The safety plan will be used to proactively identify situations prone to risk and

provide immediate guidance to the BH hotline representatives, BH Clinicians, Care Coordinators, and others responding to crises, to support the members, caregivers, and their support systems during difficult situations.

Educating Members, Caregivers, and Families on Options

Our continuous educational process promotes and reinforces the use of the most appropriate and integrated resources for emergencies and crisis through multiple sources and touchpoints:

- **Welcome calls** that promote the use of our BH hotline as the preferred point of contact for crises
- **Member materials** that contain information about what do to in a medical emergency or BH crisis on member ID cards, welcome letters, our member handbook, and on our website
- **Individual safety planning discussions with Care Coordinators** as Care Plans are developed, offering an individualized way for Care Coordinators to have robust conversations with members, caregivers, and families about options that are available to avoid crisis, de-escalate crisis, or seek care in a crisis
- **Health promotion and member materials** tailored to the children and youth in the child welfare system and including visuals about what to do in a crisis, including a magnet we will give to caregivers, families, and others involved with Program members that provides the BH hotline number and other information to support crisis management

Members and caregivers will be educated about the importance of contacting UniCare in the event they have accessed crisis services through their PCP or a crisis stabilization unit (CSU), so that a Care Coordinator may initiate immediate follow-up activities and facilitate any communication needed with the member, UM team, or Department caseworker.

Accessing Assistance During a Crisis with the BH Hotline

We will encourage our members and their caregivers to use our dedicated toll-free BH hotline to seek assistance during a crisis. The toll-free hotline, which exists currently for our members will be extended to the Program and staffed by live, trained personnel available 24/7/365. Members or their caregivers who call the BH hotline will reach a representative trained in recognizing members in crisis who will screen and triage the situation. Members may be transferred to a BH Clinician who can immediately assess the risk of harm to self or others, to the 24/7 nurse advice line for medical concerns, or to a Care Coordinator for follow-up. All calls coming into the BH hotline will be logged in Health Insight with immediate notification to the Care Coordinators, so appropriate follow-up can be addressed and adjustments to the Care Plan can be made to avoid future crises. Additional descriptions on accessing emergency hotline numbers is located in MS023-MS025.

We will encourage our members and caregivers to use the BH hotline in times of crisis, but we fully expect that crises may present through the Concierge Line or the nurse advice line. ***There is no wrong way to access crisis care.*** Crisis calls that come through our nurse advice line or our Concierge Line will be warm transferred to BH clinicians.

Identifying Alternative Crisis Responses to ER Visits and Hospitalization

UniCare's priority in responding to crisis calls is first to make sure our members and their caregivers are safe. Once we have confirmed the risk of self-harm or harm to others is limited, our secondary goal is to make sure the crisis is resolved with an established plan that the member, the caregiver, and the UniCare teams involved agree will provide the right services in the right settings to address the member's needs.

When crisis situations are deemed to be non-life-threating, the BH Clinician will consider the services and options available to the member and caregiver specific to the situation. The BH

Clinician will collaborate with the member, caregiver, and Care Coordinator to connect members to local providers or services to establish a plan to address the identified issue through an immediate solution or referral for follow-up. The established and agreed-upon plan will be fully documented in Health Insight and a referral for follow-up will be made to the member's Care Coordinator. Examples of the potential services available to members and their caregivers as alternatives to trips to the ER or hospital are summarized in Table E.1-3.

Table E.1-3. Crisis Alternatives to ER Visits and Hospitalization

Alternative	Description
In-Home Clinical Services	• Goal to de-escalate a BH crisis and stabilize placement • Includes risk assessment and in-home clinical services • Participants include treating provider(s) or the treating provider entity (clinic) with after-hours or crisis response team • Additional providers will be recruited to provide this service
Telehealth Crisis Support	• Goal is to support immediate interventions in communities that suffer from shortages of BH providers and facilities • BrightHeart Health provides medication-assisted treatment and addiction services to young adults in provider offices • LiveHealth Online provides low-acuity psychiatric and psychological services to pediatric and young adult members • FasPsych provides high-acuity psychiatric and psychological services to pediatric and young adult members on-demand
Walk-in Crisis Intervention	• Goal to provide immediate access to services in a less intensive and re-traumatizing setting than an ER or hospital • Includes assessment and coordination of follow-up services • Currently, UniCare maintains extensive relationships with community mental health centers (CMHCs) providing this service
Mobile Crisis Response	• Goal is to provide on-site Crisis Intervention Services to avoid re-traumatizing members with a trip to the ER or hospital • Services can happen in a home, school, or any safe setting • Includes immediate evaluation and crisis assessment; stabilization strategies and safety planning; short-term intensive crisis intervention; clinical consultation; and referral to acute BH services • Currently, UniCare has established referral relationships for Mobile Crisis services with CMHCs and other entities throughout West Virginia, such as United Summit Center of West Virginia and FMRS Health Systems
Crisis Stabilization Units	• Goal to offer an alternative to inpatient hospitalization, particularly for members who have experienced trauma • CSUs provide short-term stabilization services (typically three to ten days) as an alternative to hospitalization • Includes assessment of the need for treatment within a CSU and coordinating arrangements with the CSU, if necessary • Currently, UniCare has established partnerships with CSUs operated by CMHCs throughout West Virginia, such as Valley HealthCare System

UniCare is aware of and supports DHHR's recent efforts to expand mobile crisis response and wraparound services for children (AFA 3-2019 Children's Mobile Crisis Response and Stabilization Teams and AFA 4-2019 Children's Mental Health Wraparound Services). We are ready to engage with additional entrants into these roles to expand our ability to offer crisis alternatives to all our pediatric members.



Preventing Future Crises with Follow-up, Communication, and Planning

Our primary goal following any member BH crisis will be to make sure the member receives follow-up care that helps minimize the potential for future crises. Upon call resolution, a referral will be completed allowing the Care Coordinator to follow up with the member and caregiver to make sure the member receives the appropriate person-centered, post-crisis services including offering appointment assistance, if needed, and assuring a follow-up Care Plan is in place. The Care Coordinator will communicate the follow-up plan to the Department caseworker in all cases, who may elect to convene an MDT meeting to solidify next steps, update the Care Plan if needed, and/or adjust the member's safety plan.

We will work closely with caregivers after a crisis to make sure they understand, agree with, and can implement required follow-up. We will assist with needs they have identified that may be additional to those we have identified. We will also add clinical resources, such as PCIT, that can further support them in caring for the member.

Each member's dedicated Care Coordinator will work with the member, caregiver, or family to learn more about the event that precipitated the crisis and to develop strategies to engage the member in treatment for BH conditions and individual crisis planning to reduce the risk of subsequent emergencies. Interdisciplinary care teams may also be conducted by the BH Medical Director, Care Coordinators, BH Clinicians, and other team members who review emergency calls and situations from the previous 24 hours. The team will confirm the response was effective in resolving the member's crisis and incorporate it into the member's Care Plan and safety plan. The Care Coordinator will work collaboratively with the member and caregivers to create safety plans, educate caregivers on BH issues, and implement strategies to prevent crises. When a member has a crisis, but does not engage UniCare during the crisis, our Care Coordinators will follow up as soon as they become aware of the event to be sure that services are in place to prevent a recurrence.

UniCare's Approach to EPSDT

UniCare has successfully coordinated EPSDT services in West Virginia, known as HealthCheck, under the Medicaid program for 16 years. ***In addition to our top performance in the state last year for preventive childcare, we experienced a 14.60 percentage point increase in Immunizations for Adolescents – Combination 2 between HEDIS measurement years 2017 and 2019, and a 14.98 percentage point increase in Adolescent Well Care Visits in the same period.***

In 2018, we were the highest scoring Medicaid health plan in West Virginia for the following HEDIS measures:

- Adolescent Well Care Visits (AWC)
- Annual Dental Visit (ADV)
- Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)

WV_FC2019_HighestScoringHEDIS_COB_02

In our support of West Virginia's goal to improve health outcomes for the child welfare population, UniCare will meet all requirements for EPSDT screenings for Program members, as part of the full range of comprehensive and preventive services for members up to age 21 years. Our Fostering Healthy Lives model recognizes the prevalence of unmet health needs typical in foster youth populations and includes proven processes, tools, and strategies to

improve health outcomes. We conduct these activities in compliance with the Contract, DHHR requirements, and CMS policies.

Our role in getting children in West Virginia dependable access to EPSDT services will serve as a fundamental early intervention with long-acting benefits on the member's health, behavior, education, employment, and economic and social well-being. With that understanding, we will employ an enhanced approach to communicating with members in child welfare, families and caregivers, and Department caseworkers about their PCP assignments and assist in making and keeping appointments.

Initial assessments and regular medical and dental care are vital to the health and well-being of our members in child welfare. We will build on long-standing stakeholder relationships and our extensive PCP network in West Virginia. UniCare's Care Coordinator will communicate and work with all stakeholders — PCPs (or those specialists acting as PCPs) and/or medical homes, dental providers, caregivers, DHHR, BCF, and Department caseworkers and child placing agencies — to deliver consistent and proactive messages about scheduling PCP/dental provider appointments, helping members overcome obstacles to keeping appointments, and engaging members in regular preventive care.

Medical Necessity Criteria Specific to EPSDT (BA009)

UniCare currently follows UM guidelines and manages medical necessity criteria and processes for our more than 154,000 members, including approximately 78,500 TANF members, and more than 76,000 members under age 21 years.

We believe it is important for individuals throughout the state to have care available when and where they need it, and we are committed to making sure that Program members experience an individualized, professional, prompt, and seamless medical necessity review process for access to EPSDT HealthCheck services on a case-by-case basis. Our medical necessity criteria for EPSDT HealthCheck-eligible members comply with federal, DHHR UM, AAP, Centers for Disease Control and Prevention, Advisory Committee of Immunization Practices, and the American Academy of Pediatric Dentist standards for diagnostic and treatment services provided to all members under age 21 on Medicaid. This includes coverage of any covered or non-covered services judged medically necessary by a member's physician or other treating provider that could correct or improve PH or BH illnesses, conditions, or developmental delays.

UniCare's HEDIS score for Adolescent Well Visits jumped by 14% from HEDIS 2016 to HEDIS 2018 and is currently above the 75th percentile.
WV_FC2019_E7_AdolWellVisits_56_COB_03

We provide access to providers eligible and qualified to deliver Medicaid services screenings, vision, dental, hearing and other diagnostic services or treatments in all geographic service areas with attention to challenges accessing services in more rural regions of the state.

Prior to adopting UM guidelines, we assure they are relevant to our enrolled populations through review and approval by our MAC and QMC. We also consider each member's individual needs and disparities, such as placement history, trauma or disproportionate levels of food insecurity or food deserts that may have an impact on care needs, when considering medical necessity. Please refer to BA047 and BA049 for more detail on our PA processes.

For EPSDT services that require a PA, our UM Clinician will work in conjunction with the child's provider, Care Coordinator, and the Medical Director to authorize services. We track and monitor EPSDT-specific PA activity monthly and mine data sources described in response to BA012 to identify EPSDT visits due soon and make sure there are no gaps in care.

UM Clinicians will consider members' place of residence, individual circumstances, and the local delivery system in determining medical necessity for those EPSDT services that may need

authorization. We will not impose limits on the amount, duration, or scope of EPSDT services for children and youth. We will cover services not specifically included under the benefit package but required by the child's PCP based on the results of an EPSDT screening as specified in Section 1905(a) of the Social Security Act, as long as the service meets the DHHR medical necessity criteria. We will defer to a child's PCP, or a treating provider in consultation with the PCP, when identifying the services a child needs to correct or ameliorate an illness, condition, developmental delay, or other issue identified during screening.

Our medical necessity review process results in determinations that have taken into consideration whether the request:

- Is medical in nature
- Is for a covered benefit
- Is for a generally recognized medical practice or treatment
- Is safe
- Is for a member with a Children with Special Health Care Needs (CSHCN) designation
- Is effective and evidence-based
- Is the most cost-effective option
- Will correct or ameliorate health conditions
- Should apply other criteria for services for which standardized criteria do not exist

EPSDT and the Statewide Medical Necessity Process

EPSDT services will be authorized by the UM Clinician, in conjunction with the child's provider, Care Coordinator, and a UniCare Medical Director. Authorization is used to verify that no other equally effective services are available on an outpatient or in-home basis. We closely coordinate across community-based, outpatient, and inpatient providers and with the member, Authorized Representative, family, caregiver, schools, and applicable agencies or programs to support timely discharge to their placement or a lower level of care with post-discharge support and uninterrupted care management and care coordination services.

We make medical necessity criteria available to providers by mail, fax, or email upon request. Providers may also contact our Medical Director, BH Director, or UM staff for assistance using our Pre-Certification Lookup Tool to determine if a service authorization is required.

Members or potential members may request our guidelines by contacting our Concierge Line our dedicated call line for youth members, their families, and providers.

EPSDT Processes (BA010)

Our assigned Care Coordinators will partner with the state's HealthCheck Foster Care Liaison staff in the Bureau of Public Health (BPH) to arrange for the member's initial comprehensive EPSDT exam upon placement into foster care. The Care Coordinator will arrange for a comprehensive EPSDT exam by a PCP within 30 calendar days of the placement, as well as a follow-up visit within 90 calendars days of placement in accordance with SPA, Article III, Section 2.2 and the DHHR Foster Care Policy manual.

Our EPSDT activities encompass the collaborative efforts of our:

- Care Coordination team to conduct outreach to members, caregivers, and their providers to facilitate and monitor access to and referrals for EPSDT screening and treatments according to the periodicity schedule or as determined to be medically necessary
- Information Technology Services department to support EPSDT compliance queries and trigger automated and individualized member and provider outreach for reminders
- QM team to provide overall management of the EPSDT reminder system process and reporting on EPSDT performance

Concierge Representatives as a Primary EPSDT Resource

Our dedicated Fostering Healthy Lives Concierge team provides EPSDT-related education, support and assistance to members and caregivers. They will conduct proactive outreach as quickly as possible, but no later than within five business days of enrollment notification, with the goal of contacting members within two business days. During this outreach, they will connect new members to an initial comprehensive EPSDT exam within the first 30 calendar days of placement as well as any other identified appointments, including an appropriate screening for trauma. They also reach out to members when they are identified as due for an EPSDT visit to facilitate setting up the next appointment. In addition, when members or caregivers contact our Concierge Line for assistance, Concierge Representatives refer to the Gaps in Care (GIC) HEDIS report to verify whether the member is due for an upcoming EPSDT visit, and to inform the member about scheduling an appointment.

Members, families, and caregivers can contact the Concierge Line for assistance to understand their EPSDT benefits, locate providers, and access transportation services provided by LogistiCare, DHHR's non-emergency medical transportation (NEMT) vendor. Our Concierge Representatives are available to answer members' questions; refer them to materials that explain EPSDT services; and locate and schedule the initial comprehensive exam with a PCP within 30 days of placement in foster care and within 90 calendar days for follow-up and subsequent appointments.

Care Coordinators Help Members Access EPSDT Services

Recognizing that members in the child welfare system may have a range of care needs, we will assign a Care Coordinator to every member within two business days of enrollment. While Concierge Representatives conduct a Fostering Healthy Lives Health Risk Screener (HRS) during their initial outreach to members and their caregivers, Care Coordinators conduct a comprehensive health risk assessment (HRA) within 30 days of assignment of children and adolescents who have been stratified into the complex care coordination level. Member outreach frequency is according to each member's care coordination level. EPSDT visits due soon and potential gaps in care or changes in status are addressed during the Care Coordinator's ongoing contacts.

- **Complex.** At least two contacts per month; a minimum of one face-to-face contact per month; and as requested by the Department caseworker or court system.
- **Intermediate.** At least one contact per month; a minimum of one quarterly face-to-face contact; and as requested by the Department caseworker or court system.
- **Connected.** Contacts made within two weeks of identification to address EPSDT visits due and potential gaps in care or changes in status; and as requested by the Department caseworker or court system.

In addition to frequent member contacts, our Care Coordinators will be available when members in child welfare and/or caregivers need extra help understanding and accessing EPSDT HealthCheck services. They will educate and give counsel about prescribed treatment programs and the importance of adhering to their initial EPSDT visit within 30 days of placement in foster care, follow-up visit within 90 calendar days, and ongoing. They will help them access the information they need to make medically informed decisions about their health care and follow up when recommended assessments and treatment do not occur on schedule.

The Care Coordinator will provide continual support, education, and linkage for necessary EPSDT services, to proactively meet EPSDT timeframes. In alignment with the purpose of EPSDT, care coordination emphasizes ***prevention***, continuity of care, and coordination of care, which advocates for and links members to services as necessary across providers and settings.

Meeting Medical Necessity in All Geographic Areas

We have a comprehensive, long-standing, statewide Medicaid network of more than 14,000 unique Medicaid-enrolled providers and facilities including providers currently serving members in child welfare. We contract with 500 pediatricians and over 2,200 PCPs through the State to satisfy access to EPSDT services as well as with every Federally Qualified Health Center (FQHC); Rural Health Clinic (RHC); all acute care; and tertiary hospitals, including children's hospitals in the state. Our network meets and often exceeds adequacy standards to serve members in all geographic areas (except where no providers are available for contracting). We will maintain, and expand as needed, a statewide network that coordinates the health services, including EPSDT, and social needs of our members in child welfare. We also have innovative solutions to bring EPSDT services to members in regions of the state with fewer providers, such as our School-based Well-visit Incentive Program (SBWIP), mobile dentistry, and Nurse Practitioner Home Visits described in our response to BA014. Additionally, see ND001 for details about our approach to fulfilling statewide access requirements.

Informing Members and Providers About EPSDT (BA011)

We have developed a deep understanding of the challenges and issues our members face to achieve and maintain good health outcomes. We act as a liaison and navigator to help children, youth, and their families safely and effectively navigate all of their health care services, including EPSDT HealthCheck. ***In addition to our current oral and written communication methods regarding EPSDT, we will use new and revised materials developed with the child welfare population in mind to make the most of these contacts and EPSDT visit outcomes.***

General Outreach for Members, Families, and Providers

Connecting children and youth with timely and age-appropriate EPSDT remains a key priority for UniCare. We have structured our Fostering Healthy Lives model to incorporate multiple opportunities to promote EPSDT HealthCheck services. ***We understand the challenges for obtaining accurate contact information for members in foster care and will develop new processes to send EPSDT-related communications to the right place.*** We will reengineer our process for tracking member contact information in addition to the DHHR member address and phone number on record. We will capture and load into our system member and caregiver direct contact information during Concierge Representative and Care Coordinator contacts and when recieved from our network providers.

Our members will first learn about EPSDT during their welcome call with a Concierge Representative upon enrollment, and from their assigned Care Coordinator during regular contacts at intervals consistent with their care coordination level. At a minimum, we contact members every six months when they have not received EPSDT services in that period, although our ongoing reviews of EPSDT access described in response to BA012 result in more frequent contacts through our care coordination process for the majority of members.

In addition to a welcome call, we send a new member welcome packet through the mail to provide comprehensive information about EPSDT services and benefits at our members' fingertips within five business days after we are notified of their enrollment. Members with smartphone capability and mobile access also have access to these materials on our member website. We will also inform members, families, and caregivers about EPSDT benefits on an ongoing basis in the member handbook, in Preventive Health Guidelines on our member website, via member blogs, at community events, and through social media including Facebook and Twitter in accordance with the Program.

All member materials and outreach by our staff consider West Virginia's cultural diversity, languages spoken at home with translation available, health literacy, and educational level. Our member handbook and Preventive Health Guidelines are further described.

- **Member Handbook.** All members, families, and caregivers receive comprehensive information about EPSDT access and services in our member handbook. It describes the benefits of preventive health care; EPSDT services available including screenings, diagnostic, and preventive services and treatment and how to obtain them; an EPSDT checkup schedule; a list of screenings and exams including well-child visits covered under EPSDT; and that EPSDT services are at no cost to the member. For additional information about our member handbook, please see our response to MS009.
- **Preventive Health Guidelines.** Members have access to our Preventive Health Guidelines on the member website. There are user-friendly guidelines to help members know when and how often to set up doctor visits for HealthCheck EPSDT exams, screenings, tests and vaccines. This includes detailed information about well-baby and well-child exams and exams for pregnant women, and vaccine schedules.
- **Member Outreach.** UniCare currently makes "reminder" calls, emails, and texts, when permitted, to members and/or caregivers about their appointments. We will send a preventive health reminder and conduct an automated call to all Medicaid members 45 days prior to their birthday. The reminder contains health tips, as well as the complete schedule of recommended services due in the upcoming year based upon the member's age. We also use our HealthCrowd text messaging service to send annual EPSDT service preventive reminders prior to the member's birthday. We incentivize members to attend well-child visits through our Healthy Rewards program, offered as a VAS, described further in this response.

We inform providers about EPSDT services during their initial provider orientation and in ongoing training, in the provider manual, through alerts posted on the provider portal, and through fax blasts to convey time-sensitive communications. We also develop toolkits and PowerPoint presentations to convey critical information.

Our provider manual outlines specific benefit requirements, including the EPSDT requirements, expectations, and monitoring. The provider manual is updated annually, or as needed, and used to conduct refresher trainings.

We will also disseminate informational materials throughout the year to assist providers and encourage them to offer members extended office hours for enhanced reimbursement. Our EPSDT strategy is designed to support the provider community by giving them information to supplement their efforts and encouraging member engagement through education and provider incentives.

Provider EPSDT Training. UniCare educates providers about the EPSDT program. This training includes periodicity requirements for HealthCheck screenings, the required components of initial and periodic HRS, information on EPSDT special services, EPSDT coverage even when a service may not be covered under the West Virginia Medicaid State Plan, and services that exceed benefit levels, amounts, frequencies, or duration otherwise allowed. Providers are trained about emerging health status issues among members that should be addressed as part of EPSDT. We also advise providers that no service for a Medicaid child will be denied, reduced, or terminated before it is reviewed in accordance with our EPSDT policy.

- We post EPSDT-related documents and trainings on our provider portal including:
  - EPSDT Provider Toolkit
  - Improving EPSDT Services for members presentation

  - Provider administration of EPSDT screenings and special services for West Virginia Medicaid members guidance
- A key resource for providers, the EPSDT Toolkit includes:
  - Recommended screenings by age
  - Information on EPSDT special services (medically necessary diagnostic testing, treatment, and services beyond regular EPSDT Services)
  - Documentation guidance
  - HEDIS measures, documentation guidelines, and billing codes
  - FAQs on EPSDT

Targeted EPSDT Outreach. Our designated field-based QM Practice Consultants conduct targeted EPSDT education with high-volume PCPs who serve 500 or more members and run reports such as bi-annual claims reports to identify all PCPs with 100 or more EPSDT claims per month to audit the charts of members under the age of 21 for timely periodicity screenings. The audit checks that screening services include the full array of necessary and required components. We conduct focused feedback and education with providers delivering EPSDT services for which audit findings disclose average screening rates below 80% to improve their performance with EPSDT screening outcomes. We also educate and refer providers to the West Virginia HealthCheck website for Preventive Health Screen forms.

Educating Providers and Members About EPSDT When Specialists Deliver Primary Care

We understand that some children with specialized health care needs may receive their primary care from a designated specialist who manages their overall care. Our Care Coordinators identify specialists who deliver primary care services to children and make sure these providers have complete information about EPSDT HealthCheck, including our EPSDT Toolkit, to best represent the member's timely access to screenings, diagnostic, treatment and referral needs. In addition, the Care Coordinator identifies members who receive primary care from a specialist and underscores with members the role their designated specialty PCP has in keeping them up to date on age-appropriate EPSDT services. We also perform additional coordination and monitoring to verify that these members receive EPSDT visits as planned.

Outreach to Promote Dental Care Access

We promote early and regular engagement in dental screens and services as prescribed by the dentist. We do so for members as a part of EPSDT HealthCheck and offer incentives through our *Healthy Rewards* program, offered as a VAS. Members age two years and older can receive a $25 gift card reward each time they complete an annual dental visit. We will notify Medicaid members and caregivers prior to their birthday, as described further in response to BA011, to schedule their dental visit, and we follow up with members who miss this preventive milestone.

We will leverage claims data obtained from our dental subcontractor SKYGEN USA, LLC (SKYGEN) to send appointment reminders, conduct Care Coordinator outreach about upcoming appointments, and identify missed appointments for rescheduling or reconnection with a dental provider if we identify a gap in dental care, which we detail in BA094 through BA098.

Using Reports to Track and Evaluate Access to EPSDT Referrals and Treatments (BA012)

Throughout the year, our QM team analyzes data and develops compliance targets for EPSDT services. We additionally develop specific interventions aimed at increasing member usage of EPSDT services, which will include live care coordination contacts supported by IVR outreach or mailed materials like those described previously. We conduct an annual evaluation of the EPSDT program, including interventions achieved and opportunities for improvement in the annual program evaluation.

Our QM department will review reports containing member transition data on children and youth new to UniCare, when available, PCP EPSDT-related encounters to identify members with upcoming EPSDT required visits, and those with missed EPSDT appointments. With this information, we regularly assess our performance against EPSDT periodicity schedules and conduct systematic QM activities to monitor and improve access to timely newborn physical exams, well-child visits, dental exams, immunizations, and other EPSDT services. These monitoring activities help us to track physician practice activities and target gaps and delays in EPSDT service delivery. We rely on monthly queries and extract data files from our EPSDT Datamart repository, which generates the files for:

- Preventive health reminders, text messages, or emails
- Overdue reminder post cards, text messages, or emails, and
- EPSDT provider letters of members with care gaps or upcoming preventive health screenings

The Care Coordinator uses this information to conduct regular EPSDT monitoring and will identify and take steps to address any gaps in care, including timely initiation of treatment for referrals that result from EPSDT screens.

Our set of reports for monitoring and evaluating access to EPSDT services are in Table E.1-4.

Table E.1-4. Methods for Monitoring and Evaluating EPSDT Access

EPSDT Monitoring Method	Description
Monthly Claims Encounter Data Reports	We generate monthly reports from claims encounter data at the member level to determine whether members are up to date with age-appropriate EPSDT services. A QM Practice Consultant reviews the monthly report for missed appointments and initiates outreach by the member's Care Coordinator to address care gaps.
Monthly Gaps in Care HEDIS Reports	Prepared monthly for UniCare clinical staff to identify members who have not received scheduled EPSDT services or have upcoming EPSDT services coming due. Concierge Representatives also monitor PCP HEDIS outcomes to identify member gaps in EPSDT and share these reports with physicians as they deem appropriate.
Medical Record Reviews	QM Nurses perform random medical record reviews on all PCPs with a focus on quality care, access to care, preventive care, and promotion of tools to assist the provider to meet quality standards.
Quarterly DHHR EPSDT Report	State performance report regarding EPSDT outreach/enabling services, screening, referral, well-care child, dental visit and immunization rates, submitted to DHHR within 45 days at the end of each quarter.
CMS-416 Annual EPSDT Report	Our QM department will provide DHHR with information necessary to complete the CMS-416, which reports on the effectiveness of West Virginia's EPSDT program. We use this information to assess our overall performance on EPSDT service delivery.

EPSDT Appointment Tracking and Reminders (BA013, BA014)

Care Coordinators monitor EPSDT for all of their assigned members concurrent with member contacts and case plan reviews. They also identify any barriers to appointments and offer solutions and assistance to the members and caregivers through available resources, such as transportation assistance. The Care Coordinator will collaborate with the state's HealthCheck Liaison, Department caseworker, PCP, and family to help to track EPSDT assessments, exams, and follow-up appointments, and to identify and address any barriers to EPSDT services.

Assisting Members in Making and Keeping Appointments

Our Fostering Healthy Lives established reporting, policies, and procedures will be enriched by dedicated local staff and multiple supportive tools and processes that help members and caregivers make and keep EPSDT appointments with providers and other services. Our comprehensive approach has resulted in successful EPSDT appointment completions.

Supports and Data Analytics for Timely EPSDT Appointments

Upon enrollment, the Concierge team gathers information about the member and makes welcome calls, encouraging and helping members and/or caregivers to make appointments and identifying barriers to keeping them. The Concierge Representative can also help coordinate transportation to appointments if needed. As an integral component of our model, Care Coordinators use our sophisticated data analytics, such as GIC HEDIS reports, to inform ongoing care coordination contacts both face-to-face and by phone with members and their caregivers. Our Care Coordinators will also review new member history on EPSDT services received in the intake process to support the member, family, and caregiver regarding future EPSDT appointment needs.

Care Coordinators will go over EPSDT appointment status to schedule upcoming visits and remove any barriers to accessing care, and coordinate and notify providers, Department caseworkers, and child placing agencies as necessary. ***An additional report will help Care Coordinators monitor for and perform outreach with members due or overdue for their initial post-placement 30-calendar day comprehensive EPSDT exam and 90-calendar day follow-up visit.***

Automated Calls and Texts Send EPSDT Reminders

As a complement to our ongoing care coordination outreach for EPSDT, we will make automated IVR calls with the member's option to speak with a live agent to assist with appointment and transportation scheduling. We collect and store member contact information to make sure that our texts are delivered directly to members and their caregivers whenever possible, rather than to the state office address on record.

We will follow up with members to remind them about their scheduled well-child visits, EPSDT screenings, and preventive health visits through their text messaging program. We found that more than 88% of UniCare's member phone numbers are mobile, supporting text communications for consistent member outreach success. In 2018, UniCare made over 84,000 contacts about EPSDT service needs via text to its members.

PCP Proximity to Child Placement, Addressing Continuity of Care

We find members are more likely to keep an EPSDT appointment when their PCP is conveniently located near their home and we will discuss this with foster families who may take care of a child whose PCP prior to placement is beyond their service area. While we strive to maintain each member's continuity of care with PCPs and other providers as they experience transitions in placements, we recognize this may not be a practical arrangement for foster parents. To ease barriers to scheduling and keeping EPSDT appointments we will also

collaborate with foster parents and BCF when it may be beneficial to change PCPs. Further, we work with families who care for more than one child in foster care to align their PCPs; we find this makes it easier for them to schedule and keep EPSDT visits. Our Foster Care Access Incentive Program (FCAIP) also incentivizes providers who make sure members newly enrolled and re-enrolled in the child welfare system receive initial health assessments, comprehensive EPSDT exams, and medical, dental, and trauma assessments within the timeframes prescribed by DHHR.

Addressing Missed Appointments

We will collaborate with providers on member outreach attempts to prevent duplicative reminder calls since too much outreach can frustrate rather than help member engagement efforts. If members miss appointments, we will follow up to assist in rescheduling the appointment within 24 to 48 hours of notice of missed appointments. Claims data helps us identify members who are not receiving timely and appropriate care. When we identify a missed appointment, we will work to address the issue in a number of ways:

- Care Coordinators will proactively work to confirm that members receive a comprehensive EPSDT exam within 30 days of placement by contacting the caregiver, if permitted, to determine if the visit has occurred as scheduled and to ask the reason the appointment was missed, and assist in scheduling or rescheduling as needed.
- We may contact the provider to reschedule the appointment.
- We contact the member's caregiver and Department caseworker, as appropriate, about the missed visit.
- For members receiving adoption assistance, we will reach out directly to the member's adoptive parent to reschedule the appointment with the provider.

To support our high-contact outreach process, we also send overdue postcard reminders to members who are behind on receiving EPSDT services within 90 days of a missed EPSDT visit. This postcard reminds the member, parents, and caregivers that the child is past due for a checkup and encourages them to schedule an appointment with his or her PCP.

Providers receive a monthly letter from UniCare with a list of members on their panel who are past due for EPSDT services. This mailing includes a cover letter to providers, reminding them of the importance of EPSDT services with a list of members on their panel who are overdue for EPSDT services. In addition, written past due reminders are automatically generated and mailed to each member from birth up to the age of 21 when services are 90 days past due.

Our outreach about missed appointments includes information and education about the importance of preventive care and the benefits of maintaining a good member and/or PCP relationship. We will also encourage provider offices to alert us to missed appointments, particularly those required comprehensive EPSDT exams required within 30 days of placement where timing is critical.

Identifying and Removing Barriers to EPSDT Appointments

When we learn about a missed EPSDT visit, a Care Coordinator will follow up with the provider and member to determine the root cause and address barriers to future visits. We leverage SDOH data from the HRS, SDOH assessment tool, and Care Coordinator outreach to identify and address unmet SDOH in key areas such as housing, education, employment, health literacy, and food. Care Coordinators use SDOH information to inform care planning, strengthen EPSDT adherence, and address specific services that would help to minimize missed EPSDT visits.

For example, the Care Coordinator will determine:

- If the member experienced transportation difficulties and needs a referral to NEMT
- Whether community-based resources such as West Virginia Home Visitation program that support self-management would help to improve EPSDT outcomes
- If SNS may be authorized to give members access to social services that have been identified in an assessment and that would contribute to EPSDT outcomes
- Our complete approach to addressing SDOH in care coordination is described in CM028-CM029.

Enhancing Access to EPSDT Through Innovative Solutions

Provider Partnerships

We are increasingly linking provider performance to reimbursement to align provider goals with those of DHHR. We will build off our existing incentive-based programs and launch our FCAIP to incentivize initial health assessments, EPSDT, and a trauma assessment to enhance access and wellness as described in detail in Table E.7-1 in our response to Attachment E.7, Quality. For example:

- We will reward existing providers who extend their office hours and encourage additional providers to expand their capacity to serve members during extended hours, including on weekends, with enhanced reimbursement. Extended office hours provide our members with greater convenience to PCP appointments. We identify PCPs who offer extended office hours for Care Coordinators to share with new members and caregivers who are scheduling an appointment for an initial comprehensive EPSDT exam within the first 30 days of placement in foster care.
- We will offer enhanced reimbursement to PCPs who agree to see UniCare members in foster care for emergent assessments or other services.
- We incentivize providers to meet HEDIS-based quality measures and other cost and efficiency indicators under our population health incentive programs, such as Provider Quality Incentive Program (PQIP) and PQIP Essentials, and our specialized services incentive programs, such as our Behavioral Health Quality Incentive Program (BHQIP) and OB Quality Incentive Program (OBQIP).

We have a School-based Well-visit Incentive Program (SBWIP) in place to drive improvements.

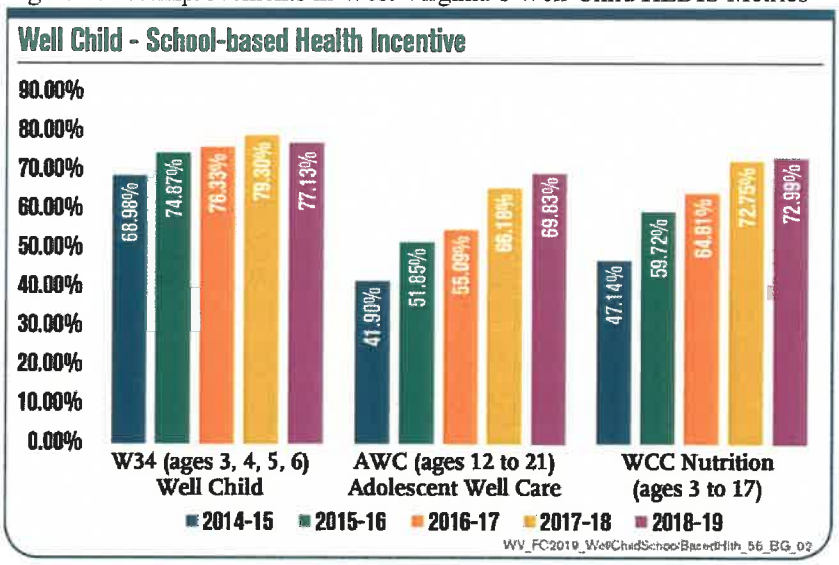
Between 2015 and 2018, we experienced year-over-year improvements in our child members' satisfaction ratings on the annual CAHPS® survey for their ability to get checkups or routine care as soon as needed with scores over the 95th percentile every year. These improvements were largely attributed to our SBWIP innovation.

Proven EPSDT Success in Partnerships with School-based Health Centers

By working together, UniCare and SBHCs achieve the mutual goals for increasing well-child and well-adolescent checkups for the youth population, including in rural service areas. In 2015, UniCare collaborated with the School-based Health Assembly to design and implement an award-winning program that incentivized participation of school-based health centers (SBHCs) and members to increase child and adolescent well visits. SBHCs with the highest number of EPSDT participants earned financial incentives. For children and youth in foster care, schools may offer the most consistent point of continuity for preventive care.

In 2018, 152 schools offered clinic services (including mobile units) in 38 counties. The largely rural geography of the state made SBHCs an ideal community partner to increase access to high-quality primary care for children and adolescents. Serving youth at school where they are already spending most of their day reduces transportation needs and minimizes lost instructional time. For each completed checkup, eligible families earned a $25 incentive. SBHCs earned a $25 incentive for each completed medical record for a well-visit. In the 2018-19 school year, the host school of an SBHC with the highest percentage of completed medical records with well-care visits received a $3,000 — an increase over previous years.

Figure E.1-7. Improvements in West Virginia's Well-Child HEDIS Metrics



After four years, the contest demonstrated dramatic improvements in three HEDIS measures. Figure E.1-7 summarizes improvements in the SBHC initiative. Members completed more than 8,000 exams that likely would not have otherwise been completed. Associated HEDIS rates increased more than 11 percentage points, exceeding state goals of achieving 5% increases over baseline rates. During year four, we distributed more than $89,000 in incentives to schools, members, and school-based clinic providers.

At the time the program was initiated, more than 4,500 child and adolescent members in West Virginia lacked an EPSDT visit. ***In the first year of our school-based contest, over 1,200 exams were completed and we were able to close almost 900 HEDIS gaps in care.*** UniCare will continue to partner with West Virginia schools on this initiative to improve well-child care for children and youth in the Program.

Telehealth, EPSDT Clinic Days, and Mobile Dentistry

We will be working with network providers including PCPs and dentists to further expand accessibility to their practices.

- **Telehealth.** We will offer timely BH assessments for members newly enrolled with us and reduce "no-show" rates through the availability of telemedicine resources. We have found telehealth complements access to care needs for children in PCP offices, schools, emergency rooms, and in rural communities. Telehealth has proven useful as an alternative method to conduct BH screenings, which we have done in partnership with LiveHealth Online and FasPsych. See our response to CM019 for additional information about our telehealth strategies to improve access and wellness.
- **Dedicated EPSDT Clinic Days.** These pop-up clinics occur in FQHCs and larger clinics. To prepare for EPSDT Clinic Days, we telephone members who have high no-show rates and gaps in care to connect them to the practice for an appointment and assist them with

transportation if needed. We are taking steps to expand EPSDT Clinic Days in 2020 and are looking for additional community partners to participate.

- **Mobile Dentistry.** SKYGEN provides our members with access to mobile dentistry services. They travel to school-based health clinics and other high-volume network providers to provide dental screenings, diagnostic, and treatment services. This service has been a valuable addition to the delivery of oral health services in rural communities.

Nurse Practitioner Home Visit Model



We are developing an innovative program to help meet our members where they are to receive needed care. Through our new Nurse Practitioner (NP) Home Visit model, we will coordinate with NPs in the network to offer an increased rate for home visits that close critical gaps in care. Our QM team will provide analytics that identify members in need, and our Care Coordinators will work with members, families, and caregivers to set up in-home appointments for overdue EPSDT services. We anticipate that this new option will benefit busy households, families, and caregivers with transportation barriers, members in rural communities with more limited provider access, and others who have under-utilized PCP services.

Utilization Management and Coordination of Services — Coordination for Specialized Health Care Needs



Our person-centered approach to UM and care coordination will enable us to deliver needed supports and services to members with specialized health care needs in the most integrated, appropriate, and cost-effective way possible. Each member with specialized health care needs will have an ICM team, comprised of integrated tools and rounds. This team will be fundamental to making sure that UM protocols accommodate the unique needs of each member. Care Coordinators with specialized skills, such as Nurse Care Coordinators with pediatric nursing or BH licensure, will work closely with UM staff to add important details to the clinical information received from providers, as well as help incorporate a trauma focused approach to service-level decisions. This helps UM staff have a more complete clinical picture when making authorization decisions for all members, and especially for those with specialized health care needs. Working collaboratively with the ICM team, as well as with UniCare's team of subject matter experts available to Care Coordinators, will help to assure that members receive needed services and seamless access to specialists in relation to their care planning.

Identification of Individuals with Complex or Serious Medical Conditions (BA079)

We use diverse and responsive methods to identify member needs and risks and match program interventions to those findings. The purpose of the initial intake and assessment process is to understand as much as possible about the member's current services, recommended services, and unmet needs. This process supplements our review of available clinical and claims information, risk stratification process, and internal and external referrals to help us promptly identify complex or serious medical conditions, and design a care coordination program appropriate for the member and caregiver.

Gathering Information to Identify Members' Care Coordination Needs

We will seek to obtain holistic information that will help us rapidly engage members in the appropriate level of care coordination. While we have sophisticated tools to guide stratification of Medicaid enrollees, we have vastly expanded these processes to reflect the myriad of non-clinical factors that influence the health and well-being of children and youth in child welfare.

Each step in our trauma-informed approach supports information gathering without unnecessary re-assessments that may exacerbate ACEs and trauma. In addition, our approach incorporates interviews with the member, families, and caregivers to encourage a family-driven and youth-guided approach to care coordination.

Assignment to a Single, Qualified Care Coordinator

Within two business days of a member's enrollment, we will assign the child or youth to a Care Coordinator in their region, collaborate with and gather information from the Department caseworker, and will contact the member or caregiver to complete or schedule our HRS by phone or in person. Our HRS includes questions about member demographics; information about who is completing the screening on behalf of a child (if the member is under 18); current health status; current health services; mental health and SUD status; SDOH; education; and caregiver strain. Discussion with the member and caregiver provides significant insight into the child or youth's care coordination needs and appropriate level of stratification.

We will also contact the member's Department caseworker to obtain or review existing assessments and screenings to make sure we have current, accurate, and complete information. We continue to gather this information on an ongoing basis to support continuous care coordination. We also consider the child or youth's initial PH screening, the medical, dental, and vision exams, as well as the child's mental health screening.

Care Coordinators also review a child or youth's risk factors identified from our proven data analytics and predictive modeling tools that include our child welfare-specific predictive model. As claims data, assessment data, and other information becomes available, it is incorporated into our data analytics process generating a risk score that may be helpful to the Care Coordinator in making a final determination of the member's appropriate level of care coordination engagement.

The purpose of the data gathering and review process is to provide continuity for the member in maintaining and supporting existing relationships with health and human service providers. This process also helps with stratifying the member into the appropriate level of care coordination. We will provide each member with the appropriate level of touch points and intensity of care.

Finally, we accept referrals from all sources employing a "no wrong door" policy and encourage our providers and system of care partners to inform us of member needs that may require additional coordination to add value to the member's care. We synthesize this information and assign members to a care coordination level based on clinical judgement, acuity, assumed risk, and factors of stability. Our stratification process is discussed in further detail in CM027.

Care Coordination Stratification Levels

After reviewing the member's profile, our Care Coordination Manager Assign members to one of three care coordination levels — connected, intermediate, or complex. With a clear understanding of the child or youth's current needs, each member's assigned Care Coordinator promotes continuity of care by verifying they remain connected to services and providers, even as they fluctuate between care coordination levels.

The Care Coordinator continues to track care and services provided to each member to confirm continuity and a Care Plan that holistically addresses all their needs and strengths. For example, a teen who is newly enrolled and pregnant, which represents a high-risk condition, is immediately assigned to the complex care coordination level and is assigned a Care Coordinator who initiates ICM and verifies that she continues to receive timely and appropriate prenatal care. CSHCN are also enrolled in our complex care coordination level and receive care management from a Care Coordinator with related expertise, such as a pediatric nurse.

Ongoing Monitoring and Assessment of Member Needs

We recognize that a member's health status may be highly fluid; therefore, we conduct continuous member assessment and monitoring for needs through our contacts with the member and those engaged in their care and ongoing analytics. As individuals' needs change, they may move in and out of specific levels of care but remain aligned with their Care Coordinator. This minimizes the need for transition plans and reduces the likelihood that children and their family will disengage from any level of care coordination and promotes stability for the youth. Throughout the process, the Care Coordinator remains the single point of contact and works collaboratively with the child, their caregiver, and Department caseworkers to provide ongoing support, identify emerging risks, and make sure necessary services are occurring as planned, removing barriers when necessary. Each Care Coordinator is part of an ICM team or ICT that provides access to multiple clinicians with varying areas of expertise, allowing a member with complex needs to remain with a single point of contact who is able to access the skills and expertise of their team members when needed.

Identification of Members with Special Needs (BA080)

UniCare has established information systems and processes to identify members with special health care needs or with complex or serious medical conditions. The Health Insight platform will be the information system of record for member care coordination and management information, integrating seamlessly with our Core Service System and data warehouse. The Health Insight platform will facilitate integration among all clinical staff and foster a holistic view of the member through combining member data and information from various sources into a single record, facilitating identification of members with special needs.

The following information sources, stored in our systems and accessible to clinical staff and providers through the Health Insight platform, will be used to identify members with special health care needs or with complex or serious medical conditions:

- Referral from any source (including a provider, collaborative partner, or the member or caregiver) indicating a member has special health need(s)
- Data received from X12 834 files regarding notification of members in the CSHCN program
- Department-obtained trauma assessments, such as the West Virginia CANS
- Child welfare plans (including case plans, individualized service plans, family service plans, and safety plans)
- HealthCheck preventive screening
- Fostering Healthy Lives HRS data
- Condition-specific assessments, as determined appropriate by the HRS
- HRA data for members in complex care coordination level
- Monthly review of claims data to identify members with special health care needs based on diagnosis codes
- Data mining activities, including predictive modeling
- UM activities
- All other data and information gathered by our Fostering Healthy Lives Concierge team or Care Coordinator will be documented in our Health Insight platform

UniCare continually monitors the needs of our members, and collaborates with the Children with Special Health Care Needs (CSHCN) Program on a daily basis to make sure that children we identify with special health care needs are promptly referred to the CSHCN Program. **UniCare has already referred 62 children to the CSHCN Program during calendar year 2019 (through June).**

WV_FC2019_BA080_CSHCN_15_COB_01

This information, accessible through the Health Insight platform, is synthesized in our ongoing care coordination process to identify special needs upon enrollment and continuously throughout our engagement with the member.

Health Insight Isolates Data Specific to Key Factors (BA081)

Health Insight enables quick identification of information in enrollment data, such as members with specialized health care needs.
WV_FC2019_BA081_HealthInsight_15_COE_03

Our Health Insight platform combines member data and information from various sources into a single record to deliver a holistic picture of the member. It features easy access to information through various data analytic search tools, hover-overs, drop-downs, and drill-throughs, enabling us to quickly isolate specific data, including data specific to an eligibility category or a diagnosis. It displays information including all member demographic and eligibility information currently on file and all available clinical data. Claims, utilization (inpatient, ER, outpatient), pharmacy, care gaps, immunization records, lab results, and diagnosis information is displayed in an easily accessible way. Each member has a personal health record with all available assessments, risk scores and alerts, history of outreach, Care Plans, and utilization history, including SNS. Text fields can be used to record components assessment results or erosion or improvement of scores over time to inform service determinations and recommendations. Additional details about data analytics that will help inform population health planning for this population are described in BA019-BA023.

A combination of tools, drop-down menus, and text boxes can be used to facilitate actionable reporting and identification of key information that can facilitate stratification decision-making and Care Coordinator assignment and that continually informs our QAPI program. Health Insight enables quick identification of information in enrollment data, including specialized health care needs and other information supporting identification of members that need to be prioritized for outreach, such as pregnant members or members with chronic conditions.

UM Protocols Facilitate Referral and Treatment Requests for Members with Specialized Health Care Needs (BA042-BA044)

UniCare currently provides services to 389 CSHCN members, and we have modified our UM protocols to support coordination with the CSHCN care coordinator.
WV_FC2019_BA042_CSHCNMembers_15_COE_02

We make sure that members with specialized health care needs, including those with disabilities (or at risk of developing a disabling condition), or a chronic or complex medical or BH condition, are identified, screened, and referred to specialty providers for assessment and appropriate treatment. We already have policies and processes in place to continually monitor our membership and refer children for inclusion in the CSHCN program, when appropriate. ***We have been working in close partnership with the CSHCN program and have received positive feedback regarding our leadership role in developing and modifying UM protocols to effectively coordinate care and facilitate access to referral and treatment for children in the CSHCN program.***

STABILIZING and STRENGTHENING FAMILIES

Our UM protocols support use of appropriate health care professionals in assessing members to identify medical procedures to address and/or monitor the conditions, and in the development of treatment plans appropriate for members determined to need a course of treatment or regular care monitoring. ***UniCare currently contracts with over 400 CSHCN program providers at more than 410 locations, comprising over 1,070 CSHCN access points.*** We also make sure that other providers are available to deliver the same level and types of services as CSHCN providers. Our UM program uses a person-centered approach, combined with evidence-based clinical guidelines, to facilitate appropriate and timely access to quality services for our members. Each review is customized to individual

members and focused on determining the appropriate level and site of services based on their specific situations and benefits.

Table E.1-5 identifies some factors that we have identified through our current experience serving children with specialized health care needs and foster care populations, and describes our approach to modifying our standard UM protocols to accommodate the unique circumstances within each factor. The factors included in Table E.1-5 are not all inclusive. We treat every child and situation on an individual basis, and maintain flexible and fluid UM protocols to facilitate our ability to make sure that every member, including those with specialized health care needs, receives timely and appropriate services.

Table E.1-5. Flexible UM Protocols Accommodate Multiple Factors and Individual Circumstances

Factor	Standard Protocol Adjustments
Information gathering to support UM determination	Outreach and coordination with the Office of Maternal Child and Family Health (OMCFH) Care Coordinators to discuss member needs, obtain the Client/Family Assessment and Client Care Plan to aid in individualized UM decisions, coordination of services, and prioritization of routine preventive and EPSDT services with appropriate CSHCN providers and clinics.
Providing for ongoing health care needs	Identify ongoing health care needs and removing standard requirements for those services due to the ongoing nature of the care required (for example, implementing extended authorization for services such as private duty nursing).
Aligning care with experienced and trained providers	Link members with one of our more than 400 network CSHCN providers whenever possible in order to align care with providers who have committed to participating in multidisciplinary treatment teams for the development and completion of the Patient/Family Assessment and Patient Care Plan. In addition, we work to align members enrolled in the CSHCN program with one of our dental subcontractor's 251 dental providers who provide services to members with specialized health care needs.
Providing standing referrals to specialists based on individual condition	Connect members with appropriate specialists based on member condition (such as a pediatric neurologist for members with cerebral palsy) to serve as the PCP, providing support, data, and education to the specialist to promote appropriate primary and preventive care.
Coordinating discharge planning and expediting post-discharge services to address complex needs	Conduct ongoing concurrent review during inpatient stays in coordination with the OMCFH Care Coordinators to make sure ongoing needs are met in the course of inpatient care, identify new equipment or supply needs upon discharge, and arrange for expedited authorization and provision of equipment and supplies prior to discharge.
Providing continuity and stability during key transitions across the system of care	Develop collaborative transition plans for when members transition across the system of care, including movement onto or off of DHHR Home Visitation programs, waivers, or other community-based programs to assure that there are no gaps in the services received.

We will further adapt our UM processes to account for additional considerations for children and youth engaged with the child welfare system. For example:

- When there are no appropriate placements to match the needs of the child or youth, we will seek to identify ancillary services, such as additional behavioral support services, that could be put in place in a lower level of care in order to retain the youth in the community and prevent long-term institutional placements.
- When the court determines a change in the permanency goal resulting in emergent placement needs, we will react quickly to make sure that necessary services are authorized, specialized equipment and supplies are transitioned with the member, and additional

necessary services are identified, coordinated, and authorized expeditiously to assure stability, safety, and permanency for the child.

- When foster parents are showing signs of caregiver burnout and express barriers to accessing appropriate respite care, we will work with local child welfare organizations, such as the Foster Parent Association, in order to develop a listing of foster parents willing to serve as respite providers to encourage utilization of services to retain caregiver resiliency and placement stability.

We use systematic processes to assess needs and monitor treatment plans of members identified with specialized health care needs, and we strive to eliminate barriers to care by providing direct access to experienced specialists within our network.



We will continue to collaborate with DHHR, BPH, and OMCFH to implement coordination strategies and to guide modification of our UM guidelines and standard processes so that we are better able to serve the Program members with specialized health care needs. CSHCN members will be assigned to Nurse Care Coordinators with pediatric experience, and will be in our highest level of care coordination. Our Care Coordinators will share Care Plans with OMCFH, incorporate goals into our Care Plan, and work collaboratively to optimize outcomes and make sure that we do not duplicate services already provided by OMCFH.

Standing Referrals (BA043 and BA059)

We are committed to providing continuity, coordination, and quality of health care services for our members. The PCP is the principal coordinator of care when members require medical services from other health care service providers. We expect the PCP to send and receive formal written communication describing the care they rendered to members who have been referred for specialty care.

UniCare has an established policy and procedures to grant members a standing referral to specialists. Our current standing referral processes are flexible and do not limit duration or a maximum number of visits allowed, already accommodating members with specialized health care needs; therefore modification is not necessary. We understand that our policy and procedures for standing referrals will be reviewed and approved by DHHR.

Our policy currently grants members direct access (standing referral) to all in-network specialists. Standing referrals are made by the member's PCP to in-network specialists. In this capacity, the specialists may treat, authorize referrals, procedures, tests and other medical services for the member. The in-network specialist may continue to provide care without a pre-service authorization, as long as the specialist deems the visits medically necessary to facilitate ongoing treatment or regular care monitoring.

In special circumstances and when deemed to be in the best medical interest of the member, we will approve referral requests for OON providers. The PCP must request a pre-service authorization from UniCare, and the request is reviewed by UM and authorized based on medical necessity. Further detail about our process to facilitate continuing relationships with non-network provider is provided in our response to BA070.

Expedited Review Processes (BA044)

UniCare has expedited review processes to assure expedited authorization for services when the provider indicates that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. We make the expedited authorization decision and provide notice to the member and their provider as expeditiously as

their health condition requires, but no later than two business days or three calendar days of the receipt of request (whichever is the least from request receipt date). This timeframe may be extended up to 48 hours for expedited pre-service authorizations and up to 72 hours for expedited concurrent reviews upon request of the member or if we justify to DHHR in advance and in writing a need for additional information and that the member will benefit from such extension. ***The member's assigned Care Coordinator facilitates our ability to respond expeditiously and collaboratively to any factors and individual circumstances.***

Condition-specific Protocols and Standards for Members with Special Health Care Needs (BA045)

UniCare has established policies, procedures, and strategies that we currently use to coordinate with DHHR, BPH, and OMCFH to provide services to members with specialized health care needs. We will build upon these established protocols to successfully meet the comprehensive needs of members we will serve through the Program. As we described in our response to BA015 and BA053, our endorsed policies and clinical guidelines will undergo a rigorous review process to assure appropriateness in administering the Program's benefits for PH and BH services, including adoption of flexible protocols and standards that will guide management of members with specialized health care needs. Our Medical Director oversees the development and review of all UM and medical policies and clinical guidelines, and local providers on our MAC will review, provide input, and approve the criteria before use. The MAC providers include a pediatrician and psychiatrist, and will include other provider types, such as SNS providers, who will bring knowledge and perspective of the local delivery system to help us make sure our UM criteria, including levels of care, is appropriate and will meet the needs of our members with specialized health care needs that we will serve through the Program.

Our care coordination protocols have been modified, and will continue to be refined as needed, to guide additional levels of coordination that will help us make sure we deliver and coordinate the full range of services that members with specialized health care needs may require. Our Care Coordinators will share Care Plans with OMCFH for members with specialized health care needs, will make sure we do not duplicate services already provided by OMCFH, and will further coordinate with OMCFH to:

- Assure that all enrolled CSHCN have access to a medical home and receive comprehensive, coordinated services and supports pursuant to national standards for systems of care for CSHCN
- Assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT
- Accept clinical evaluations conducted by OMCFH to authorize and provide access to medical foods, as needed, for members with specialized health care needs
- Assure children and their established Care Plans are being met
- Improve the rates and content of well-child visits
- Improve care coordination for CSHCN, particularly those with multiple systems of care

We will continue to coordinate with OMCFH and share data to improve service delivery and outcomes through quality improvement activities, education, and other initiatives targeted at improving the care and health outcomes for CSHCN. To support enhanced coordination and data sharing activities, we will also make the member's information available to the OMCFH care coordinator and other authorized users through the YouthRAP, as approved by DHHR. This will provide the OMCFH Care Coordinator with as-needed access to the most up-to-date assessment, care planning, and service information for their assigned members.

Care Coordination Protocols Support Specialized Treatment Needs

The Care Coordinator will facilitate communication and coordination between all members of the health care team, including OMCFH, to make sure that all Care Plans from the CSHCN Program are met and to minimize fragmentation and duplication in health care delivery to these children and youth. The Care Coordinator will also work collaboratively with the member's PCP and other health care providers to monitor the quality and appropriateness of care through the Care Coordination process, which serves to continuously assess, plan, implement, monitor, coordinate, and evaluate the care plan for these children and youth.

Through the care coordination process, an appropriate treatment plan is developed in collaboration with the member's PCP, with participation from the member and the member's Care Coordinator, and in consultation with any specialists caring for the member. The treatment plan must meet applicable quality assurance and utilization standards. These treatment plans will be time-specific and updated periodically by the PCP. The Care Coordinator will also work collaboratively with the member's PCP and specialist(s), as appropriate, to make sure that the treatment plan specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.

In addition to working closely with the member's PCP, specialist(s), and OMCFH as applicable, the Care Coordinator will also work collaboratively with the Department caseworker, non-medical providers, caregivers, and UM staff to assure access to, and appropriate utilization of, medically necessary covered services, non-capitated services, and other services and support services to meet medical, psychological, emotional, and physical needs. This includes facilitating authorization of specialty and sub-specialty care, specialized equipment, and supplies.

PH and BH Guidelines for Specialist Providers (BA060)

As described in our response to BA042, we allow specialty providers to assume the role of a PCP for members who have a chronic illness, a disabling condition, or for CSHCN. Our Network Development Consultants will work with specialists choosing to assume this responsibility to make sure they understand exactly what is required and will provide specialized training related to children and youth in the child welfare system when needed (for example, training in trauma-informed care and ACEs). We will also develop and implement guidelines to further define responsibilities of specialty PCPs for the Fostering Healthy Lives model, including their role in:

- Communicating and information sharing with the Care Coordination team, such as treatment plans and assessments to assist in making service determinations and making sure the member has the right level of care.
- Participating in the interdisciplinary planning process to holistically address the needs of the member in collaboration with internal staff's expertise and/or engaged relevant external parties, which could include a pharmacist, UM, Medical Directors, BH Clinician, other treating providers, Department caseworker, OMCFH Care Coordinators or others as determined necessary.

Specialty providers who agree to take on the role of the PCP will also be required to assume other critical roles and responsibilities of a PCP, such as:

- Coordination of members' health care 24/7
- Development of members' care and treatment plans, including preventive care
- Maintenance of members' current medical records, including documentation of all services provided and any specialty or referral services
- Adherence to required wait times
- Providing or arranging for:

- Routine and preventive health care services, including EPSDT requirements
- Emergency care services
- Hospital services
- Ancillary services
- Interpreter services
- Referrals for specialty services
- Coordination with outpatient clinical services, such as therapeutic, rehabilitative, or palliative services

Specialty Provider Roles and Responsibilities (BA064, BA065)

As described in our response to BA043, we provide standing referrals to specialists for members with specialized health care needs or complex medical conditions. UniCare's current policy and procedures enable a specialty provider acting in this capacity to directly deliver services to the member as well as schedule or provide ancillary services (BA064), or refer the member to sub-specialists or other providers (BA065) as needed.

Specialists who assume the role of the PCP are expected to be the principal coordinator of care when members require medical services from other service providers, including other specialists, and should communicate and coordinate with the assigned Care Coordinator as required to update member goals and develop treatment plans that will optimize member well-being, safety, and permanency.

Admit and Choose the Hospital of Admission (BA061 and BA062)

UniCare contracts with all acute care and tertiary hospitals in West Virginia, including children's hospitals. Any provider, including a specialty provider, can send the member to any in-network hospital. If medically necessary, authorization may be requested for admission to an OON hospital.

Our guidelines will reinforce the responsibility of the PCP, or specialist providing treatment to the member or assuming the role of the PCP, to collaborate with the member's Care Coordinator for assistance in choosing a hospital for admission. The Care Coordinator can provide insight into information such as the geographic location of the placement that may impact selection of the hospital. The Care Coordinator has in-depth knowledge of their member, and works closely with UM Clinicians to add important details that can support and facilitate authorization decisions in the best interest of the member.

Determine the Patient Must Remain Hospitalized (BA063)

Our guidelines require coordination with the facility, UM, UniCare Care Coordinator, caregivers, Department caseworker, and other involved parties as applicable, to make sure that all facets of the individual member are considered when conducting concurrent review and discharge planning activities. While the PCP or specialist providing care to the member have a strong voice in determining that the patient should remain hospitalized, additional factors will be applied to the medical necessity decision.

Throughout the member's hospitalization, our focus is on supporting the member's established discharge and transition plan and collaborating with all stakeholders to carry out our role within the context of the larger system of care. The Care Coordinator supports the provider's role as an essential care team participant and will collaborate with the provider and align the member's Care Plan with the provider's treatment plan and their ISP and FSP, identifying services covered or coordinated by UniCare that can help avoid a higher level placement by maintaining the member in their current placement or moving them to a lower level of care.

Guidelines for Medical Referrals (BA069)

The risk of receiving care that is not evidence-based is a more significant concern for members with specialized health care needs or medical complexity. These members have complex clinical care coordination needs and potential functional limitations, often necessitating many services and supports to maintain their health. Using evidence-based practices to support the identification and delivery of clinical services such as radiology, specialty medications, and durable medical equipment (DME) is a key component to preserving the safety of children and youth in child welfare while assuring their access to timely care.

To facilitate access to needed services and continuity of care for these members, we maintain flexible processes for medical referrals and remove standard requirements. For example, enteral nutrition is typically approved during a phone conversation if all required information is available to meet our medical necessity review. If required information is not available, we inform the vendor at the time of the phone call, pend the referral, and immediately contact relevant providers to obtain required clinical data. In this situation, the service is approved upon receipt of sufficient clinical information to meet criteria and within the contractual seven-day timeframe. Medical referrals are approved for an extended duration of time to meet the ongoing nature of the care required. For example, we typically approve a referral for enteral nutrition for a duration of six months, and then reassess need and extend accordingly, sometimes authorizing for a longer period of time based on the child's need for ongoing services.

Evidence-based Medical Necessity Criteria

We follow an evidence-based hierarchy of established medical necessity criteria, supported by policies and procedures when applying medical necessity criteria to service authorization requests based on individual member needs. Our NCQA- and MBHO- accredited UM program is guided by West Virginia-specific policy and nationally recognized medical policy and clinical guidelines, including Milliman® Level of Care Guidelines (MCG), ASAM criteria for SUD services, CMS standards and guidelines as stated in the Special Terms and Conditions of the WV approved 1115 SUD Waiver, and West Virginia policies and guidelines for crisis stabilization and SNS. Our UM processes and guidelines are consolidated in a written UM Program Description that will be shared with DHHR for review and approval.

Approach to Processing Referrals for Medical Services

UniCare's Care Coordination teams will include staff that have knowledge and experience in specialized areas, such as RNs, BH Clinicians, and those with experience in child welfare and community-based services, and support our ability to effectively apply UM guidelines to authorize appropriate services.

We consider multiple factors in authorizing services. We will be positioned to know immediately when our members have specialized health care needs, complex service needs, or are admitted to a higher level of care. Care Coordinators will also make referrals to the CSHCN Program as needs are identified, assuring appropriate access to all necessary services.

Our multidisciplinary approach will provide the Care Coordinator access to multiple avenues of expertise in addressing the needs of the child. The member's assigned Care Coordinator will retain responsibility for care coordination of the member, but will also have access to experts (other staff members) with specialized skills who can support the care coordination process. Care Coordinators can add important details to the clinical information received from providers by UM Clinicians as well as help incorporate a trauma-informed approach to service-level decisions. This is especially important when the member has specialized health care needs, and helps UM Clinicians have a more complete clinical picture when making authorization decisions. This

coordinated approach assures members receive ***the right care at the right time to address their health care needs.***

Continuing Relationships with Out-of-network Providers When in Members' Best Interest (BA070)

UniCare understands the importance of relationships with providers for some children. We have policies that enable members to continue their relationships with an OON provider or a provider that leaves our network when it is in the member's interest. Our established processes and guidelines, based on NCQA and West Virginia standards and approved by DHHR, will support the development of our Care Plan, with goals for optimizing member health outcomes.

Our continuity of care process authorizes continuation of services with a non-participating provider under specified conditions and for a designated period of time, with a Care Plan to transition the member to an appropriate network provider. Medical conditions that may qualify a member for continuing access to OON care may include, but are not limited to:

- An acute condition
- A serious chronic condition
- Pregnancy, regardless of trimester, through immediate postpartum care
- Terminal illness
- Degenerative and disabling conditions (a condition or disease caused by a congenital or acquired injury or illness that requires a specialized rehabilitation program, or a high level of care, service, resources, or continued coordination of care in the community)

Continuation of covered services with the OON provider are allowed for up to 90 calendar days or through the current period of active treatment, whichever is less. We collaborate with the provider to develop a reasonable transition plan that avoids a disruption of care or lapse of service.

A member's PCP or a member/Authorized Representative may request continuation of care with an OON provider. ***With a keen understanding of the special needs and circumstances of the foster care population, our Medical Director will review the request if it is not initially approved by our UM staff, and confer with the PCP as needed to determine whether continuation is in the best medical interest of the member.***

Real Stories

A UniCare Care Coordinator connects a member with specialized health care needs to the services he needed so that he could begin school

Phillip, a four-year-old member from Bluefield, lacked normal physiological development and was unable to walk independently. His parents did not know what steps to take to get Phillip the specialized health care services he needed and asked Phillip's UniCare Care Coordinator, Betty, for help. Betty contacted the Mercer County Board of Education pre-school specialist to let them know about Phillip's situation. The pre-school specialist and the mother were grateful for being connected in order to give Phillip the services he needed. Today, Phillip is attending pre-school and receiving needed therapy. After just a few weeks, Phillip's mom was able to see a difference in his ability to try to walk, and was so grateful to UniCare for connecting them to the services they needed for their son to live a happy and healthy life.

WV_FC2019_Phlip_RS_04

Continuity When Providers Leave the Network

UniCare maintains policies to provide continuity of care when a practitioner, physician group, or hospital leaves the network. For UniCare-initiated provider terminations, we provide written notice to members within 15 days of issuing the termination notice. In cases where the PCP withdraws from the provider network, UniCare will provide members with at least 30 calendar days' notice, or within 30 calendar days of receiving notification from the provider. Terminating providers may also contact UniCare to request continued access to care and assistance in transitioning to a network provider on behalf of the member. The member/Authorized

Representative has an opportunity to select a new PCP, and we provide assistance in finding the right fit based on location, medical condition, preferences, and other factors. Should changes in the network constrain a member's ability to access care, UniCare will seek and negotiate with non-contracted area providers to continue the same level of care.

When an individual provider or participating medical group/Independent Practice Association terminates its contract or is terminated by UniCare, UniCare notifies members of the impending termination and of their right to request continued access to care and transition assistance. If a hospital leaves the network, UniCare notifies members as soon as termination is known.

Barring sanctions or quality reasons for the exit from the network, UniCare allows members undergoing active treatment access to the discontinued provider for the lesser of the current period of active treatment, up to 90 calendar days, or until we have assessed and issued a new authorization with an appropriate in-network provider. ***Exceptions are made, and this timeframe is extended, if in the best medical interest of the member, as approved by the Medical Director in consultation with the member's PCP.***

Continuing Care Beyond 90 Days

We will contact OON providers directly to discuss the members' well-being, health status, treatment, and Care Plans; initiate a single-case agreement; and discuss the opportunity for the provider to join our network. For qualified providers, we will expedite the credentialing process to assure timely participation. In the rare instances when a provider refuses to join the network for ongoing courses of treatment past the first 90 days, we would reassess, at a minimum of every 90 days thereafter, the following:

- Whether the member continues to require the relationship and/or the services provided
- Whether UniCare's network is now able to provide the needed services and we could begin a transition plan
- Whether the OON provider is now willing to join the network

We will continue to authorize OON providers when determined to be in the member's best interest.

Educating Members About Family Planning Resources (BA075)

We are committed to preconception and perinatal care and education to reduce the incidence of preventable medical conditions, unplanned pregnancies, infant mortality, and premature and low birth weight babies in West Virginia. To address these goals, UniCare partners with the state to engage its current members and providers in family planning services, and will continue to do so for members in foster care.

Currently, our staff educate members of child-bearing age 15 to 44 about their family planning options and resources at the time of enrollment and in ongoing communications. Health education and counseling to this group is necessary to help them make informed choices and understand methods of contraception. All members receive a member handbook in their welcome packet within five business days of the enrollment notice. The member handbook has a section on family planning services and the member's option to access these services from any licensed family planning clinic or provider.

The member handbook includes details about the types of family planning care members can receive to avoid an unplanned pregnancy, get protection from STIs, and to support early and ongoing prenatal and postpartum care, such as:

- Family planning, education, and counseling
- Medical visits for birth control
- Annual cervical cancer screenings

- Pregnancy tests
- Lab tests if medically indicated in the choice of contraceptive methods
- Tests for STIs
- Screening, testing, counseling, and referral for treatment for members at risk for HIV

We also send members targeted educational materials on information regarding family planning, as well as our West Virginia brochure *Birth Control That's Right for You.*

Members are informed that they do not need PCP approval or a PA to seek family planning services and can use any licensed family planning clinic or provider. We encourage members to seek family planning services from within our network to support care coordination efforts, but will assist members who prefer to use OON providers for family planning. We also encourage members who seek family planning services from an OON provider to tell their PCP about the services they received so their care will be well-coordinated. We have easy-to-understand education and referral processes in place so that members have convenient access to family planning services.

Supporting the Mission WV THINK Program

UniCare is a proud sponsor of an evidence-based program that supports teen pregnancy prevention, Mission WV: Teaching Health Instead of Nagging Kids (THINK). Project THINK offers an evidence-based holistic approach to educating youth ages 11 to 19 who live in high-need communities within rural West Virginia Appalachia to foster positive youth development and reduce high-risk behaviors. We provided $25,000 to expand Project THINK in Putnam County, which served over 600 children. See CS001 for details.

Increasing Access to Long-acting Reversible Contraceptives

We will promote access to long-acting reversible contraceptives (LARC) with female members of child-bearing age in our Fostering Healthy Lives model. UniCare is a leader in family planning and the education of female members and providers about the availability of LARC to reduce the health repercussions associated with unintended pregnancies. We work closely with all providers of family planning services to inform members of child-bearing age about LARC as a safe and highly effective contraceptive alternative whenever they inquire about contraception alternatives and immediately postpartum.

Our Care Coordinators assess female members' interest in LARC during the HRA and identify risk factors that may indicate the need for LARC during the OB screening assessment. They will also review the results of the HRS which will ask female members of child-bearing age (and not just pregnant members) of their interest in LARC. They will educate female members about this alternative to contraception if they express interest in learning about it and help them identify providers of LARC services if they need assistance accessing services. Care Coordinators send female members educational materials with in-depth information on LARC, such as collateral used to support teens. Our Fostering Independence Coordinators who engage transition age youth (TAY) also review this option with female members as it relates to TAY planning. They may also engage with our Maternal Postpartum Outreach Program (MPOP) to provide additional education about LARC postpartum and assist female members to plan arrangements, as necessary.

We have strong ties with local organizations to promote our common purpose of achieving state goals, fulfilling our responsibilities to provide access to family planning services. ***UniCare's current Medical Director, Dr. Tracy Dlott, founded and leads the State's LARC workgroup, which is responsible for coordinating access to both immediate postpartum LARC and outpatient LARC services.*** Dr. Dlott will work with our Fostering Healthy Lives Medical Director

to facilitate LARC access. Postpartum LARC services are now available at all three teaching hospitals in West Virginia with plans to implement access in the smaller community hospitals through education and support. The workgroup also is facilitating training for primary care providers to provide LARC services instead of having to refer their patients to OB/GYN providers to access outpatient LARC services.

Timely Payment to Family Planning Providers (BA076)

In order to provide prompt payment to providers, we have configured our claims processing system to identify and automatically adjudicate claims for family planning services based on the included diagnosis code(s). We reimburse providers for covered family planning services, regardless of whether they participate in our network. OON family planning providers will be reimbursed 100% of the Medicaid fee schedule. No pre- or post-authorization is required for family planning services.

Early Identification, Early and Often Prenatal Care (BA077, BA078)

UniCare uses multiple methods to identify members who are pregnant upon enrollment and as soon as possible thereafter to confirm that they enroll in our comprehensive perinatal program. Early identification is critical to engage members who are pregnant, including screening for risks to good birth outcomes, education and referral to community-based resources, and enrollment into our OB Case Management program when indicated.

We identify members who are pregnant as early in their pregnancies as possible during the HRS and HRA, and through the review of DHHR enrollment files, claims data, lab reports, hospital census reports, a provider's notice about a member's pregnancy as well as delivery notification forms, and member self-referrals. Once members who are pregnant are identified, we act quickly to assess OB risk to determine appropriate levels of care and initiate care management services to mitigate risks to healthy birth outcomes. ***We also assist members to schedule a prenatal care visit within 14 calendar days of the date we determine she is pregnant.***

To preserve continuity of care during pregnancy, UniCare will honor all PAs for new members who are pregnant during the transition period and seek to contract with their existing provider or assist the member with a transition to an in-network provider, as needed.

We will assign all members who are pregnant and in the child welfare system to our complex care coordination level of care, which is the highest level to closely manage their care, with at least two contacts a month, of which at least one contact will be face-to-face. We recognize the heightened risks these members experience for a healthy birth outcome that arise from a history of having fewer social supports and will identify and address their health and social risks under our high-contact model of care.

Identification and Screening

Our Taking Care of Baby and Me® program (TCOBAM) is a comprehensive maternal and child health program that addresses maternal and newborn health risks by making sure members have timely access to the information, care, and support needed to stay healthy before, during, and after pregnancy. This program helps us identify members who are pregnant as early as possible, conduct a thorough clinical and psychosocial assessment to determine each woman's risk, and then develop an individualized maternity Care Plan based on the member's risk. For females of child-bearing age enrolled in the program, the assigned Care Coordinator will coordinate with OB Case Managers and the Department caseworker to access appropriate obstetrical, medical, and BH care services and engage members in education, coaching, and self-management as advocates for a healthy pregnancy and newborn.

An OB Care Manager will coordinate with the member's assigned Care Coordinator and Department caseworker to obtain background information and contact each member identified as pregnant to conduct an OB screening tool. This helps us to better manage their prenatal care since newborns of members in foster care are at increased risk for health complications at birth. We use our proprietary OB High-risk Screener to identify all opportunities to engage the member and provide appropriate support during and after her pregnancy.

The assessment, as seen in Supplemental Document E.2-2, includes a variety of domains regarding pregnancy care and barriers to care as well as nutritional, behavioral, and social issues that may have an impact on the pregnancy.

Members may also submit a web-based health needs screener through the member website or submit it by mail. The proactive assessment to identify care management needs generates a score calculated from a member's answers to the OB Screener and is also displayed monthly on our proprietary predictive modeling Chronic Illness Intensity Index (CI^3). This information coupled with the results of an HRA or other information sources are taken together to determine a member's final stratification level.

OB Care Managers conduct outreach to all members in the child welfare system who are pregnant, whom we stratify into the complex care level, since they are determined at risk of delivering an infant who has high social needs or that may be admitted to the Neonatal Intensive Care Unit (NICU) and may warrant interventions. OB Care Managers share information with a member's Care Coordinator as necessary to integrate care; the OB Care Manager and Care Coordinator share in the use of our Health Insight platform to document the information gathered during member contacts.

We conduct screenings across members' terms of pregnancy and postpartum periods. The screening tools help us integrate the management of comorbid conditions such as diabetes, depression, hypertension, heart disease, and SUD, including tobacco, into our care of members who are pregnant.

Promoting Early and Continuous Maternity Care

We know that early and sustained member engagement is critical for improving birth outcomes. Our staff foster meaningful member engagement with members who are pregnant and with caregivers to encourage members to act as self-advocates in their health, and that of their babies by seeking early and continuous prenatal care. We offer members and caregivers a continuum of programs designed to address our members' and their babies' individual needs through our comprehensive program, TCOBAM.

Taking Care of Baby and Me

TCOBAM uses person-centered care planning, recognizing a member's strengths, needs, and preferences, while incorporating risk factors identified in our screening and assessment processes. We encourage members who are pregnant to optimize the outcome of their pregnancy, prepare for the delivery and homecoming of their infant, and participate in their infant's care in the event of a NICU stay. TCOBAM offers targeted OB case management for members who are pregnant and their caregivers and will coordinate seamlessly with the member's assigned Care Coordinator. The TCOBAM program:

- Engages members in prenatal care in the first trimester or as early as possible when enrolled with us after the first trimester
- Engages all members in prenatal care in health education and counseling to help them make informed choices

- Provides members with a complex level of care coordination to provide extra support throughout their pregnancy
- Engages members in individualized OB care management to support a healthy pregnancy through outreach and technology solutions such as My Advocate™, an automated service that promotes regular OB visits and general health education through automated telephone outreach, text messaging, or a smartphone application throughout the pregnancy and postpartum period
- Coordinates access to local resources and programs such as Women, Infants, and Children (WIC), Healthy Start/Helping Appalachian Parents and Infants (HAPI), the West Virginia Tobacco Quitline, and the West Virginia Home Visitation Program (WVHVP)
- Gives providers tools and resources to deliver quality health care and address the social needs of members and infants
- Offers gift card incentives of up to $75 in rewards to encourage members to keep up with their prenatal and postpartum checkups and well-child visits after the baby is born
- Offers members more than 340 perinatal providers at 240 locations, including both OB/GYNs and nurse midwives. See Attachment E.5, Table E.5-1, Network Development, for details

We provide educational materials and link members with community resources to promote optimal health before, during, and after a woman's pregnancy. The program encourages our members to receive timely checkups during their pregnancy and after giving birth. For members in foster care, Care Coordinators will work with Department caseworkers to educate young women regarding the need to comply with BCF requirements for her baby and how her baby will be in state custody upon birth, developing goals to meet these requirements and plan for the baby's arrival.

UniCare also collaborates with providers to share information and provide resources and supports to enhance perinatal visits and identify member needs. We enroll providers in our OBQIP to incentivize and reward the providers who improve their perinatal metrics over time.

Maternal Health Member Education

Through the TCOBAM program, members receive health information, and baby gifts for receiving necessary prenatal care and attending prenatal classes. Members who are pregnant receive a pregnancy education package that includes:

- A letter welcoming the member to the TCOBAM program
- Healthy You, Healthy Baby booklet
- TCOBAM reward program brochures
- A nurse advice line fact sheet

Periodic mailings of educational materials and information on community resources and access to coaches round out our support for our members. Our TCOBAM program offers an array of colorful materials, including, but not limited to:

- Having a Healthy Baby brochure
- Baby and Me postpartum flier
- Baby blues and postpartum depression brochure

Baby & Me Tobacco Free™ Program

Among the programs we offer members in perinatal education is Baby and Me Tobacco Free, an evidence-based, smoking cessation program for pregnant and postpartum members who want to quit smoking. The program provides counseling cessation support and resources to improve birth outcomes and offer long-term positive outcomes for members and their families. Care Coordinators use the OB High-risk Screener with all members who are pregnant to identify and refer them for enrollment in the Baby & Me Tobacco Free program, as needed, and share information about the program with the brochure. Baby & Me Tobacco Free is a public health initiative that available to UniCare members and others through our partnership with the State's home visitation and targeted case management initiative, Right From the Start (RFTS). RFTS takes this program to expectant moms, offering tobacco cessation sessions in the home or clinic settings in Regions 1, 2, and 3 at convenient locations including their home and clinic setting.

Members who test tobacco-free at prenatal sessions qualify for Walmart gift cards up to $25 per month for diapers and baby wipes for up to 12 months postpartum.

Preventing Neonatal Abstinence Syndrome and Neonatal Opioid Withdrawal Syndrome

West Virginia has experienced an increasing and disproportionate number of newborns diagnosed with neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS) year over year attributed to high substance exposure during pregnancy, leading to the increased placement of children in state custody. UniCare is committed to supporting members of reproductive age in an effort to reduce the incidence and impact of NAS and NOWS to reduce the need for placement in state custody and optimizing overall health outcomes for the children of West Virginia.

In response to the opioid epidemic, UniCare developed a comprehensive ***NAS/NOWS program*** that seeks to improve outcomes for members and newborns affected by substance use disorders, including opioid use and misuse before and during pregnancy. The program includes primary and secondary interventions including efforts to prioritize screening for members who are pregnant, increase member engagement in treatment and recovery, increase access to reproductive counseling and preconception care, and increase familiarity of evidence-based standards of care for newborns with NAS/NOWS.

In addition, our ***Substance Use in Pregnancy OB Case Management program*** provides members who are pregnant and at risk with support and coordination throughout their pregnancy. A dedicated OB Case Manager calls pregnant members with or at risk of substance use disorders to provide intensive wraparound case management through six months post-delivery. The OB Case Manager supports our providers and members by:

- Providing coordination for overall health and well-being, including social determinants
- Facilitating access to treatment
- Preparing members for delivery, NAS treatment, discharge, and post-discharge newborn care
- Providing interconception (family planning coaching)

We are also partnering with the state to reduce NAS by educating providers about the risks associated with opioid and other substance use during pregnancy and how to mitigate these risks. We developed the ***Primary Care Toolkit for NAS/NOWS Prevention and Post-Hospital Follow-Up program*** to support trainings with PCPs, obstetricians, pediatricians, and family practitioners; these

Through our comprehensive NAS Provider Toolkit program, we have reduced the number of our Members' babies born with NAS by 19%, from 2018 to present.
WV_FC2019_NASProToolkit_COB_02

providers are in the best position to prevent NAS and NOWS risks by screening for substance use during annual visits beginning at age 12. We train our providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT) to educate members at risk about family planning options and to postpone pregnancies until they are in recovery or have stabilized in a treatment program. We also share information with all providers about the risks associated with prescribing opioids to members of child-bearing age, and if necessary, to limit use, especially in the first trimester.

We have also established our ***Women's Wellness & Recovery program*** that supports non-pregnant members with or at risk for SUDs. The program receives a report based on an algorithm that identifies members of child-bearing age who are using substances or at risk for substance use. At the request of the Care Coordinator, a Women's Wellness & Recovery (peer support) specialist will reach out to these members in an effort to connect her to care, recovery, and social support services; engage her in reproductive life planning; and offer peer-based social and emotional support.

We will leverage all these programs to support Program members and their families, as appropriate.

Referral to West Virginia Home Visitation Programs

In addition to RFTS, Care Coordinators refer members who are pregnant to state-run community-based home visiting programs such as Maternal Infant Health Outreach Workers (MIHOW). MIHOW focuses on family health, positive birth outcomes, early childhood development and parenting practices. It is available in all 55 counties and offers monthly home visits during pregnancy that continue through the child's third year. Care Coordinators refer to the WV Home Visitation Program Resource Directory for a listing of all home visitation options available to members from the DHHR, BPH, and Office of Maternal, Child, and Family Health to determine appropriate programs available in each member's community.

Group Support for Pregnant Members

We also give members an opportunity to participate in group support by working directly with the Centering Healthcare Institute. By partnering with the BPH, we will promote and encourage our providers to adopt the CenteringPregnancy model of care, which:

- Allows participants to experience their prenatal care visits in a comfortable small group setting outside of exam rooms with other members who are due at the same time. Visits are 90 minutes to two hours long.
- Encourages members to educate, motivate, and support each other, creating lasting friendships as they share common experiences of pregnancy, birth, and family care.
- Encourages members to actively engage in their own health care and own their health information.
- Results in healthier babies in a program that nearly eliminates racial disparities in preterm birth.

CenteringPregnancy currently operates in Morgantown and Harper's Ferry. We are looking for ways to expand the CenteringPregnancy model of care in partnership with BPH and our obstetric providers throughout the state.

Healthy Rewards for Perinatal Care

We will further promote early and continuous engagement in perinatal care by members with appropriate incentives through our Healthy Rewards program, offered as a VAS.
Members who are pregnant can receive a $25 gift card reward each time they meet any of the following perinatal goals:

- Attending their first prenatal checkup within 42 days of enrollment
- Attending their postpartum checkup 21-56 days after delivery
- Bringing their infant up to two weeks of age to their first well-baby visit
- Attending six well-baby checkups before their child's 15th month
- Completing a cervical cancer screening for women age 21 and over

Value-Added Services

Members who are pregnant will also be eligible to receive a car seat or a portable crib by attending at least six prenatal visits through our VAS.

Baby Shower

UniCare hosts local community baby showers to help educate expectant and new moms about their health benefits for them and their children. We continue to host community baby showers and conducted an average of 40 baby showers a year over the past three years throughout the state. During baby showers, we also discuss the harm of alcohol, tobacco, and drug use during pregnancy. We distribute literature and practical gifts to all who attend.

In the past three years, UniCare also sponsored baby showers initiated by community partners. For example, we funded the following baby shower events:

Stronger Together

- **Big Creek People in Action.** UniCare sponsored this annual community baby shower with a $1,000 donation.
- **Randolph County Baby Pantry.** UniCare sponsored the cost of restocking this baby pantry with diapers, baby wipes, cream, formula, and other baby supplies with a $2,500 donation.
- **Meadowbrook Mall.** UniCare sponsored events for mothers and children like Tuesdays for Toddlers, Mom & Baby Fairs, and Camp Marshmallow with a $9,000 donation.

Perinatal Partnership Initiatives

The work of the West Virginia Perinatal Partnership (Partnership) is centered on the goal of improving health outcomes for pregnant members who are pregnant and their babies in West Virginia. As a state with one of the highest rates of infant mortality and low birth weight in the nation, the Partnership set out to address the many challenges that affect mothers and their babies. Dr. Dlott has been an active member of the Partnership and its various initiatives for over four years. We have additionally had a staff person, Cari Harper, an OB Practice Consultant, attend the Partnership's Substance Use in Pregnancy subcommittee meetings to address harm reduction. We are also a part of the Substance Use and Pregnancy Task Force. As part of the Tobacco Free Pregnancy program, we contributed to the creation and distribution of the infographic Help2Quit.

Relationships we have formed with the leadership in the Partnership's initiatives have been key in promoting UniCare's initiatives to improve perinatal care and experience healthy outcomes for our members.

Leveraging Technology for UM and Managed Care Operations

UniCare recognizes that Management Information Systems (MIS) provide critical support for our health care operations and effective management of clinical and health care services data. Our MIS is managed internally through combined health plan accountability and support from the Anthem's Technology Services team. With 16 years supporting West Virginia programs and more than 28 years of experience in Medicaid managed care systems, this highly skilled team will configure our MIS and integrate the data we receive to support the Program, including clinical, operational, and reference data in the type and format necessary to support the delivery of care and services to our members, including text data as appropriate.

Establishing Flexibility with Modular System Design

Our MIS enables us to collect and process data from all relevant sources and share it with all stakeholders who need it. Our modular integration among components is a key design premise of our MIS. The components interoperate where needed, but are adequately independent to provide specialized functionality to fulfill Contract requirements. This approach protects data integrity and prevents inconsistencies between systems. The MIS comprises the following five components:

Core Service System. Our core administration platform serves as the primary source for UniCare's provider, member (including enrollment and eligibility), service authorization, claims, and grievance and appeal data. All updates to this information occur through the user interface or through application-specific data loads such as enrollment files received from DHHR. We maintain data quality through many interfacing applications that apply rules-based standardization, verification, and validation logic to data elements.

Health Insight Platform. Our care management system is the system of record for member care coordination and management information, integrating seamlessly with our Core Service System and data warehouse. Developed based on the input of care management teams across our affiliates in 22 markets, this platform streamlines workflows and will provide timely and accurate information to our Care Coordinators and providers. Member utilization data, such as claims history, authorizations, immunization records, lab results, and care and chronic condition management data will deliver a holistic picture of each individual's service utilization, Care Plan, and gaps in care, enabling all stakeholders to identify and manage members' needs.

Data Warehouse. Our data warehouse platform uses SQL Server and supports operational processes, analytics, and reporting. Fed directly from the system of record to promote data quality, control, and consistency, it delivers a comprehensive source of health information about our members, and will include encounter claims data for medical, BH, dental, vision, and SNS they receive. We will integrate additional information into the data warehouse to support other processes, including lab results and immunization, pharmacy data received from DHHR's pharmacy program, and clinical data for our members to be used for utilization and care management. The data warehouse supports access to integrated member health information through our Health Insight platform; advanced analytics, including our predictive modeling system to identify members for enhanced levels of care coordination; and our operational, management, and regulatory reporting process information.

Supplemental Applications. Additional integrated applications support overall functionality, including provider payment, member ID cards, EPSDT, HEDIS, and document imaging. Dashboards, business intelligence, analytic reporting, and other supplemental applications maximize functionality, efficiency, security, and data analytics.

Member and Provider Websites. Member and provider websites have public and secure self-service areas, and use industry-standard web services, as well as content management system technologies. Our websites feature responsive design, affording users access to all content, features, and functionality regardless of the device they use (desktop, laptop, tablet, or smartphone). Frequently, this is important for members who only have internet access via a mobile device and not a computer. Our 2019 year-to-date metrics show that 42% of our web traffic comes from mobile devices. We also provide quick access to members' account management options (for example, user name, and password), the online provider directory, Health A to Z symptom checker, and a mobile ID card.

Maintaining Data to Support Member Care, Utilization Management, and Managed Care Operations (BA019-BA023)

As part of our MIS, we have established a UM system that incorporates end-to-end workflows and enables the collection of complete case data, using the type and format that best supports managing members' access to care, including:

- Clinical Notes
- Inpatient Requests
- Review Criteria
- Case History

Access to comprehensive data and reporting and workflow automation support daily processes that integrate UM and care coordination functions, supporting person-centered care by assuring that the specific needs of each member are taken into account when making a determination.

Collecting Information During the Intake Process

Using an integrated dashboard, the Concierge team will have the tools necessary to easily create a new case and add a new service request — locating the member record, verifying HIPAA information, selecting the service provider, and entering the requested service details — all from one integrated interface. Concierge Representatives can also search for an existing case and make updates as needed.

Providers who opt to use the online self-service tools available via the website have access to the ICR tool described in BA018. This tool includes a lookup function where providers can determine whether or not an authorization is needed, and supports the collection of all relevant information, including service details and case history, attaching clinical reviews as part of the request. Using our medical policy and clinical guidelines, combined with integrated data from the claims system, the system prompts the provider for the minimum information necessary to process the request and deliver a timely response.

Access to Clinical Notes (BA020)

The UM system supports the entry of clinical notes during both the intake and review processes. Notes are maintained as part of the saved case record and identify the user who created them.

UM Clinicians enter notes associated with their review to indicate the guidelines used, individualized considerations, and UM decisions. Our UM program uses a person-centered approach, combined with evidence-based clinical guidelines, to facilitate appropriate and timely access to quality services for our members. Each review is customized to individual members and focused on determining the appropriate level and site of services based on their specific situations and benefits. Since our UM process considers the whole picture of a member, not just UM criteria, notes become a critical factor in making a determination.

UM Clinicians are able to see historical information through integrated clinical notes and dashboards that can provide necessary information in making determinations in the future, creating a more complete picture that fosters better communication between the UM and Care Coordination team, which in turn supports better care for the member.

Processing Inpatient Requests (BA021)

UniCare's inpatient UM process includes initial authorizations and concurrent and retrospective reviews. If an inpatient authorization request meets criteria, the UM Clinician will notify the provider of authorized days and the next review date for continued stay. We conduct concurrent review for all inpatient and residential services if the provider and member determine that treatment should continue beyond initial authorization. A census report is run twice daily that includes the current or anticipated discharge date, facilitating reviews based on authorization data maintained in the system, and assuring that review time frames are met and information is shared across the team as appropriate.

We also conduct retrospective reviews when services were provided without obtaining authorization due to circumstances that prevented timely authorization, such as member eligibility or a medical emergency, including a request for coverage of an acute inpatient stay after the member's discharge. The UM Clinician will use the submitted claim data and any imaged medical records along with relevant information, such as diagnoses, medical treatment, timeliness of services rendered, and any social or environmental factors that impacted the member's medical condition when reviewing medical guidelines and making a determination of medical necessity, length of stay, or level of care. The approved services are documented directly in our claims systems for prompt processing. If the UM Clinician is unable to approve the claim with the information provided, it is routed to a Medical Director for further evaluation of the specific clinical issues.

Applying Review Criteria (BA022)

Our system is configured to identify and automatically route service requests that require clinical review and approval to the appropriate queue for review. The UM Clinician will have access to medical guidelines and policies, and will assign the appropriate determination based on review of the available information. If a determination cannot be made by the UM Clinician, the case will be routed for Medical Director review. The system maintains status and tracking information as the case is routed through the workflow process, including any peer-to-peer outreach. The system flags and monitors appropriate turnaround times based on the type of request. We will communicate each review determination to the requestor via written communication.

Maintaining Case History (BA023)

We maintain full case histories for each episode of care by aggregating all information entered to support each service request, as well as details collected throughout the process — from approval through service delivery and claims payment. Information is collected in the most appropriate format, with selection-based fields to control values when needed, and text-based fields to enable entry of relevant information.

This history is critical to making appropriate and informed UM decisions and optimizing outcomes for our members. Strategic use of case history information is a key component in person-centered care coordination and helps avoid fragmented care, duplication, and unnecessary services.

Interfacing with Other Systems to Support Timely and Accurate Claims Payment (BA024, BA025, BA026)

To support delivery of medically and socially necessary services to our members and maintain all managed care operations, such as claims payment, we will incorporate and use all applicable data, including that from external systems such as DHHR's Medicaid Management Information System (MMIS).

Accurate and timely claims payment requires up-to-date data, including that processed through internal systems and received from external sources as appropriate:

- Enrollment and Eligibility Information from DHHR
- Service Authorizations
- Prior Utilization and Claims History
- Other Health Insurance

As a current West Virginia Medicaid MCO, we have already established key data exchanges with DHHR to support our operations for the West Virginia Medicaid programs and will process and load all data files provided by DHHR for the Program according to the established schedule, including timely imports for current eligibility data to be used when processing claims.

Supported by flexible data exchange systems and procedures, as well as Anthem's experienced data exchange team, we can readily work with DHHR, subcontractors, providers, and other supporting entities to establish mutually agreed-upon protocols to exchange data that support day-to-day operations or provide seamless transition for members transferring between MCOs, including all electronic standard health care transactions such as X12, NCPDP, XML, and JSON formats. Batch and real-time data exchanges will be fully automated with internal procedures and system-based controls to monitor the timing, format, and integrity of all data exchanges. Technology Services uses encrypted file transfer protocols to secure Protected Health Information (PHI) exchanged both within and outside of UniCare and Anthem.

Enrollment and Eligibility

We will establish a comprehensive enrollment load process to add or update member demographic and eligibility information using data from inbound X12 834 files received from DHHR's MMIS. We will maintain complete eligibility history for all members, using uniquely dated spans to manage variation in each individual's benefit category and product — providing a complete timeline of participation in the Program.

As we are notified of new members through receipt of the 834 files, UniCare will assign each a unique ID to track and manage them throughout all systems within our span of control, including our relationship with subcontractors. This number stays with members even as they move between benefit plans and products. In addition to tracking members by their uniquely assigned number, we also maintain the individual's Social Security numbers and any State-assigned Medicaid ID. The automated load process will also flag suspected duplicate records for review prior to updating or creating any member records. UniCare's Enrollment team will work with DHHR to make a final determination on disposition of records identified as potential duplicates. ID cards will be available electronically within five business days of enrollment.

Service Authorizations, Prior Utilization, and Claims History

Authorization information collected and stored in our UM system, including service provider, date, code, units, and location, is reviewed during claims processing. During adjudication, our claims system automatically checks for an open authorization for those services where one is required. Matching to an existing authorization does not require the claim to be submitted with the assigned authorization number. The adjudication process also uses key data elements on the claim to locate and match the correct authorization in the system.

As appropriate, service authorization, prior utilization, and claims history data can be exchanged with DHHR to maintain continuity of services for members. This data can be exchanged in mutually agreed-upon formats and will be used to support care coordination and claims payment.

Other Health Insurance

We will also maintain a process to review and load other health insurance data as appropriate and available through multiple avenues, such as:

- Initial third-party information and ongoing electronic data files from DHHR if available
- Claims-mining processes performed on all inbound claims
- Providers indicating this information on or with claim submissions
- Subcontractor partnerships for acquisition of Medicare and other health insurance (OHI) information
- Medicare or dual eligible status information available on the eligibility file
- Daily Medicare, OHI, and Third Party Liability (TPL) leads received throughout the company from members, providers, and internal Member Services and Care Coordination staffs

Reporting Specialized Managed Care for Children and Youth Encounters

UniCare will manage submission of encounter data through Anthem's robust encounter process, dedicated staffing, and a tightly managed schedule. Our encounters management process will be customized to comply with State MMIS business rules and include controls that enable our Encounters team to closely monitor compliance during creation of each data file. Following a strict submission schedule, we extract claims data from our claims processing system and manage receipt of encounter data from our subcontractors. This schedule of system processes includes review tasks and submission dates necessary to deliver complete, accurate, and timely encounter data to DHHR. Aging summary reports identify paid or void and adjustment claims that require remediation before the encounter data can be submitted to DHHR.

Supporting Member and Provider Inquiries (BA027, BA028, BA029)

Our toll-free Concierge Line will serve as our primary point of contact for all questions and concerns relating to our Program members. In addition to our Concierge Line, we will also have a 24/7 toll-free nurse advice line and 24/7 BH hotline for the Program. When members or caregivers call our Concierge Line, they will be able to speak to a live Concierge Representative during regular operating hours, or select a prompt that will immediately connect them to our BH hotline for crises, or our nurse advice line for non-crisis issues. Members and caregivers can also be warm transferred between these lines if they do not use the prompts to connect to other lines. Our Concierge Line will also provide 24/7 automated self-service for members to check their enrollment status, change PCPs, update their address and phone number, and request an ID card, member handbook, or provider directory.

Integrated Desktop Improves Efficiency (BA027)

UniCare uses a customer service application that helps our Concierge team handle member and provider inquiries and requests more efficiently. This application integrates information from multiple back-end systems into a single screen view. When a member calls in to request a copy of an ID card or inquire about an authorization or benefit, the integrated desktop eliminates the need for the Concierge Representative to spend time flipping between screens — while the member or provider is waiting — in search of information during the service call.

The integrated desktop displays necessary information in an organized and simplified fashion, according to the business rules of the specific market and product. These pre-programmed rules guide our Concierge Representatives to enhanced efficiency in servicing our members' and providers' requests, while the integrated desktop system captures detailed call documentation, including issue status, to support customer service reporting and metrics.

When a Concierge Representative is unable to resolve an inquiry, such as a provider complaint, during the first call, the issue is immediately transferred to the appropriate business area for resolution — with issue status tracked and available for all viewers. All Representatives are trained on the escalation processes and when it is necessary to use the warm transfer approach. While UniCare never rushes callers or places a maximum time limit on member or provider calls, the system optimizes the use of the time, adding convenience and speed to promote first call resolution for our members and providers.

Accessing Data to Support Complex Inquiries (BA028)

UniCare effectively addresses member and provider inquiries by providing the responding teams with access to member data, such as claims history, authorizations, immunization records, lab results, and care and chronic condition management data that is maintained in our MIS, including data loaded from DHHR systems such as member eligibility and demographic data, and utilization information from our subcontractors.

Interfacing with the Department's Call Center to Support Claims Payment and Member and Provider Inquiries (BA026, BA029)

We understand that the initial stages of transition for any new program can be confusing for members and providers and will develop and leverage FAQ and quick action guides to facilitate consistent and helpful responses to all inquiries. Our policies and operating procedures will be adjusted to accommodate any instance where it is necessary to work with DHHR's Call Center to support the best outcome for a member.

Our call center platform fully supports warm transfer capability via the representative's computer screen, and is scalable, replicable, and already operational. Today, UniCare transfers calls to DHHR's Call Center as needed to support claims or inquiries for service dates where the member was not actively enrolled with UniCare. We will also reach out to DHHR's Call Center regarding coordination of benefits inquiries.

Establishing Required Interfaces (BA030, BA031, BA032, BA033)

We are confident that our systems and technical teams deliver the flexibility needed to support rapid development and deployment of interfaces or new functionality required to interface with DHHR's MMIS as well as the Families and Children Tracking System (FACTS) and Integrated Eligibility System (IES). With an average tenure of more than 10 years, our Technology Services team has the deep knowledge, experience, and skills required to build, support, modify, or enhance data exchanges and systems as needed to meet requirements for all necessary interfaces to support the Program. A standard software development life cycle (SDLC) methodology governs development and testing of all interfaces, including internal unit and user acceptance testing, followed by interface testing with the DHHR and its vendors.

As a best practice to support continuity and streamline solutions, Technology Services will partner with the dedicated Information Technology (IT) Director/HIPAA Compliance Officer, Leslie Caluya, to work with the DHHR, our UniCare operations team, and other Technology Services staff actively engaged in supporting the Program. The IT Director will be an integral part of all technology-based implementations and ongoing operations, and will be the single technical point of contact for DHHR and its vendors — both during the implementation and day-to-day operations.

The IT Director will collaborate with DHHR and its vendors to develop new system interfaces required to support Program operations, reviewing all data exchange requirements and meeting with DHHR, designated stakeholders, and other MCOs as needed to discuss technical details including format, transfer method, development timeline, and testing.

Initiation and Coordination of System Changes

For all system changes, including encounter submission, EDI, clearinghouse, and financial reporting, Technology Services will follow formal change notification policies and procedures that include standards for requirements gathering, analysis, design, tests, and implementation. The change management processes will be documented, repeatable, monitored, and subject to continuous process improvement activities.

Technology Services will use their existing Scaled Agile Framework (SAFe) to manage the life cycle of applications and systems, and will maintain procedures, templates, checklists, and processes that enable systems projects to move through iterative cycles, or sprints of:

Requirements Analysis. A trained group of Business Analysts will work with designated business owners to identify business and high-level system requirements, and cross-functional impact in a Requirements Review Document. This document will be the primary artifact tracked

via the enterprise change management tool, and will be continuously updated and approved by the corresponding business owner(s).

Design. Business Analysts will work collaboratively with the assigned development team so that the developers fully understand the requirements when designing the system solution. The system design details will also be added to the Requirements Review Document. A requirements traceability matrix will be built as part of the design process to make sure that all requirements are accounted for in the system design.

Development. Developers will continue to work closely with the Business Analysts during the coding process. During coding, the developer will be responsible for unit testing and a senior-level developer or team lead will perform a code review, crosschecking the development against the requirements traceability matrix. A successful review will indicate readiness for the testing phase.

Testing. The Business Analysts will work with the designated business owner and development team to develop test scenarios and scripts for each requirement. Business Analysts will develop complete data for each test script that fully exercises system capabilities. For changes that interface with State systems, staff, and others as appropriate, will be important members of the testing team, making sure that all systems are ready for operations. System changes will go through a number of testing phases to verify that they are ready for a production environment, including unit testing, system testing, regression testing, and user acceptance testing.

Maintaining Case History (BA034)

The UM system captures all information collected and all actions taken on each case along with the user taking the action. This information will be accessible to appropriate team members and is readily used to optimize outcomes for members. It can also be exported for reporting and analytic purposes and helps us identify new opportunities for programs and member outreach.

Our integrated system maintains audit trails for any subsystem used to store and maintain operations- or systems-critical information, including case history. We maintain case history and all utilization data according to record retention requirements. Whenever an authorized user makes a change to one of the database tables, the application automatically creates a history of the update transaction. That data is stored in an audit table that can be used to generate reports that detail the before-and-after picture of the update, along with other pertinent data such as:

- The unique log-on or terminal identification number of the person who made the change
- The subsystem used to generate the change
- The time and date of the change

Audit trail reports can be generated to facilitate auditing of individual records as well as batch audits. All of these logs can be used to create comprehensive reports of system and user activity.

Pharmacy Services

Per the Vendor Response Guidance on the Detailed Specifications from Addendum 3, we are providing a general description of the strategies we would use to meet these specifications if pharmacy benefits are carved in at a future date.

To help ensure comprehensive, coordinated care, and promote optimal health outcomes for our members, UniCare will work collaboratively with DHHR to support members, their caregivers, and providers through integrated care planning with all system partners.

We stand ready and able to work with the DHHR in a variety of ways to develop a state of the art pharmacy program in support of the Fostering Healthy Lives model. Whether it be within the current carved-out environment where we receive daily data feeds to supply our sophisticated predictive modeling tools, or exploring how the State can tap into the purchasing power,

formulary, and medical management sophistication of our affiliate pharmacy benefit manager (PBM), IngenioRx, Inc. (IngenioRx) in a carved-in environment, we are prepared to coordinate with DHHR as the needs of the Fostering Healthy Lives model evolve.

As discussed in other responses, including CM005 and CM013, over the course of review during the UM process or during clinical rounds, and as part of our care management process including health risk assessments, health risk screenings, and discharge planning, we will review members' medications to identify medication use and misuse and conduct medication reconciliation and medication risk assessments. UniCare will also provide a local, in-house Pharmacist to work closely with the DHHR's pharmacy program staff, our Care Coordinators, Medical Directors, and, at the request of our clinical staff, with a member's multidisciplinary treatment team (MDT). As the member's safety is of the utmost importance to us, UniCare's West Virginia Medical Director will be available for case conferencing with providers concerning pharmaceutical concerns or medication management for members in the program. In addition, we will use provider toolkits that address how providers may safely and effectively manage members' pharmaceutical needs in areas such as opioid use and BH medications.

In 2018, we created a provider toolkit to help doctors understand the challenges of opioids and pain management. This toolkit provides doctors with the resources they need to manage their patients' pain while decreasing over-reliance on opioids. Other similar toolkits include the NAS toolkit and the substance-exposed infants toolkit. A toolkit is also available to providers with members on psychiatric medications including information on the prevalence of children in the child welfare system on psychiatric medications. The kit has a link to our screening and identification of BH disorders toolkit and the guiding principles for the use of psychotropic medications in children and adolescents. We provide additional resources such as legislative rules outlining the use of psychiatric medications in children and contact information for relevant organizations as a reference.

If the State decides to carve in the pharmacy benefit, the following responses provide additional information regarding how we will manage the benefit through an integrated solution.

UniCare's Innovative Pharmacy Benefit Management Program (BA041, BA083, BA084, BA085, BA086, BA087)

UniCare has experience managing the pharmacy benefit program in West Virginia from 2015-2017. In collaboration with IngenioRx, UniCare stands ready to again bring innovative pharmacy benefit program management strategies to our West Virginia members in the Fostering Healthy Lives model. IngenioRx, a subsidiary of our ultimate parent company Anthem, Inc. (Anthem), is a new company and a new name, but is staffed with the same team that has managed the pharmacy benefit for our members previously — a team with 24 years of experience managing pharmacy benefits in 17 markets.

Our fully integrated pharmacy program will support members' total PH and BH needs and include joint operations, joint clinical meetings and committees, shared data and reporting, shared goals, and pharmacy participation on Care Coordination teams. In addition to our locally based and dedicated Pharmacist, we will have a dedicated Pharmacy Director, who will work closely with clinical areas, UniCare's leadership, and IngenioRx staff to make sure that pharmacy services meet all applicable State, federal, and DHHR requirements.

We will support DHHR's goal of improved health outcomes by assuring access to high-quality, comprehensive, cost-effective health care services, including pharmacy services that address the top health issues for children and youth in the child welfare system in West Virginia. We are cognizant that these children and youth are at high risk for over-prescription, particularly over

prescription of psychotropic medications. These medications can have long-term deleterious effects on development and health and should be monitored closely. We will run pharmacy clinical programs to help address polypharmacy, gaps in care, safety issues, and adherence. We will use the power of our integrated data to enable our members and their caregivers to make better decisions, which result in improved health and lower total costs.

In addition, we will support our members to improve their health and engage in their health care through Member Care Notes that will educate members and their caregivers on the importance of adhering to their medications. We will also engage in live, telephonic outreach for members with chronic disease states through IngenioRx's Clinical Pharmacy Care Center (CPCC), staffed with licensed pharmacists and nationally certified pharmacy technicians.

We are also committed to simplifying health care so providers can focus on health. We will achieve this by implementing processes to reduce administrative burdens for providers, like the implementation of autoPAs that can help bypass the need to submit a PA via intelligent and automated logic at the point of sale (POS) and ePA, which allows for electronic submission of a PA and, when criteria is met, an automatic approval of a PA.

Detecting Fraud and Abuse of Pharmacy Services (BA041)

UniCare recognizes that FWA can manifest under many different circumstances. We will take a multi-pronged approach to manage FWA, both proactively at the POS and retrospectively through ongoing targeted interventions, investigations, and claims review. Our FWA programs are comprehensive and will have a sentinel effect on these types of activities.

Special Investigations Unit

One of the primary means we will use to control FWA is through a team of investigators within our SIU. They will perform daily monitoring of claims for potential fraudulent or abusive behavior, maintaining close relationships with law enforcement agents to quickly identify potentially illegal conduct. The SIU will regularly perform the following activities:

- Review internal substance abuse reporting to identify members utilizing a high number of prescribers and pharmacies to obtain controlled substances.
- Evaluate both pharmacy and medical data during review, looking for excessive diagnosis of pain, injury, and ER visits.
- Target cases of potential "doctor shopping" or drug diversion and refer them to the Department of Insurance and/or law enforcement.
- Review internal substance abuse reports to identify prescribers who appear to have a large population of member narcotic users.
- Refer prescribers to the Department of Insurance, state medical board, and/or law enforcement by SIU when further investigation is warranted.

IngenioRx will work closely with the SIU to partner on identified cases. In addition to this collaboration, the SIU has pharmacy-focused initiatives to help monitor and address FWA. This includes **Operation Pillbox**, which will involve ongoing collaboration between our SIU investigators and law enforcement. The information that we share with law enforcement will allow law enforcement agents to better understand prescribing trends, pharmacies used, as well as insight into possible illegal activity. As part of this program, our SIU will share controlled substance prescribing activity by providers on a quarterly basis. We will rank providers by volume of controlled substance prescribing to identify possible targets for investigation.

Drug Utilization Review

We are committed to the reduction of prescription drug abuse and diversion while promoting clinically appropriate patient care. At the POS, we will leverage drug edits to assure appropriate

utilization of drug therapy, accurate claims submission, and alignment with the intent of our benefit structure. These proactive strategies support the CDC guidelines for clinically appropriate prescribing of opioids, and help reduce waste.

Subject to DHHR approval, we will set quantity limits and require PA on certain first fills and cumulative morphine equivalent dosing. Restrictions can be placed on certain compounds and non-FDA approved medications. Claims surveillance will be used to review for appropriate dosing, quantity, and pricing.

Through the use of drug utilization review (DUR) at POS, as well as retrospective DUR like the Controlled Substance Utilization Management (CSUM) program and lock-in program, we will seek to decrease drug-seeking behavior, diversion, and pharmacy and prescriber shopping.

Comprehensive Retail Pharmacy Audit Programs

IngenioRx will use highly innovative and effective audit techniques to ensure the integrity of prescription claims while maintaining a superior network of pharmacies for our members through diligent oversight and education.

IngenioRx will monitor pharmacy claims to identify outliers and to help promote safety and compliance with laws and government regulations. They will use built-in audit tools, a fraud tip hotline, and other monitoring resources to help reduce the potential for FWA. System edits will facilitate the early detection of errors before pharmacies receive payment. Advanced steps in the process will target pharmacies and claims with high-risk factors.

Seamless Integration and Coordination (BA083)

IngenioRx employs an integrated, holistic approach to health care by considering the whole member view to quickly identify gaps in care, improve health outcomes, and lower overall costs. IngenioRx's integrated and coordinated medical and pharmacy solution provides access to actionable data that translates into better clinical management and decision-making.

IngenioRx will use one integrated claims processing system to provide retail, specialty, and home delivery pharmacies with consistent, integrated member information. This platform brings member, physician, pharmacist, and drug data together for pharmacy plan analyses and DUR, assuring the accurate and efficient processing of each claim. It provides flexibility, clinical functionality, administrative accuracy and efficiency, and service capabilities developed and refined over years that cannot be matched by a patchwork of individual system competitors.

While medical and pharmacy claims are adjudicated on separate claims platforms, they will be integrated to make sure we maintain accurate maintenance of member profiles which is essential for our Care Coordination team. We will regularly exchange data with IngenioRx, such as member diagnosis data to auto-adjudicate authorizations at POS. Our integrated approach with IngenioRx will uniquely enable us to support whole-person care on behalf of our members.

IngenioRx's next generation reporting platform will provide real-time updates on performance across both medical and pharmacy. This data will become an integral part of the member's record. It will be readily available to the clinical team and network providers for ongoing reviews of the member's needs, changes in health status, or treatment plans. Also, we will use this pharmacy information to support the overarching goal of safe, appropriate, and effective use of psychotropic medication through the development of programs, processes, and policies that align with American Academy of Child and Adolescent Psychiatry (AACAP) recommendations. Our UM and Care Coordination teams will work with IngenioRx to better enhance care coordination for the member through the use of this data. We will be able to quickly identify changes in medications so that action and follow-up may be taken with the members, their caregivers, and providers to mitigate any risks and increase effectiveness.

UniCare is committed to full transparency and accountability. We will ensure IngenioRx is compliant with all contractual and regulatory requirements through our Subcontractor Oversight program. We will promote frequent, open, and effective communication that emphasizes the delivery of quality services to members. We will monitor and evaluate IngenioRx's performance through ongoing collaboration, regular monitoring, and formal auditing processes to make sure they meet or exceed DHHR requirements.

Implementing Prescription Limits (BA084)

IngenioRx has experience managing both single State preferred drug lists (PDLs) and State-required prescription limits and PA criteria, as well as MCO-managed PDLs and development and implementation of their own prescription limits and PA criteria. Prescription limits that are developed and implemented include, for example, quantity limits and PA requirements for opioids as well as limitations on brand name and generic prescriptions.

Policies and Procedures

IngenioRx has a robust set of policies and procedures (P&Ps) addressing all aspects of pharmacy benefit management see Table E.1-6. As these P&Ps are confidential, we are providing a list of the policies and procedures in place for other markets regarding prescription limit and medical necessity policies. We would be happy to provide these and other P&Ps to DHHR for review and approval should pharmacy be carved in.

Table E.1-6. Available Pharmacy Benefit P&Ps Regarding Prescription Limits and Medical Necessity

Policies and Procedures		
Clinical Claim Edits	Drug Use Evaluation	Lost, Stolen, & Vacation Override Requests
Medicaid Formulary System Process	Medication Fraud, Waste and Abuse Procedures	Medication Therapy Management
Member Notification Timeline Requirements for Negative Formulary Changes	Peer to-peer Request Process	Pharmacy Benefits Transition of Care, Continuity of Care
Pharmacy Lock-in Programs (state specific)	Pharmacy Prior Authorization	Prescriptions for Out of Area Travel
Provider Communications of Medicaid Formulary Changes	Providing Copy of Denial Criteria	Step Therapy
Clinical Pharmacy Policies and Procedures tailored for market specifics and include UM for cost-effective treatments and positive outcomes		

Point of Sale Edits

IngenioRx adjudicates pharmacy claims via an online, real-time POS system. This single integrated platform provides a uniform level of plan flexibility, clinical functionality, administrative accuracy and efficiency, and service capabilities. The online claims processing system runs a series of edits before adjudicating a claim, including the following:

- Member eligibility
- Drug coverage
- Rejection edits for third-party liability and coordination of benefits
- Step therapy, therapy duplication, and other clinical edits, as applicable
- Prospective DUR edits
- Formulary and preferred drug list compliance
- Benefit design edits (quantity, day supply, and refill-too-soon)

These system edits, applied at the POS, act as an automated management tool to monitor and help ensure compliance with program parameters before a prescription is dispensed to help

make sure there are no duplicate prescriptions or overlaps in therapy and to screen for early refills. These provide a stringent set of online electronic claims verification and authorization edits. Examples of POS edits include drug-drug interactions, drug-disease interaction, therapeutic duplication, age limitations, and high/excessive dosing.

These alerts provide valuable information to pharmacists to prevent adverse events, support appropriate prescribing, and assist with member and caregiver counseling — especially important for the safety of our West Virginia members. In addition to member safety, POS edits identify providers who demonstrate aberrant prescribing patterns or who are on the federal or State exclusion list. Prescriptions written by excluded providers will not pay under any circumstances.

The claims processing system also verifies PA requirements. AutoPA at pharmacy POS uses intelligent and automated logic that checks the claims system against the member's prescription profile and medical claim data to determine if the prescription meets established PA criteria. If the prescription has autoPA rules attached and meets criteria, it will process without the need for a traditional PA. AutoPA reduces provider burden and eliminates delays for the member.

Prior Authorization Requirements

IngenioRx will offer multiple options for submitting pharmacy PA requests: providers can submit PAs via fax, phone, or electronically (ePA) via the web or from the provider's EHR at no charge.

Our pharmacy service authorization process will use ePA to reduce administrative burden and expedite approvals for providers. If all PA criteria are met, the ePA system automatically generates a PA approval. It builds upon e-Prescribing processes with which many providers are already familiar. This allows more claims to process in real time because the delay for PA is avoided.

In addition, through the Real-time Benefit Check through e-Prescribing, providers will be able to find ***member-specific*** prescription benefit information within their EHR, including formulary status of the selected medication, formulary alternatives, and coverage alerts, including PA and step therapy. This capability allows providers to have easy access to formulary and PA information. We will also have educational programs for our providers that will include education on PDL and PA processes and procedures.

To facilitate a prompt response to each authorization request, the PA team will have real-time access to information about members' eligibility, medication history, diagnosis information from medical claims, and the formulary and PDL benefit design. IngenioRx will use this integrated data information when reviewing the PA request against the PA criteria.

Medication Management (BA041, BA085, BA086, BA087)

Because the member's health and safety is of the utmost importance to us, UniCare — in partnership with IngenioRx — will provide a robust set of medication management programs to identify and manage polypharmacy utilization, monitor potential abuse or inappropriate utilization of controlled prescription medications, and manage members with a history of prescription drug abuse. IngenioRx will perform periodic reviews of pharmacy claims data to identify potential cases of drug use or misuse, under- and over-utilization, and coordination of care issues and analyze prescribing patterns by reviewing pharmacy claims data using established processes to stratify pharmacy claims data to identify prescribing and usage patterns and trends. The goal is not to infringe on providers' decision-making practices, but rather to provide education and training on best practices for prescribing medications to support prescriber self-regulation.

IngenioRx's 24/7 Member Services call center will also have the capabilities required to deliver an enhanced service experience, which will include specialized pharmacy-focused employees, and will allow for greater opportunities to improve member engagement including adherence counseling and benefit-specific therapeutic alternatives in a single interaction.

Drug Utilization Review Program (BA041, BA085, BA086, BA087)

Together with IngenioRx, UniCare will offer a comprehensive clinical DUR program that will address over- and under-utilization of prescription medications, and include both prospective DUR (proDUR) and retrospective DUR (RDUR) programs. DUR helps verify that the appropriate drug is dispensed properly and used safely by the member by applying evidence-based, industry-standard medication regimens that promote the effective use of prescribed medications to improve health outcomes and will help us achieve a low-cost trend for prescription drugs. DUR program execution is achieved through a cross-functional, interdisciplinary approach that involves coordination of effort across multiple departments and functional areas. We will assess program impact through retrospective, member-level analyses, and health plan cost impact.

Prospective DUR

The proDUR program will use Medi-Span's clinical drug screening logic to generate DUR edits and screening results at POS. These edits alert the dispensing pharmacy to potential drug therapy problems resulting from therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug allergy interactions, and clinical abuse or misuse. Based upon these edits, the dispensing pharmacist will contact the prescriber or member to discuss contraindications and alternatives.

Retrospective DUR

The RDUR program will take a retrospective look at member utilization. We will use pharmacy claims data to identify members or prescribers whose drug therapy regimens may indicate overutilization or drug safety issues. RDUR programs will also identify underutilization, which triggers member and prescriber interventions to promote medication adherence. IngenioRx designed its programs to close gaps in care and improve adherence, especially among members whose diagnosis puts them at a higher risk of adverse outcomes when drug therapies are not taken consistently or appropriately. These programs will also support pharmacy-related HEDIS measures.

BH Medication Management (BA041, BA085, BA086, BA087)

The BH Medication Management program will provide support to promote medication adherence and improve prescriber practices for members with mental health and substance use conditions. It addresses increased concerns about the safe, appropriate, and effective use of psychotropic and controlled substance medications, including opioids. It is a comprehensive program that improves members' quality of care through more clinically appropriate prescribing, improves member adherence to appropriate medication treatments, promotes care coordination between prescribers, decreases the cost of care, and improves performance on HEDIS measures. Components of this program that will impact children and youth in the child welfare system include:

- Metabolic monitoring for children and youth in the child welfare system taking antipsychotics
- Outreach to prescribers that encourages use of first-line psychosocial care for children and youth that are in the child welfare system that are newly started on antipsychotic medication
- ADHD medication management to reduce overutilization of stimulant medications in children and youth in the child welfare system

The Psychotropic Medication Management program is a provider outreach program that will target members with multiple prescribers and multiple psychotropic medications to address

polypharmacy issues, inappropriate prescribing of psychotropic medications for children under the age of six, and the use of antipsychotics in children when there is no evidence of providing first-line psychosocial care or metabolic monitoring. This program will also include additional prescriber messaging on drug-drug interactions and high-dose alerts (dosages that are higher than the FDA-approved doses), which include rules for members under 18 years of age that will look at compliance at taking antidepressants and the maximum dose of stimulant medications to prevent exceeding maximum dose. With DHHR approval, we would also implement POS claim edits to prevent the dispensing of duplicate therapy with use of psychotropic medications, and PAs for antipsychotic use in children 17 years of age and younger. Table E.1-7 illustrates the overall impact of the psychotropic polypharmacy and child age appropriateness programs for child welfare members in our affiliate markets in 2018.

Table E.1-7. Overall Impact of the Child Age Appropriateness and the Psychotropic Programs

Psychotropic Programs	Overall Impact of the Child Age Appropriateness
Child age appropriateness	50% of child welfare members under age six identified discontinued the inappropriate psychotropic medication
Psychotropic polypharmacy	69% of child welfare members identified discontinued one or more of the multiple psychotropic medications

The ***ADHD New Start Program*** is a targeted medication management program for members under 18 years of age who recently started a new ADHD medication. This member mailing informs parents or guardians of the side effects to watch out for, benefits of the medication, and reminds them of the importance of seeing their provider regularly. We also provide the member's provider with a prescription profile for the member to assist them in identifying gaps in prescription fills and polypharmacy issues. We encourage the provider to discuss treatment options and medication adherence with the member and caregivers to assure the member is receiving appropriate treatment.

Controlled Substance UM Program (BA041, BA085, BA086, BA087)

The CSUM program is designed to decrease controlled substance overutilization, by identifying members receiving multiple controlled substance medications, including opioids, from multiple providers filled at multiple pharmacies, or combinations of controlled substances that may indicate risk. IngenioRx relays the information to prescribing providers so they can engage members at risk for adverse events related to misuse. The CSUM program reduces FWA by addressing drug-seeking behavior and doctor or pharmacy shopping. The CSUM program includes similar components as our parent company's award-winning Medicare Opioid Overutilization Management program, which received an ***Excellence Award for Care Management Strategies*** from the Pharmacy Benefit Management Institute. The CSUM program also provides member education; CSUM's Opioid New Start program identifies members with new opioid prescriptions and sends them a letter educating them on the safe and appropriate use of opioids and proper storage of them. The letter also encourages the member or caregiver to contact his or her prescriber or pharmacist and provides a link for additional tips on safe opioid use. Table E.1-8 shows the overall market success of some of the CSUM program components in 2018.

Table E.1-8. Impact of CSUM Program

CSUM Program Impact
87% of targeted members discontinued one or more of the targeted medications reducing the number of medications they were taking from 10 or more to less than 10
100% of targeted members discontinued one or more of the targeted medications in the harmful combination of opioids, benzodiazepines, and muscle relaxers
59% of targeted members discontinued use of multiple opioids from multiple providers

Opioid Management Program (BA041, BA085, BA086, BA087)

The Opioid Management Program will help reduce the opportunities of misuse of opioid treatment, including the development of opioid use disorders, by targeting outlier provider opioid prescribing patterns, as well as assisting members in gaining access to more clinically appropriate treatment. This program assesses physicians' opioid prescribing patterns evaluated against several utilization metrics, such as an overall opioid prescription count, percentage of patients that are newly started on opioids, and opioid utilization summary of at-risk members. The ***Opioid Prescribing Summary Report*** of providers' opioid prescribing practices compares prescribers to peers in their specialty practice areas. The information is provided to prescribers in the form of a report card to educate them on their prescribing patterns and offers providers multimodal support to reduce the opportunities for opioid misuse and abuse among their members. Additionally, we will assess members' risk of opioid misuse, and those that are identified as "At Risk" or "High Risk" will have a clinical pharmacist outreach to their opioid prescribers telephonically to discuss the opioid medication related concerns identified and to develop an action plan that will reduce opportunities for opioid overutilization and misuse.

Asthma Medication Management (BA085)

The Asthma Medication Management program will address gaps in care and adherence for our asthmatic members and their providers. A New Start Education letter will educate members on the importance of keeping appointments, knowing their triggers, and staying on their controller medication. Through the Asthma Adherence calling program, outreach targets members identified as non-compliant to asthma medications and focuses on the importance of controller medications and addresses adherence barriers. In addition, a communication is sent to prescribers identifying pediatric members who have not had a pediatric spacer in the past year and recommending the use of a spacer for patients, under five years of age, using a metered-doses inhaler. The program is designed to offer targeted education and outreach to pediatric members and caregivers, supporting providers with information related to the member's gaps in care, and incorporating medication adherence and utilization monitoring.

Comprehensive Medication Management (BA085)

IngenioRx also offers comprehensive medication reviews (CMRs) by clinical pharmacists that help prevent medication duplications, inappropriate or extenuated use, and incorrect dosing, any of which could lead to an unnecessary encounter. CMRs provide medication therapy management services for members to address medication adherence, gaps in care, and safety. CMRs are incorporated into IngenioRx's programs. In some cases, pharmacy technicians will also conduct telephonic outreach to members and their caregivers for issues related to adherence to medications to help identify and address barriers to obtaining medications and address any side effects that may be preventing the member from staying compliant with their medications. Our Care Coordinators will also have access to data regarding pharmacist outreach as a result of the CMRs to assist with coordinating care for members.

Medication Review and Patient Highlights Program (BA041, BA085, BA086, BA087)

The program has two subparts: Medication Review refers to the messages that will be sent to the member and their caregivers about their medications, and Patient Highlights refers to the messages that will be sent to prescribers about medications they have prescribed and will identify members with pharmacy care opportunities including medication safety or potential medication misuse. Communications will be sent to the prescribers encouraging them to coordinate care with other prescribers on the safe and effective use of medications. This program will focus on waste and abuse areas, such as polypharmacy, overutilization, off-label use, and concurrent therapy such as ADHD/amphetamine concurrent use.

Lock-in Program (BA041, BA085, BA087)

Having managed the pharmacy benefit and the Rx Safe Choice Lock-in program in West Virginia previously, we know what the State is looking for in a pharmacy lock-in program. IngenioRx also manages lock-in programs in the 17 markets where they currently manage the pharmacy benefit, including pharmacy and pharmacy/prescriber lock-in programs, and therefore has the experience and expertise to manage the program in West Virginia.

If we identify potentially abusive or dangerous behavior, we will activate the lock-in program for that member. This restriction will be put into place to promote the member's safety through coordination of care and limiting the member to the use of one pharmacy. The lock-in program will be designed to provide members and their caregivers with education and to identify and reduce improper and/or service overutilization with the support of automated monitoring tools.

The identification and referral process will consist of:

- Monthly reports identifying members previously locked into a single pharmacy
- Reviewing data available that may indicate the need for pharmacy restriction
- Members identified to meet certain provider, pharmacy, controlled substance, and/or opiate thresholds including drugs used in the treatment of opioid dependence

Following review of the member identified for the lock-in program by UniCare, the member and caregivers will be notified prior to being restricted to one pharmacy. The PCP and other identified prescribers, as well as the designated pharmacy, will also be notified in writing of the decision to lock the member to a single pharmacy. UniCare will evaluate the continued need for pharmacy restriction at minimum once per year. Members and their caregivers will have the right to file a grievance if they do not agree with UniCare's decision to restrict the member.

As we have done in the past, UniCare will collaborate with DHHR on pharmaceutical issues affecting West Virginia children in foster care, including the administration of a lock-in program.

Data Needs (BA087)

In a carve-in situation, no additional data will be needed from DHHR to manage members with a history of prescription drug abuse, as IngenioRx will have access to both the medical and pharmacy data needed to run these programs.

Dental Management

Oral health is a critical but often overlooked component of overall health and well-being among children and adults. At UniCare, we understand that access to oral health services and instilling good oral health habits in children sets the stage for healthy lives as adults. Dental and oral health care remains some of the most difficult health services to access for children and youth in foster care, in particular. Approximately 35% of children and teens enter foster care with significant dental and oral health problems.

UniCare has subcontracted with SKYGEN USA, LLC (SKYGEN) since 2011 to provide a robust network of dental providers and services to members in our West Virginia Medicaid programs. We will continue to subcontract with SKYGEN to provide necessary dental services to members within the Program, emphasizing preventive care, and assuring continuity of care throughout the duration of treatment. We will build on the well-

> *We recently had a special needs patient that had to be seen in the operating room (OR), because he was a large teenager who is non-verbal, who had bitten through multiple dental mirrors in the office setting. We obtained approval to treat him in the OR setting for multiple preventive and restorative treatments. We were able to arrange a simultaneous molar extraction by an oral surgeon, so we wouldn't have to sedate the member twice. Working with UniCare and SKYGEN makes it so much easier to give these members the care they need. It makes a huge difference that a member has UniCare, because they seem to rarely question cases such as these.*
> — **Local dentist**, Charleston

established relationships and processes we have developed with SKYGEN to support our Program members and will look for opportunities to enhance our coordination. ***We will hire a dedicated Dental Liaison who will be a licensed dental hygienist to perform in a case management role, providing necessary coordination with dental providers, Care Coordinators, members, caregivers, and SKYGEN.*** As Care Coordinators identify dental needs, the Dental Liaison will engage to remove barriers to care, identify dental providers, communicate with other providers as necessary, and advise regarding individual dental needs. They will be responsible for oversight and monitoring of performance on key dental outcomes, including EPSDT preventive dental visits. The Dental Liaison will identify targeted community outreach needs and will coordinate with SKYGEN regarding community-based events, including dental clinics and mobile dentistry, to enhance member access to dental screenings and care and improve overall dental outcomes.

Providing Necessary Dental Services to Members (BA094)

UniCare, through its relationship with SKYGEN, will meet contract requirements by providing dental services to its members that its dental providers recommend as reasonable to meet their oral health needs. These preventive, therapeutic, palliative, and injury-related services will include emergency and non-emergency services, such as:

- Diagnostic services and testing
- Preventive care, treatment, and screenings
- Restorative treatment
- Endodontic treatment
- Periodontal treatment
- Extractions and surgical procedures
- Orthodontic treatment
- Complete and partial dentures, relines, and repairs
- Medically necessary adjunctive services
- Injectable medications
- Oral and maxillofacial surgery

Services will be provided by licensed dentists, orthodontists, or oral surgeons in appropriate ambulatory or facility settings. SKYGEN's staff of licensed dental consultants, in consultation with caregivers and the member's PCP, make determinations of medical necessity. The licensed dental consultants consider all submitted documentation, the appropriateness of the requested service, the member's individual needs, EPSDT guidelines, and periodicity schedule, assessment of the local delivery system, and Program benefits and exclusions in the final determination of medical necessity. These decision-making processes will be accessible to providers through a provider services website, so dentists can follow the decision matrix and understand the logic behind authorization decisions. ***We will encourage providers to offer feedback about the factors relevant to medical necessity decision-making for Program members.*** SKYGEN's UM program requires all professional clinical reviewers to employ the same clinical guidelines, ensuring the consistent application of clinical criteria for authorization determination.

SKYGEN has successfully provided high-quality dental services to all members in the MHT program under the direction of the UniCare Dental Director, Diane Paletta, DDS, whose main responsibility is to make sure that members receive timely, high-quality, and efficient dental care. The Dental Director plays a critical role in utilization review of dental decisions and the oversight of the clinical algorithms used to determine dental authorizations.

Working Closely with PCPs to Reinforce Dental Practices

Our Fostering Healthy Lives model prioritizes outreach and collaboration among providers, caregivers, members, families, Department caseworkers, and our Care Coordination team to optimize health outcomes for our members. Therefore, we will encourage our PCPs to play an active role in ensuring members receive appropriate dental care through active collaboration,

data sharing and coordination with our dental providers. ***This collaborative PCP-driven model has achieved superior quality results in our Georgia affiliate's similar foster care program, where their 2018 HEDIS measure of Annual Dental Visits scored over the 90th percentile in NCQA's Quality Compass.***

PCPs will specifically:

- Provide direct referrals to dentists for babies within six months of their first tooth eruption and no later than 12 months of age
- Reinforce the need for regular six-month checkups
- Work closely with Care Coordinators when new members enter the Program to identify continuity of care issues or necessary dental care and screenings

We will also educate PCPs about fluoride varnish application, encouraging them to complete the Smiles for Life curriculum and participate in DHHR Infant and Child Oral Health Fluoride Varnish program.

Meeting Dental Needs in Underserved Areas

Numerous counties and geographic areas within West Virginia have been designated as health professional shortage areas (HPSAs) for dental care, largely because of their rural location. Along with SKYGEN, UniCare is committed first and foremost to identifying high-quality dentists and dental specialists to include in the network available to our Program members. Recognizing that demand for timely dental services frequently exceeds available supply in specific markets, UniCare and SKYGEN will also implement a number of innovative approaches to providing high-quality, timely services to members, as described in Table E.1-9.



Table E.1-9. Bringing Innovation to Dental Care Across West Virginia

Innovation	Description and Impact from Other Markets
School-based dental clinics	• Provided mobile sealant program to 17 schools and educational programs on prevention of oral disease in an additional five counties • Resulted in 1,694 dental cleanings; 3,344 oral health screenings; and 3,401 fluoride/topical applications
Community youth outreach	• Participated in more than 50 events annually in one state, including community events, such as back-to-school events, health fairs, food drives, resources fairs, and community baby showers • Coordinated with Head Start educational and promotional activities

SKYGEN currently contracts with mobile and school-based dental practices through West Virginia for our MHT program.

Reminding Members and Caregivers of Screenings (BA095)

UniCare is committed to building healthy habits in its members and to avoiding significant dental interventions through appropriate screening and preventive care through HealthCheck, EPSDT program in West Virginia. We will follow the schedule and guidelines for pediatric preventive screenings using the most recent recommendations and established standards of the American Academy of Pediatric Dentistry (AAPD), Bright Futures, and CMS. Specifically, we will educate members and their caregivers on following established guidelines:

- ***Initial screenings*** for new members, which include identification of dental needs, within 30 days of placement or a change in placement
- ***Initial screenings for babies***, within six months of first tooth eruption and by 12 months
- ***Regular checkups*** for all members every six months after initial screening

Our Care Coordinators, PCPs, and dental providers will each play roles in initiating and reminding members and caregivers about dental screenings, as noted in Table E.1-10.

Table E.1-10. Ensuring Dental Screenings Become Part of Our Members' Routines

Responsibility	Care Coordinator	PCP	Dental Provider
Initial screenings			
Initiate screening for new members	X		
Identify continuity of care needs for new members	X	X	
Initiate screening for babies on schedule	X	X	
Assist members in selecting dental providers	X		
Assist members in scheduling initial visits	X		
Send reminders of initial screenings	X		
Assist members with transportation to initial visits	X		
Regular checkups			
Assist members in scheduling regular checkups	X		X
Send reminders about regular checkups	X		X
Reinforce message about regular checkups	X	X	X
Assist members with transportation to checkups	X		
Assist members to schedule follow-up visits	X		X
Make new caregivers aware of ongoing dental schedules and needs for members changing placement	X		

Care Coordinators, who will play a vital role in coordinating dental care, will be notified when members enter the Program and will identify dental providers and needs during the initial HRA. Care Coordinators will educate caregivers on dental screening policies and the assistance that is available to them in identifying dentists, scheduling appointments, and arranging transportation. They will also help educate PCPs on their responsibilities in initiating dental care for their members and in the educational resources and guidance available.

Care Coordinators will receive monthly lists of members who are due for screenings, have upcoming appointments, or have missed appointments. Care Coordinators will also receive a weekly electronic feed from SKYGEN of scheduled appointments. Based on this information, members will receive reminders of upcoming dental visits from their Care Coordinators through telephone or secure email 48 hours in advance of the appointment.

Making Sure Members Receive Dental Screenings

UniCare and SKYGEN have focused significant attention on prevention of oral disease and screenings; we will extend that focus to our Program members. Our HEDIS scores improved substantially between 2018 (Measurement Year 2017) and 2019 (Measurement Year 2018) as a result of focused efforts to improve member participation:

- Percent of eligible that received dental services **increased by 4.7%**
- Annual dental visits for two and three year olds **increased by 3.3%**
- Dental sealants for six to nine year olds **increased by 52.9%**

Providing Dental Care to Members with Special Needs (BA096)

In some cases, our Program members may have special needs that preclude them from accessing dental services without additional support, such as:

- BH challenges
- Language and communication barriers
- Sensory impairments, such as vision or hearing issues
- Psychosocial issue, such as low oral health literacy, dental anxiety, and past negative dental experiences

> One SKYGEN dental provider uses a therapy dog at their office. A four-year-old MHT Program member has always feared treatment and required restraint for dental services. The last time she received treatment, the dog jumped into the chair with her and lay down. She was so comforted that she did not require restraint.
> WV_FC2019_E.1.5_SKYGEN_COB_01

UniCare's Care Coordinators will identify potential special needs during the HRS and will work closely with dental providers on accommodation strategies, such as language assistance or alternatives to reduce anxiety.

SKYGEN maintains information on whether its dental providers service members with disabilities or special needs. Currently, more than one-third of SKYGEN's West Virginia providers (251 out of 667) indicate they can provide services to members with special needs. Care Coordinators seeking dental care for Program members with special needs can request assistance from SKYGEN through their contact center or online, with support by our dedicated Dental Liaison.

SKYGEN will also have the ability to offer on-site services when Program members cannot receive care in a traditional office setting, although the range of services that can be provided will necessarily be limited by the equipment that can be transported. In the majority of cases, however, we expect to make arrangements with inpatient and outpatient facilities, as necessary, to accommodate Program members with special needs.

Monitoring Utilization of Dental Screenings (BA097)

All information regarding appointments, care received, and follow-up will be contained in each member's personal health record, so that it is available to Care Coordinators through Health Insight and to other users, including dentists, Department caseworkers, caregivers, and other authorized stakeholders through the YouthRAP. As noted, Care Coordinators receive system-generated lists of members who are due for screenings, have upcoming appointments for regular checkups or follow-up care, or have missed appointments. In addition to using this information to remind members and their caregivers of dental screening priorities, UniCare uses it to determine the effectiveness of its dental screening program and identify opportunities to improve overall quality of care:

- Annual member-specific gaps-in-care reports are available to Care Coordinators, PCPs, and other clinical staff
- Monthly trend rates and statistics on dental screenings, regular checkups, and missed appointments are compiled by SKYGEN

UniCare will use the information provided by these regular means to not only follow up with members, their caregivers, and in some cases, their Department caseworker, but also to inform the effectiveness of the program. In our current Medicaid programs in 2018, we sent 84,282 text message reminders to members and their caregivers for preventive dental care through our HealthCrowd application to improve overall screening rates. Our staff currently conducts monthly meetings with SKYGEN during which we review the Performance Indicator report, which provides a comprehensive view of all the metrics needed to ensure compliance with dental related contract requirements and highlights any issues of noncompliance. At these meetings, we discuss remediation and improvement opportunities based on the metrics and trends.

When members do not receive appropriate preventive care, we will implement several strategies designed to understand and remediate barriers to care. Care Coordinators will contact members and their caregivers to understand why care has not been accessed. Typical barriers might include lack of transportation, inability to take a member for an appointment because of a caregiver's work schedule, or lengthy wait times for appointments. Depending on the barrier to dental care, Care Coordinators will employ different remediation strategies specific to the identified barrier, such as finding alternative transportation, identifying providers with extended hours, scheduling appointments, or finding alternative providers.

UniCare's Care Coordinators remain in frequent contact with the Department caseworker on all issues related to health status and health care. In the rare instances where our efforts to schedule dental services are not successful, we will inform the Department caseworker and discuss additional dental care strategies.

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Supplemental Document E.1-1: Utilization Management Guidelines

Supplemental Document E.1-1 includes the following:

- Supplemental Document E.1-1a: MCG Care Guideline Development 2019
- Supplemental Document E.1-1b: MCG Chronic Care Guidelines
- Supplemental Document E.1-1c: MCG General Recovery Care Guidelines for Payers
- Supplemental Document E.1-1d: MCG Inpatient Surgical Care Guidelines for Payers
- Supplemental Document E.1-1e: MCG Behavioral Health Care Guidelines for Payers
- Supplemental Document E.1-1f: MCG Recovery Facility Care Guidelines
- Supplemental Document E.1-1g: MCG Summary of Guideline Development Policies and Procedures
- Supplemental Document E.1-1h: Customization to MCG Care Guidelines

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CARE GUIDELINE DEVELOPMENT

INTRODUCTION

MCG care guidelines play a vital role in the healthcare journey of millions of patients all over the world. Many health plans and care providers also rely on them to support critical business functions. Therefore, it is important that customers of MCG Health have confidence in the research methods and editorial processes which lead to their development.

EDITORIAL AND FINANCIAL INDEPENDENCE

MCG care guidelines are based on published medical evidence, clinical expertise, and objective, standardized analysis of various databases. Neither MCG nor its employees accept any remuneration from outside sources to support or influence guideline development. Guideline development is financially supported by licensing fees paid by clients for access to our content. Our clients represent many aspects of healthcare, including hospitals and physician groups, insurance companies and TPAs, and government agencies including Medicare and Medicaid oversight organizations. Our clients routinely inform us how much they value the unbiased, evidence-based content that MCG provides.

OVERVIEW OF METHODOLOGY FOR GUIDELINE DEVELOPMENT

The guideline development cycle (summarized graphically in Figure 1, right) occurs annually. Expert clinical editors — medical doctors, registered nurses, and other healthcare professionals search the medical literature systematically, seeking the very latest information and evidence for each guideline. We employ customized, tested, proprietary search strategies to allow efficient yet comprehensive identification and analysis of relevant publications for a given topic and to maximize retrieval of articles with information pertinent to a specific guideline.

Retrieved materials are individually reviewed by an MCG clinical editor and selected for use based on quality and relevance to the guideline in question. Available evidence of the highest quality and published in the most widely read and referenced journals is preferentially used. Based on careful review of this evidence, an MCG clinical editor makes any necessary changes to the guideline. Once this update process is complete, each guideline is reviewed again by a supervising clinical editor to verify the accuracy and appropriateness of all changes.

Each guideline undergoes external review by clinically active experts (board-certified specialist physicians who affirm no financial conflicts of interest) to confirm the relevancy and clinical appropriateness of each guideline in accordance with the selected evidence and real-world clinical practice. A supervising clinical editor evaluates external reviews and changes the guideline as appropriate.

Figure 1. MCG care guideline development



MCG CARE GUIDELINE DEVELOPMENT

Certain components of our solutions (such as Goal Length of Stay) are additionally developed and validated through the analysis of several databases that include millions of inpatient and outpatient records. Comparing optimal care as described in the medical literature to care as actually delivered helps ensure the reasonability and clinical appropriateness of the guidelines' benchmarks.

EVIDENCE GRADING

MCG seeks out the most authoritative evidence available and strives for transparency in the presentation of that evidence. We support our recommendations with graded evidence from the medical literature and other sources, applying a generally accepted hierarchy of evidence (described below). References cited in many content solutions are graded according to the level of authoritativeness to give insight into the quality of supporting evidence for our recommendations.

Evidence Grade 1

- Meta-analyses
- Randomized controlled trials with meta-analysis
- Randomized controlled trials
- Systematic reviews

Evidence Grade 2

- Observational studies, including:
  - Cohort studies with statistical adjustment for potential confounders
  - Cohort studies without adjustment
  - Case series with historical or literature controls
  - Uncontrolled case series
- Published guidelines
- Statements in published articles or textbooks

Evidence Grade 3

- Unpublished data, including:
  - Large database analyses
  - Written protocols or outcomes reports from large practices
  - Expert practitioner reports

To give additional insight into the underlying reasoning and strength of certain recommendations, MCG includes a system of recommendation grades. In the Ambulatory Care guidelines, each potential indication has been assigned one of five recommendation grades that summarizes the evidence-based reasoning behind this conclusion. Recommendation grades are as follows:

RG A1	Evidence demonstrates at least moderate certainty of at least moderate net benefit.
RG A2	Evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care.
RG B	Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
RG C1	Evidence demonstrates a lack of net benefit; additional research is recommended.
RG C2	Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.

FREQUENCY OF UPDATES

We publish an updated edition of the care guidelines in Q1 of every calendar year, based on an annual process of systematic evidence review, conducted throughout the previous year. Each edition typically includes approximately 40,000 unique citations, of which around 30% are new references. Throughout the annual production cycle, our clinical editorial staff monitors medical literature for new evidence (including published research studies, practice guidelines, and new editions of textbooks) that may be relevant to current guideline content. When new evidence dictates a marked change to accepted clinical practice referenced in the care guidelines, we notify our clients.

About MCG Health

MCG, part of the Hearst Health network, helps healthcare organizations implement informed care strategies that proactively and efficiently move people toward health. MCG's transparent assessment of the latest research and scholarly articles, along with our own data analysis, gives patients, providers and payers the vetted information they need to feel confident in every care decision, in every moment. MCG can integrate with virtually any EHR/EMR or Utilization Management platform to provide evidence-based guidance directly within the clinical workflow.



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Guidelines
Chronic Care

Chronic diseases and conditions have become the leading cause of death and disability in the United States and are among the most common, costly, and preventable of all health problems. This alarming trend makes it essential that evidence-based care and disease management tools are used effectively to address chronic care needs. Our Chronic Care guidelines can help healthcare organizations evaluate needs, identify goals, develop personalized care plans, and support effective self-care for persons.

IMPROVE OUTCOMES
Enhance care quality and lower costs with modular guidance designed to quickly and efficiently assess and meet the unique needs of each person.

REDUCE READMISSIONS
Reduce preventable readmissions stemming from chronic conditions by improving treatment of chronic conditions that contribute to them, such as heart failure and chronic obstructive pulmonary disease.

PROMOTE SELF-CARE
Help persons with chronic diseases care for themselves with easy-to-understand handouts, available in both English and Spanish.

Support for Achieving NCQA Accreditation*
The NCQA 2019 Population Health Program (PHP) Standards list MCG Chronic Care guidelines as an example for meeting Standard 1, Element A. These new standards cover population health and disease management programs.

* **NOTE:** NCQA does not endorse or require the use of MCG care guidelines.

Chronic Care guidelines help clinicians evaluate needs, identify goals, develop personalized care plans, and support effective self-care for patients with chronic diseases or complex care issues. The modular design supports quick, efficient assessments and enables the management of multiple comorbidities and behavioral health conditions.

High-Intensity Care and Disease Management

Designed for persons needing telephonic or in-person support, high-intensity disease guidelines consist of various modules clinicians can use to create comprehensive assessments and care plans, including:

- **Enrollment** – establishes a person's eligibility for the case management program
- **Start of Care** – addresses the status of a person's medical, behavioral, and psychosocial wellbeing, helping clinicians identify needs and prioritize assessments and care plans
- **Self-Management** – offers disease- and condition-specific modules for assessing and improving individual understanding and self-care (including detailed plans of care for breast, colorectal, lung, prostate, and skin cancers)
- **Health Status** – provides assessments and care planning tools related to specific clinical interventions, supports medication management, and covers common symptoms that may fall outside of the usual issues related to a person's chronic condition
- **Transition Tools** – covers issues related to transitions of care, including risk of hospitalization, changes in medication, and post-discharge follow-up with a primary care physician or specialist
- **Psychosocial** – addresses mental and behavioral health issues and social needs that may affect a person's ability to self-manage a chronic condition
- **Functional Status** – evaluates a person's ability to perform activities of daily living and instrumental activities of daily living (ADL/IADL)
- **Wellness** – ascertains wellness issues, such as tobacco or alcohol use, that if addressed could improve a person's overall health

Low-Intensity Disease Management

Low-intensity guidelines support low-touch disease management programs with patient education materials covering topics related to the given condition.

Patient Engagement Tools

Simple, non-technical, and often illustrated educational handouts, available in English and Spanish, that clinicians can distribute to patients.



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Guidelines

General Recovery Care

Designed to complement Inpatient & Surgical Care, General Recovery Care helps health plans manage cases when there is no clear diagnosis, when no specific Inpatient & Surgical Care guideline appears applicable, or when the clinical situation is too complex for a specific guideline. With General Recovery Care, you can:

ENSURE APPROPRIATE ADMISSIONS

Ensure appropriate admissions and timely discharges for members that present with multiple illnesses, traumas, or other unclear or complex conditions or symptoms.

PRESENT GUIDELINES THAT COVER 100% OF ADMISSIONS

Use in conjunction with the condition-specific guidelines in Inpatient & Surgical Care to cover 100% of admissions, reducing the need to create medical policy or license multiple decision-support tools.

ENSURE APPROPRIATE TRANSITIONS TO LTACHs

Establish the medical appropriateness for discharge of clinically complex members to a Long-Term Acute Care Hospital (LTACH) based on predicted benefit from multidisciplinary LTACH care.

MANAGE UTILIZATION OF INPATIENT PALLIATIVE CARE

Establish the medical necessity for inpatient palliative care.

GENERAL RECOVERY CARE

Taken together, Inpatient & Surgical Care and General Recovery Care cover the entire spectrum of conditions and procedures requiring hospital admission. General Recovery Care provides information to assist in care management of complex clinical situations where a single Inpatient & Surgical Care guideline or set of guidelines does not apply.

Clinical indications for admission or procedure

Indications summarized in each guideline, making them quick and easy to use while providing clinical detail for managing members with complex or uncertain conditions.

Benchmark length of stay (BLOS)

Benchmark length-of-stay values developed from the analysis of data on large groups of members with similar diagnosis or procedure codes, combined with clinical reviews of discharge databases.

Long-term acute care hospital (LTACH) care

Admission criteria for members who need intensive clinical intervention and frequent diagnostic services, including daily physician visits in a longer-term setting.

Additional criteria and information

- Body System Guidelines
- General Recovery Course
- Discharge Criteria
- Evaluation and Treatment
- Operative Status Criteria
- Case Management Guidelines
- Care Management Tools
- General Recovery Guidelines tools, including Inpatient Palliative Care, Home Care, and Recovery Facility Care criteria



Guidelines
Inpatient & Surgical Care

The Inpatient & Surgical Care guidelines offer evidence-based criteria, goals, optimal care pathways, and other decision-support tools, making them a valuable resource for proactive care management, case review, and assessment of members facing hospitalization or surgery.

ACHIEVE CORRECT LEVEL-OF-CARE

Enable utilization staff to make objective admission and level-of-care decisions – including observation vs. inpatient determinations – according to strict standards of evidence-based medicine.

MANAGE LENGTH OF STAY

Use integrated length of stay data – including care timelines and benchmarks derived from the medical literature – to promote optimal recovery and timely discharge (additional clinical content included to manage members who require extended stays).

OPTIMIZE UTILIZATION

Assess your organization's performance – using the Benchmark Statistics Dashboard – based on utilization data sorted by region or utilization model (e.g., loosely, moderately, and well managed systems for commercial and Medicare populations).

INPATIENT & SURGICAL CARE

Designed for use in conjunction with a physician's or case manager's clinical judgment, the care guidelines describe best practice member care and recovery, supporting care quality and efficient resource management. Inpatient & Surgical Care offers evidence-based criteria, goals, care pathways, and other decision-support tools, making it a valuable resource for proactive care management, case review, and assessment of members facing hospitalization or surgery.

Clinical Indications for Admission or Procedure

Discrete criteria for efficient utilization management and documentation of medical necessity.

Observation Care Guidelines

Comprehensive criteria covering observation care admission and discharge decisions.

Goal Length of Stay (GLOS)

The length of stay reasonable for a substantial number of members, assuming optimal recovery, decision-making, and health system design and performance.

Rapid Recovery Guidelines

Provide quick status determination with side-by-side inpatient vs. observation criteria.

Optimal Recovery Course

A tabular description of optimal care and member status in six categories (Level of Care, Clinical Status, Activity, Routes, Interventions, and Medications) that helps care teams proactively manage a member's recovery.

Evidence Summaries, References, and Footnotes

The current best evidence, integrated directly into the guidelines, including instantly accessible abstracts for many references.

Extended Stay

A description of comorbidities or complications that can cause a hospital stay to exceed the GLOS, even with optimal care – plus estimates of the duration of those extended stays.

Readmission Risk Guidance for Key Conditions

Readmission risk factors, risk reduction guidance, and risk screening tools.

Benchmarks and Data Website

Statistical benchmarking tools, including Length of Stay Tables (sorted by region and payer type), Inpatient Care Utilization Models (demographically adjustable), Readmission Rate Benchmarks, Emergency Room and Observation Statistics, and the DRG Cross-Reference Table.

Additional Criteria and Information

- Alternatives to Admission or Procedure
- Intensive, Intermediate, and Telemetry Care Guidelines
- Common Complications and Conditions
- Patient Education for Clinicians
- Extended Stay Risk Assessment
- Assistant Surgeon Guidelines
- Neonatal Levels of Care Guidelines (I, II, and III)
- Separate content to address care for adult and pediatric populations

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Guidelines

Behavioral Health Care

Our guidelines address medical necessity screening criteria and provide care guidance to help utilization management teams make comprehensive and consistent care decisions with confidence. You can help ensure compliance with federal and state parity mandates while driving effective care for your members across the many levels and settings of the behavioral health journey.

Ensure Quality Behavioral Care Across Multiple Settings

Access 90 diagnosis-based guidelines that enable you to manage the right level of care based on the latest evidence. Our Level of Care Comparison Charts address five levels of care—inpatient, acute outpatient, residential, partial hospital, and intensive outpatient—to help you quickly determine a member's level of care.

Maintain Regulatory Compliance

MCG care guidelines align with regulatory requirements, including the Mental Health Parity and Addiction Equity Act.

Support Reducing Costs

Our community-based care content helps promote improved function and independence in the community, with the goal of reducing unnecessary admissions or intensive/emergency care.

Workflow Integration Available
MCG content and software solutions can integrate with virtually any utilization, medical management, or population health platform. Ask your MCG representative for a list of our strategic alliance partners.

BEHAVIORAL HEALTH CARE

Behavioral Health Care describes best practices for the majority of behavioral health and substance use diagnoses – with guidance spanning the many levels and settings of the continuum of care.

Care Guidelines for Behavioral Health

Covers 16 diagnostic groups, each of which represents a single diagnosis or cluster of similar diagnoses, and feature evidence summaries for each diagnosis-specific level of care.

Behavioral Health Level of Care Guidelines

30 guidelines for use prior to diagnosis to help determine appropriate level of care (covering the same five levels as diagnosis-specific guidelines – plus crisis intervention, observation, day treatment, custodial care, and long-term community-based residential care); each guideline includes a recovery course with expanded recovery milestones and criteria for continued stay and discharge.

Opioid Management

- Medication-Assisted Opioid Withdrawal
- Outpatient Opioid Maintenance Therapy
- Medications, including various formulations of buprenorphine and naltrexone, and long-acting opioids

Community Services

- Assertive Community Treatment
- Mental Health Support Services
- Peer Support Services
- Psychological Rehabilitation
- Social Skills Training
- Targeted Case Management
- Therapeutic Behavioral On-Site Services

Testing Procedures

- Neuropsychological Testing
- Psychological Testing
- Urine Toxicology Testing

Therapeutic Services

- Applied Behavioral Analysis
- Bright Light Therapy
- Early Psychosis Intervention
- Electroconvulsive Therapy (ECT)
- Eye Movement Desensitization and Reprocessing (EMDR) Therapy
- Transcranial Magnetic Stimulation

Level of Care Comparison Charts

- Behavioral Health, Adult
- Behavioral Health, Child or Adolescent
- Eating Disorders, Adult
- Eating Disorders, Child or Adolescent
- Substance-related Disorders, Adult
- Substance-related Disorders, Child or Adolescent



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Guidelines
Recovery Facility Care

A well-coordinated plan is key to transitioning people to skilled nursing (SNF) and inpatient rehabilitation facilities (IRF). Recovery Facility Care is an easy-to-use, detailed, and comprehensive set of guidelines for making informed healthcare decisions, providing the highest quality care, and managing resources effectively during these transitions of care. Recovery Facility Care guidelines also address comorbid conditions requiring concurrent management. With Recovery Facility Care, you can:

OPTIMIZE LEVEL-OF-CARE

Transition persons from the hospital to the most appropriate recovery care settings using evidence-based level of care guidelines.

MANAGE LENGTH OF STAY

Appropriately reduce length of stay by actively managing persons with an optimal recovery course.

REDUCE READMISSIONS

Reduce unnecessary readmissions by ensuring persons receive the care they need, in the right setting, following discharge from the hospital.

RECOVERY FACILITY CARE

Recovery Facility Care provides evidence-based guidance to support level-of-care decisions and effective resource management during transitions to and from recovery facilities.

Clinical indications for admission to recovery facility

Evidence-based criteria to help guide recovery facility admission and discharge decisions, taking into account level of need, severity of condition, physical, cognitive, or functional deficits, and required treatments or therapies.

Length of stay data

Get targets for diagnosis and condition-specific length of stay and care transitions with admission, goal, and median length of stay measures, by accessing our tables with percentile values based on samples of Medicare and commercial health plan utilization data.

General treatment course

Table showing clinical status and medical interventions by recovery stage, including therapies expected in post-acute facilities and key physical, functional, and psychosocial recovery milestones.

Extended stay

Detailed information on when a stay may extend beyond the anticipated treatment plan.

Patient education

Outlines comprehensive information that clinicians can use to explain care details to patients, family members, and caregivers.

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RFC-001 02/18

Summary of Guideline Development Policies and Procedures

MCG Health
Shared Resources
23rd Edition -
Content Preview

- Editorial and Financial Independence
- Overview of Methodology for Guideline Development
- Evidence Grading and Strength of Recommendation
- Frequency of Updating of Guidelines

Editorial and Financial Independence

The content and recommendations of the care guidelines are based solely upon published medical evidence, clinical expertise, and objective, standardized analysis of various databases. Neither MCG nor its employees accept any funding or remuneration from outside sources to support or influence guideline development. Guideline development is financially supported by licensing fees paid by clients for access to our content. Our client base includes entities representing all aspects of healthcare, including payers (eg, insurance companies), providers (eg, hospitals, physician groups), and government agencies (eg, Medicare and Medicaid oversight organizations), who value our objective, evidence-based, and unbiased content.

Overview of Methodology for Guideline Development

For each guideline, the published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized, tested, proprietary search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximize retrieval of articles with certain desired characteristics pertinent to a guideline. For example, some of the Inpatient & Surgical Care guideline searches preferentially seek randomized controlled trials, systematic reviews, published clinical guidelines, and publications related to inpatient length of stay or potential appropriateness of ambulatory patient care.

For each guideline, all retrieved publications are individually reviewed by an MCG clinical editor and assessed in terms of quality, utility, and relevance. Preference is given to publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals (ie, journals that are read and cited most often within their field).
3. Address an aspect of specific importance to the guideline in question (eg, admission criteria, length of stay).
4. Represent an update or contain new data or information not reflected in the current guideline.

An MCG clinical editor evaluates all new evidence and updates the guideline as needed to ensure its continued clinical validity. MCG medical librarians and clinical editors track newly released or updated guidelines from outside sources (eg, medical specialty societies, Cochrane Reviews), as well as new editions of textbooks. Relevant new content is incorporated into all guidelines as appropriate. Each updated guideline is then reviewed by a supervising clinical editor to verify accuracy and appropriateness of all changes.

On an annual basis, each guideline undergoes external review by clinically active experts (eg, board-certified specialist physicians without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy, validity, and applicability of each guideline. A supervising clinical editor evaluates all comments from these external reviewers and makes necessary changes to the guideline.

Certain content (eg, inpatient goal length of stay) is supported by and validated through utilization analysis using various claims-based databases. These databases include nationally representative samples of inpatients and outpatients. Databases utilized include those developed outside of MCG as well as those that are proprietary to MCG. In terms of guideline development, the purpose of database analysis is to confirm the reasonability and clinical appropriateness of care guidelines' utilization goals and objectives.

After the release of an updated edition of the care guidelines, if an error in content is detected that, in the judgment of the editorial staff, is significant enough to potentially adversely affect patient care, all clients are notified and a corrected version of the care guidelines is released.

Evidence Grading and Strength of Recommendation

Recommendations are supported by evidence from the medical literature or other sources, and MCG strives to seek out and use the most authoritative evidence. To give insight into the evidence base for each recommendation, cited references in many products are graded according to level of authoritativeness. The evidence hierarchy is as follows:

- **(EG 1) Evidence Grade 1:**
  - Meta-analyses
  - Randomized controlled trials with meta-analysis
  - Randomized controlled trials
  - Systematic reviews
- **(EG 2) Evidence Grade 2:**
  - Observational studies; examples include:
    - Cohort studies with statistical adjustment for potential confounders
    - Cohort studies without adjustment
    - Case series with historical or literature controls
    - Uncontrolled case series
  - Published guidelines
  - Statements in published articles or textbooks
- **(EG 3) Evidence Grade 3:**
  - Unpublished data; examples include:
    - Large database analyses
    - Written protocols or outcomes reports from large practices
    - Expert practitioner reports

To give additional insight into the reasoning underlying certain recommendations and the strength of recommendation, a system of Recommendation Grades has been introduced. For all Ambulatory Care guidelines, each Criteria annotation and Inconclusive or Non-Supportive Evidence annotation has been assigned a Recommendation Grade that summarizes the reasoning behind this conclusion in terms of the evidence base. One of 2 different Recommendation Grades may be assigned to a Criteria annotation, and one of 3 different Recommendation Grades may be assigned to an Inconclusive or Non-Supportive Evidence annotation. Recommendation Grades are as follows:

- **RG A1:** Evidence demonstrates at least moderate certainty of at least moderate net benefit.
- **RG A2:** Evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care.
- **RG B:** Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
- **RG C1:** Evidence demonstrates a lack of net benefit; additional research is recommended.
- **RG C2:** Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.

Frequency of Updating of Guidelines

The latest edition of the care guidelines is published in February, based upon systematic evidence review completed the previous December. Throughout the annual production cycle, the clinical editorial staff of MCG monitors the medical literature for new evidence (including published research studies, practice guidelines, and new editions of textbooks) that may be relevant to current guideline content. If new evidence is found that has an immediate impact and markedly changes accepted clinical practice regarding items referenced in care guidelines' recommendations or existing policies, procedures are set in motion to notify our clients.

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Shared Resources 23rd Edition
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CUSTOMIZATION TO mcg CARE GUIDELINES
23rd EDITION

Issue Date:	Original Date:
June 7, 2019	March 22, 2019

NOTE:

- ***The five (5) products licensed include the following:***
  - ***Inpatient & Surgical Care (ISC): Manage, review, and assess people facing hospitalization or surgery proactively with nearly 400 condition-specific guidelines, goals, optimal care pathways, and other decision-support tools.***
  - ***General Recovery Care (GRG): Effectively manage complex cases where a single Inpatient & Surgical Care guideline or set of guidelines is insufficient, including the treatment of people with diagnostic uncertainty or multiple diagnoses.***
  - ***Recovery Facility Care (RFC): Coordinate an effective plan for transitioning people to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).***
  - ***Chronic Care (CCG): Evaluate needs, identify goals, develop personalized care plans, and support effective self-care. The modular design supports quick and efficient assessments and enables you to manage multiple comorbidities and behavioral health conditions.***
  - ***Behavioral Health Care (BHG): Provides evidence-based guidelines to help healthcare professionals guide the effective treatment of patients with psychiatric disorders.***
- ***This document provides a high level summary of customizations and modifications made to MCG care guidelines (hereinafter referred to as "customized guidelines").***
- ***Customized guidelines are available on request.***
- ***Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the customized guidelines. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, as well as applicable state and/or federal law. The customized guidelines do not constitute plan authorization or a guarantee of payment, nor are they an explanation of benefits.***
- ***We reserve the right to review and modify the MCG care guidelines 23rd edition or customized guidelines at any time.***
- ***No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.***
- ***Issue Date: March 22, 2019 / Publish Date: June 24, 2019 for MCG care guidelines 23rd edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.***
- ***The June 7, 2019 Issue Date reflects review and approval of the following new customization to MCG care guidelines 23rd edition based on November 1, 2019 Publish Date:***
  - ***ISC Chemotherapy (W0162)***

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Types of Customizations:

1. Customizations to MCG care guidelines clinical indications based on integration with our medical policy and clinical UM guidelines and other third party criteria.

2. Customizations to MCG care guidelines clinical indications with changes to the original MCG criteria which include adding or revising appropriateness criteria.

3. Customizations to MCG care guidelines goal length of stay with changes to the original MCG criteria.

4. Other customizations to MCG care guidelines may include adding reference(s), or other changes to MCG care guidelines.

Review and Approval of Customizations:
The Medical Policy & Technology Assessment Committee (MPTAC) reviews and approves all customizations to MCG care guidelines. In addition, when a new edition of MCG care guidelines is released, the new edition is approved by the MPTAC.

Disclaimer:
Customized guidelines include a disclaimer at the top of the guideline after the guideline title indicating: *This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.*

Guideline History:
All customized guidelines include a "Guideline History" section that provides (1) the date of the Medical Policy & Technology Assessment Committee (MPTAC) meeting review and approval of the customization, and (2) a summary of the customization to the MCG care guidelines.

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Subject: Customizations to mcg Care Guidelines 23rd Edition

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Coronary Intervention (W0120)	March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent percutaneous coronary intervention, see Cardiology Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective PCI
Cardiology - Atrial Fibrillation (W0114)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
Cardiology - Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For electrophysiologic study and insertion of implantable cardioverter-defibrillator, see the following: o CG-SURG-97 Cardioverter Defibrillators o CG-SURG-63 Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure
Cardiology - Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For electrophysiologic study and intracardiac catheter ablation, see the following: ▪ CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation o For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see the following: ▪ CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
Cardiology - Left Atrial Appendage Closure, Percutaneous (W0157)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For percutaneous left atrial appendage closure, see the following: o SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
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Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
CV Surgery - Aortic Valve Replacement, Transcatheter (W0133)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For transcatheter aortic valve replacement, see the following: o SURG.00121 Transcatheter Heart Valve Procedures
CV Surgery - Cardiac Septal Defect: Atrial, Transcatheter Closure (W0016)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For transcatheter closure of patent foramen ovale (PFO), see SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
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CV Surgery - Percutaneous Revascularization, Lower Extremity (W0121)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For percutaneous revascularization, lower extremity, see the following: o CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities
CV Surgery - Sympathectomy by Thoracoscopy or Laparoscopy (W0044)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For treatment of hyperhidrosis, see CG-MED-63 Treatment of Hyperhidrosis

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Common Complications and Conditions Venous Thrombosis and Pulmonary Embolism (W0136)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Inpatient Care: o Removed MCG clinical indications for vena cava filter placement
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General Surgery - Gastric Restrictive Procedure with Gastric Bypass Title change to: Gastric Restrictive Procedure with or without Gastric Bypass (W0054)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Title changed from Gastric Restrictive Procedure with Gastric Bypass to indicate Gastric Restrictive Procedure with or without Gastric Bypass • Revised Clinical Indications for Procedure: For gastric restrictive procedure with or without gastric bypass, see the following: o CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0D190ZB, 0DB60Z3, 0DV60CZ, 0DW60CZ o Added CPT® codes: 43842, 43843, 43845, 43848
General Surgery - Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy (W0014)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure with gastric bypass by laparoscopy, see the following: o CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Updated Coding section with the following:

Subject: Customizations to mcg Care Guidelines 23rd Edition

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	○ Added ICD-10 Procedure codes: 0D164Z9, 0DB64ZZ
General Surgery - Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy (W0033)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure without gastric bypass by laparoscopy, see the following: ○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
General Surgery - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure, sleeve gastrectomy, by laparoscopy, see the following: ○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
General Surgery - Hiatal Hernia Repair, Abdominal (W0159)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair
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General Surgery - Mastectomy, Complete (W0002)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: ○ For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory • Under the Goal Length of Stay (GLOS) section added: ○ Reason: Organization approved 2 day stay ○ Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory

Subject: Customizations to mcg Care Guidelines 23rd Edition

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Added references
General Surgery - Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander (W0022)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory or 1 day postoperative • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory or Inpatient • Added references
General Surgery - Mastectomy, Complete, with Tissue Flap Reconstruction (W0023)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references
General Surgery - Mastectomy, Partial (Lumpectomy) (W0008)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory
Hematology - Oncology Return to Index	
Hematology - Oncology - Chemotherapy (W0162)	**Publish Date: November 1, 2019** June 6, 2019 MPTAC review: • Approval of May 13, 2019 Third Party Criteria Subcommittee of the MPTAC review May 13, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission: o Added examples for: ▪ Aggressive hydration needs that cannot be managed in an infusion center ▪ Prolonged marrow suppression

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	○ Added Regimens that cannot be managed as an outpatient with examples ○ Added references ○ Added footnotes
Neonatal Facility Levels and Admission Guidelines Return to Index	
Neonatal Facility Levels and Admission Guidelines – Neonatal Facility Levels of Care Guidelines • Neonatal Facility, Level I • Neonatal Facility, Level II • Neonatal Facility, Level III • Neonatal Facility, Level IV Neonatal Care Admission Guidelines • Neonatal Admission Levels Comparison Chart • Neonatal Care, Routine Care, Level 1 • Neonatal Care, Continuing Care, Level 2 • Neonatal Care, Intermediate Care, Level 3 • Neonatal Care, Intensive Care, Level 4	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Removed the MCG Neonatal Facility Levels and Admission Guidelines in the 23rd edition
Neonatology Return to Index	
Neonatology – Newborn Care, Routine (W0087)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Neonatology – Newborn Care, Term, with Severe Illness or Abnormality (W0106)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For newborn care, term, with severe illness or abnormality, see the following: ○ CG-MED-26 Neonatal Levels of Care

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Neonatology – Sepsis, Neonatal, Confirmed (W0107)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, confirmed, see the following: o CG-MED-26 Neonatal Levels of Care
Neonatology – Sepsis, Neonatal, Suspected, Not Confirmed (W0108)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, suspected, not confirmed, see the following: o CG-MED-26 Neonatal Levels of Care
Neurology Return to Index	
Neurology – EEG, Video Monitoring (W0115)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For EEG video monitoring, see the following: o CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring
Obstetrics and Gynecology (OB / GYN) Return to Index	
OB / GYN - Cesarean Delivery (W0045)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Retained MCG clinical indications for emergency cesarean delivery o Added clinical indications for early elective cesarean delivery o Revised MCG clinical indications for elective cesarean delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Included note under Codes: Additional ICD-10 diagnosis codes may apply to this guideline when the requested service is for early elective delivery. This is not an all-inclusive list of codes that may apply
OB / GYN - Hysterectomy, Abdominal (W0109)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: ▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition

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	▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated • It was tried but did not adequately treat patient's condition • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding) ▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of **1 or more** of the following: ▪ For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable ▪ For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): ▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms" changed to "Investigation has ruled out other causes for symptoms" ▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: ▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when abdominal hysterectomy is considered not medically necessary: o **Abdominal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable
OB / GYN - Hysterectomy, Laparoscopic Title change to: Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted (W0010)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Title changed from Hysterectomy, Laparoscopic to indicate Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: ▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition ▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated

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	• It was tried but did not adequately treat patient's condition • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding) ▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of **1 or more** of the following: ▪ For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable ▪ For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): ▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms" changed to "Investigation has ruled out other causes for symptoms" ▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: ▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy is considered not medically necessary: o **Laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable
OB / GYN - Hysterectomy, Vaginal (W0110)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: ▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition ▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated • It was tried but did not adequately treat patient's condition • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding)

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	▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of **1 or more** of the following: ▪ For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable ▪ For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): ▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms" changed to "Investigation has ruled out other causes for symptoms" ▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: ▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when vaginal hysterectomy is considered not medically necessary: o **Vaginal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable
OB / GYN - Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0026)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques o For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery • Revised Clinical Indications for Procedure: o "Prophylactic bilateral salpingo-oophorectomy" changed to "Risk-reducing salpingo-oophorectomy" o For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "Bilateral oophorectomy" changed to "Risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy" o Additional indication listed for oophorectomy: ▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, mother, sister, daughter) **or** one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer o Removed MCG indications for infertility evaluation or treatment
OB / GYN - Laparotomy, for Gynecologic Surgery, Including Myomectomy,	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:

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Oophorectomy, and Salpingectomy (W0025)	• Revised Clinical Indications for Procedure: o "Prophylactic bilateral salpingo-oophorectomy" changed to "Risk-reducing salpingo-oophorectomy" o For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "Bilateral oophorectomy" changed to "Risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy" o Additional indication listed for oophorectomy: ▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, mother, sister, daughter) **or** one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer
OB / GYN - Vaginal Delivery (W0047)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for when induction of labor is appropriate o Added clinical indications for elective induction of labor o Added clinical indications for early elective induction of labor • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Included note under Codes: Additional ICD-10 diagnosis codes may apply to this guideline when the requested service is for early elective delivery. This is not an all-inclusive list of codes that may apply
OB/GYN - Vaginal Delivery, Operative (W0048)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For early elective vaginal delivery, see W0047 Vaginal Delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Orthopedics Return to Index	
Orthopedics - Acromioplasty and Rotator Cuff Repair (W0139)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For acromioplasty and rotator cuff repair, see the following: o Musculoskeletal Program Clinical Guidelines Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For acromioplasty and rotator cuff repair, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Ankle Arthroscopy (W0155)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indication for osteochondral lesions • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For ankle arthroscopy for osteochondral lesions, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

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Orthopedics - Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy (W0071)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Fusion, Anterior (W0111)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent anterior cervical fusion • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent anterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Fusion, Posterior (W0112)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent posterior cervical fusion • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent posterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Laminectomy (W0097)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent cervical laminectomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent cervical laminectomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Arthroplasty (W0105)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: o Included note under Clinical Indications for Procedure: For computer-assisted musculoskeletal surgical navigational procedures, see SURG.00082 Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System • Revised Clinical Indications for Procedure:

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	○ Removed MCG clinical indications for elective, non-emergent hip arthroplasty not due to developmental dysplasia of hip • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent hip arthroplasty not due to developmental dysplasia, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Arthroscopy (W0096)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: ○ Removed MCG clinical indications except for (a) fracture amenable to arthroscopic repair and (b) debridement and lavage of septic hip • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For hip arthroscopy other than (a) fracture amenable to arthroscopic repair or (b) debridement and lavage of septic hip, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Resurfacing (W0098)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For hip resurfacing, see the following: ○ CG-SURG-85 Hip Resurfacing • Updated Coding section with the following: ○ Added CPT® code: 27299* ○ *CPT® 27130 and 27299 [when specified as partial or total hip resurfacing]
Orthopedics - Knee Arthroplasty, Total (W0081)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For (a) bicompartmental knee arthroplasty and (b) computer-assisted musculoskeletal surgical navigational procedures, see the applicable clinical document • Revised Clinical Indications for Procedure: ○ Removed MCG clinical indications for elective, non-emergent total knee arthroplasty not due to congenital deformity • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent total knee arthroplasty not due to congenital deformity, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Knee Arthroscopy (W0113)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For knee arthroscopy, see the following: ○ Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For knee arthroscopy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Knee Arthrotomy (W0140)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review

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	March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications except for debridement, drainage, or lavage for osteomyelitis or infected joint • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For knee arthrotomy other than debridement, drainage, or lavage for osteomyelitis or infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Lumbar Diskectomy, Foraminotomy, or Laminotomy (W0091)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed: MCG clinical indications for elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Orthopedics - Lumbar Fusion (W0072)	**Publish Date: June 24, 2019**
	March 21, 2019 MPTAC review:
	• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review
	
	March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:
	• Included the following notes under Clinical Indications for Procedure:
	  o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery
	  o For axial lumbar interbody fusion, see SURG.00111 Axial Lumbar Interbody Fusion
	• Revised Clinical Indications for Procedure:
	  o Removed MCG clinical indications for elective, non-emergent lumbar fusion
	• Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Orthopedics - Lumbar Laminectomy (W0100)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent lumbar laminectomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar laminectomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Shoulder Arthroplasty (W0137)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent shoulder arthroplasty

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Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent shoulder arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Shoulder Hemiarthroplasty (W0138)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent shoulder hemiarthroplasty • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Spine, Scoliosis, Posterior Instrumentation (W0116)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following: o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Pediatrics Return to Index	
Pediatrics - Diabetes, Pediatric (W0117)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Extended Stay: Added o Need to receive comprehensive patient, parent or caregiver education **and** comprehensive diabetic education programs are not available on an outpatient basis in the community ▪ Expect minimal stay extension ▪ Note: Obtain verbal or written attestation from provider regarding lack of outpatient diabetic education resources
Pediatrics – EEG, Video Monitoring, Pediatric (W0122)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric EEG video monitoring, see the following: o CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring
Pediatrics – Fundoplasty, Esophagogastric, by Laparoscopy, Pediatric (W0161)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair
Pediatrics - Heart Transplant, Pediatric (W0123)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review

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Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric heart transplant, see the following: o TRANS.00026 Heart/Lung Transplantation o TRANS.00033 Heart Transplantation
Pediatrics - Liver Transplant, Pediatric (W0124)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric liver transplant, see the following: o TRANS.00008 Liver Transplantation
Pediatrics - Lung Transplant, Pediatric (W0125)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric lung transplant, see the following: o TRANS.00009 Lung and Lobar Transplantation o TRANS.00026 Heart/Lung Transplantation
Pediatrics - Renal Transplant, Pediatric (W0126)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric renal transplant, see the following: o CG-TRANS-02 Kidney Transplantation
Pediatrics - Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric posterior instrumentation, spine, scoliosis, see the following: o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For pediatric posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Thoracic Surgery and Pulmonary Disease Return to Index	
Thoracic Surgery and Pulmonary Disease - Deep Venous Thrombosis of Lower Extremities (W0135)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Admission to Inpatient Care: o Removed MCG clinical indications for vena cava filter placement
Thoracic Surgery and Pulmonary Disease - Lung Transplant (W0076)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For lung transplant, see the following: o TRANS.00009 Lung and Lobar Transplantation

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Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	○ TRANS.00026 Heart/Lung Transplantation
Thoracic Surgery and Pulmonary Disease - Pulmonary Embolism (W0134)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Admission to Inpatient Care: ○ Removed MCG clinical indications for vena cava filter placement
Urology Return to Index	
Urology - Prostatectomy, Transurethral, Alternatives to Standard Resection (W0029)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For alternatives to standard transurethral prostatectomy resection, see the following: ○ SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
Urology - Renal Transplant (W0027)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For renal transplant, see the following: ○ CG-TRANS-02 Kidney Transplantation

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CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Body System GRG Return to Index	
Body System Cardiovascular Surgery or Procedure GRG (W0099)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on cardiovascular surgeries or procedures see the applicable clinical document • Revised Clinical Indications for Procedure: ○ Removed MCG clinical indications for when surgery or other procedures are indicated for (a) Transmyocardial or percutaneous laser revascularization, (b) Catheter-based valve repair or implantation (eg, prosthetic cardiac valve), (c) Vena cava filter placement, and (d) Ventricular assist device
Body System	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review:

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General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
General Surgery or Procedure GRG (W0142)	• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for (a) Mastectomy appropriate in the context of female to male gender reassignment and (b) Breast augmentation mastoplasty appropriate in context of male-to-female gender reassignment
Body System Musculoskeletal Surgery or Procedure GRG (W0118)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For (a) ankle arthroplasty, (b) bicompartmental knee arthroplasty, and (c) sacroiliac joint fusion, see the applicable clinical document • Revised Clinical Indications for Procedure: o For medial or lateral unicompartmental knee arthroplasty: ▪ Added note: For elective, non-emergent medial or lateral unicompartmental knee arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines ▪ Removed MCG clinical indications for elective, non-emergent medial or lateral unicompartmental knee arthroplasty o For patellofemoral arthroplasty: ▪ Added note: For elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines ▪ Removed MCG clinical indications for elective, non-emergent patellofemoral arthroplasty o Removed MCG clinical indications for: ▪ ankle arthroplasty ▪ minimally invasive sacroiliac joint fusion • Included the following note under both Operative Status Criteria and Benchmark Length of Stay (BLOS): o For (a) elective, non-emergent medial or lateral unicompartmental knee arthroplasty and (b) elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Body System Neurosurgery or Procedure GRG (W0119)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on spinal surgeries or procedures, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Body System Obstetric and Gynecologic Surgery or Procedure GRG (W0143)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for oophorectomy (usually with hysterectomy and salpingectomy) appropriate in context of female-to-male gender reassignment
Body System Urologic Surgery or Procedure GRG (W0141)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review

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General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for (a) Orchiectomy appropriate in context of male-to-female gender reassignment, (b) Genital reconstructive surgery (eg, vaginoplasty, penectomy, labioplasty, clitoroplasty) appropriate in context of male-to-female gender reassignment and (c) genital reconstructive surgery (eg, vaginectomy, metoidioplasty, scrotoplasty, phalloplasty, urethroplasty, placement of testicular prosthesis) appropriate in context of female-to-male gender reassignment
General Recovery Guidelines Tools Section Return to Index	
General Recovery Guidelines Tools Section Inpatient Palliative Care Criteria (W0086)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Alternatives to Admission o For Home hospice added the following: ▪ Outpatient: Continuous Home Care (CHC) ▪ Outpatient: Routine Home Care ▪ Patients who may benefit from hospice care ▪ Nursing care • Added reference
Problem Oriented GRG Return to Index	
Problem Oriented Medical Oncology GRG (W0074)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For (a) chimeric antigen receptor (CAR) T-cell therapy, (b) transcatheter arterial chemoembolization, (c) high-dose radioactive iodine or radioactive implant treatments needing inpatient admission, and (d) hematopoietic stem cell transplantation, see the applicable clinical document • Revised Clinical Indications for Admission to Inpatient Care: o Removed MCG clinical indications for allogeneic and autologous hematopoietic stem cell transplant

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CUSTOMIZATIONS – BEHAVIORAL HEATLH CARE GUIDELINES (BHG)

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Testing Procedures Return to Index	
Testing Procedures Urine Toxicology Testing (W0150)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For urine toxicology testing, see the following: o CG-LAB-09 Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain

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Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Therapeutic Services Return to Index	
Therapeutic Services Applied Behavioral Analysis (W0153)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For applied behavioral analysis (ABA), see the following: o CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder
Therapeutic Services Transcranial Magnetic Stimulation (W0151)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For Transcranial Magnetic Stimulation, see the following: o BEH.00002 Transcranial Magnetic Stimulation

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CUSTOMIZATION HISTORY

Date	Action	Reason
06/07/2019	Release document for Customizations to MCG Care Guidelines 23rd Edition	Updated document for Customizations to MCG Care Guidelines 23rd Edition based on November 1, 2019 Publish Date.
03/22/2019	Release document for Customizations to MCG Care Guidelines 23rd Edition	New document for Customizations to MCG Care Guidelines 23rd Edition. Publish Date: June 24, 2019 for MCG care guidelines 23rd edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.

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Supplemental Document E.1-2: Sample Letters

Supplemental Document E.1-2 includes the following:

- Supplemental Document E.1-2a: Sample UM Approval Letter
- Supplemental Document E.1-2b: Sample UM Denial Letter
- Supplemental Document E.1-2c: Sample Language Letter

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UNICARE.
An Anthem Company

UniCare Health Plan of West Virginia, Inc.
Medicaid Managed Care

[Contact name]
[Contact Address Line 1]
[Contact Address Line 2]
[Contact City, State ZIP code]

[Date]

[Addressee name]
[Addressee address]
[Addressee address]
[City, State ZIP code]

Reference no.: [Ref no.]
Provider: [Name of provider]
Facility/vendor: [Name of facility/vendor]
Client: [Name of client]
Patient: [Patient ID]
Subscriber: [Patient name]

Admit date: [DD-MM-YYYY]
Date created: [DD-MM-YYYY]
DD-MMM-YYYY [HH:MM]

Inpatient stay	Start date	End date	Days	Total days	Level of care
[Medical]	[DD/MM/YYYY]	[DD/MM/YYYY]	[X]	[X]	[LOC]

Quantity	Code	Description
2 Unit(s)	23330	Removal of other foreign body without incision

Subject: Approval of medically necessary services

Diagnosis: [Code no. and NAME/TITLE]
Review outcome: [Certification]
Place of service: [Inpatient hospital]

Dear Provider:

We certified the requested service(s) listed above based on medical necessity.

This certification is valid for 90 days from the initial approval date. If the service date changes, please contact us at the phone or fax numbers listed below. You can also submit changes to the request through the Interactive Care Reviewer on Availity. Please notify us if the member needs to stay in the hospital longer than the approved number of days, and we will review additional requested days for medical necessity.

Keep in mind this letter and our review simply affirm our certification that the requested services are medically necessary. **It does not guarantee claims payment** since we cannot determine benefits until we receive claims.

www.unicare.com

Benefits are subject to all policy exclusions, limitations, waivers and coverage eligibility when the requested services are provided. Benefits may also be limited or denied if the information submitted with the claim differs from that given during the review.

For questions regarding information in this letter, please contact us at:

UniCare Health Plan of West Virginia, Inc.
Utilization Management
P.O. Box 91
Charleston, WV 25321-0091
Phone: **1-866-655-7423**
Fax: **1-855-402-6985**

As always, we believe the decision regarding which treatment is best remains with the patient and the health care provider, and we appreciate your service to our members.

Sincerely,

Utilization Management
UniCare Health Plan of West Virginia, Inc.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

DRAFT

UniCare Health Plan of West Virginia, Inc.
[Contact Address Line 1]
[Contact Address Line 2]
[Contact City/State/Zip]



<Contact Name>
<R_RECIPIENT_NAME>
<R_RECIPIENT_ADDRESS_1>
<R_RECIPIENT_ADDRESS_2>
<R_RECIPIENT_CITY> <ST> <R_RECIPIE

Reference No:	[Reference No.]
Provider:	[Name of Provider]
Facility/Vendor:	[Name of Facility/Vendor]
Client:	[Name of Client]
Patient:	[Patient ID]
Subscriber:	[Patient Name]
Admit Date:	[Name of Reviewer]
Date Created: DD-MMM-YYYY HH:MM	[DD-MMM-YYYY]

Requested start date	End date	Days	Level of care

Quantity	Code	Description

Diagnosis: [CPT-123.1] [BROKEN ARM]

Review Outcome: Initial Denial: Not Medically Necessary
Place of Service: [Place of service]

We want you to know that we denied the services that you asked for. A doctor at [UniCare Health Plan of West Virginia, Inc.] reviewed your health records and the reasons for your request. Your health records do not show that you need the services for medical reasons. Even though this service is not authorized, you and your healthcare provider still should decide what treatment is best for you.

[Denial rationale]

To learn more about why we denied your request, call our Utilization Management (UM) team. Ask for a free copy of what we used to make this decision.

We know that you may have special needs. You can get this letter in other formats such as Braille, large-size print, video or audio. Please call our Customer Care Center if:
•You need help to translate or understand this letter.
•You want this letter in a language of your choice.

•You need a copy of this letter in a different format.

Call your healthcare provider if you do not hear from him/her about this request. Your healthcare provider also can tell you about your medical care. Please call our Customer Care Center if you, or the person you chose to act on your behalf, like a family member, lawyer or your healthcare provider has questions or wants to file an appeal. You must call within 60 days from the date of this decision. Or, you also may write to us:

UniCare Health Plan of West Virginia, Inc.
[Contact Address Line 1]
[Contact Address Line 2]
[Contact City/State/Zip]

If your healthcare provider wants to talk to the doctor who reviewed your request, he or she can call our UM team within 24 hours from notification of the denial.

You, or the person you chose to act on your behalf, like a family member, lawyer or your healthcare provider may file an appeal with us. We will give you an answer to your request within 30 days. We will give you an answer within 72 hours when a delay in care could cause serious injury or death. We will tell you how to appeal if we said no to the urgent care you asked for. To learn more about filing an appeal, call our UM team. You can give us information or medical records to help your appeal. We will look at all of the information you, or the person you chose to act on your behalf, gives us for the review of your appeal.

UniCare phone numbers

Customer Care Center]	1-800-782-0095
TTY	1-866-368-1634
Utilization Management (UM)	<CONTACT_PHONE>
TTY	<CONTACT_PHONE_2>

Sincerely,

Tracy Dlott MD

<Medical Director Name>
Medical Director
UniCare Health Plan of West Virginia, Inc.

<cc: [PROVIDER NAME][PATIENT NAME][FACILITY/VENDOR NAME]>

IMPORTANT NOTE: You are not permitted to use or disclose Protected Health Information about individuals that you are currently not treating. This applies to Protected Health Information accessible in any online tool, or sent in any other medium including mail, email, fax, or other electronic transmission.

Do you need help with your health care, talking with us, or reading what we send you? We provide our materials in other languages and formats at no cost to you. Call us toll free at 1-800-782-0095 (TTY 1-866-368-1634).

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Proporcionamos nuestros materiales en otros idiomas y formatos sin costo alguno para usted. Llámenos a la línea gratuita al 1-800-782-0095 (TTY 1-866-368-1634).

Vous avez besoin d'aide pour vos soins médicaux, pour communiquer avec nous ou pour lire les documents que nous vous envoyons ? Nous fournissons nos publications dans d'autres langues et sous d'autres formats, et c'est gratuit. Appelez-nous sans frais au 1-800-782-0095 (TTY 1-866-368-1634).

Benötigen Sie Hilfe bei Ihrer medizinischen Versorgung, der Kommunikation mit uns oder beim Lesen unserer Unterlagen? Unsere Materialien sind auf Anfrage auch in anderen Sprachen und Formaten kostenlos erhältlich. Rufen Sie uns gebührenfrei an unter 1-800-782-0095 (TTY 1-866-368-1634).

您需要醫療保健的幫助嗎？請向我們諮詢，或是閱讀我們寄給您的資料。我們以其他語言和格式提供我們的資料，您無需支付任何費用。請撥打免費電話 1-800-782-0095 (TTY 1-866-368-1634)。

هل تحتاج إلى مساعدة في رعايتك الصحية أو في التحدث معنا أو قراءة ما نقوم بإرساله إليك؟ نحن نقدم المواد الخاصة بنا بلغات وتنسيقات أخرى بدون تكلفة عليك. اتصل بنا على الرقم المجاني 1-800-782-0095 (TTY 1-866-368-1634).

In caso si necessiti di assistenza con il servizio sanitario, per parlare con noi o comprendere le informazioni ricevute, sono disponibili materiali gratuiti in altre lingue e formati. Contattare il numero gratuito 1-800-782-0095 (TTY 1-866-368-1634).

Kailangan ninyo ba ng tulong sa inyong pangangalagang pangkalusugan, sa pamamagitan ng pakikipag-usap sa amin, o pagbasa kung ano ang ipinapadala namin sa inyo? Nagbibigay kami ng aming mga materyal sa ibang mga wika at anyo na wala kayong gagastusin. Tawagan kami nang walang bayad sa 1-800-782-0095 (TTY 1-866-368-1634).

의료 서비스, 당사와의 소통 또는 당사에서 보내는 자료 읽기와 관련해 도움이 필요하십니까? 무료로 자료를 다른 언어나 형식으로 제공해 드립니다. 무료 전화 1-800-782-0095(TTY 1-866-368-1634) 번으로 문의해 주십시오.

Quý vị có cần chúng tôi giúp với việc chăm sóc sức khỏe của quý vị, trao đổi với chúng tôi, hoặc đọc những tài liệu chúng tôi gửi cho quý vị hay không? Chúng tôi cung cấp các tài liệu bằng các ngôn ngữ và định dạng khác, miễn phí cho quý vị. Hãy gọi cho chúng tôi theo số miễn phí 1-800-782-0095 (TTY 1-866-368-1634).

Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Мы можем бесплатно предоставить вам материалы на других языках и в других форматах. Позвоните в нам по бесплатному телефону 1-800-782-0095 (TTY 1-866-368-1634).

ヘルスケアに関してご質問やご相談はありませんか？当社からお送りした資料のことでお困りですか？資料は英語以外の言語や別のフォーマットでもご用意しています。いずれも無料です。ご希望の方はフリーダイヤル 1-800-782-0095 (TTY 1-866-368-1634)

คุณต้องการความช่วยเหลือในการดูแลทางด้านสุขภาพของคุณ การพูดคุยกับเรา หรือการอ่านสิ่งที่เราส่งให้คุณหรือไม่ เรามีคู่มือของเราในภาษาและรูปแบบอื่นๆ ให้กับคุณโดยไม่เสียค่าใช้จ่าย โทรหาเราได้ฟรี 1-800-782-0095 (TTY 1-866-368-1634)

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Χρειάζεστε βοήθεια σχετικά με την υγειονομική σας περίθαλψη, να μιλήσετε μαζί μας ή να διαβάσετε ό,τι σας έχουμε αποστείλει; Παρέχουμε το υλικό μας σε άλλες γλώσσες και μορφές χωρίς καμία επιβάρυνση για εσάς. Καλέστε μας χωρίς χρέωση στο 1-800-782-0095 (TTY 1-866-368-1634).

Precisas de ajuda com a tua assistência à saúde, para falar connosco ou acerca do que enviamos para ti? Fornecemos os nossos materiais em outros idiomas e formatos sem custo algum. Liga-nos gratuitamente pelo número 1-800-782-0095 (TTY 1-866-368-1634).

Supplemental Document E.1-3: Clinical Practice Guidelines

Enclosed in the following attachment are the listings of the proposed clinical guidelines for the following requirements BA053 and CM035. The guideline matrix is a full listing of the proposed guidelines, specifically, there are two guidelines regarding Adverse Childhood Experiences (ACEs) and Trauma Informed Care (TIC). These guidelines have been highlighted for ease of review.

Full guidelines are available for review upon award as part of implementation preparedness.

Section #: BA053

- Clinical Practice Guideline Matrix
- Preventative Practice Guidelines

Section #: CM035

- Clinical Practice Guideline for the Treatment of Post-traumatic Stress Disorder (PTSD)
- Trauma Care A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services

Supplemental Document E.1-3 includes the following:

- Supplemental Document E.1-3a: Clinical Practice Guidelines Matrix
- Supplemental Document E.1-3b: Preventative Practice Guidelines

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Clinical Practice Guidelines Matrix

Date reviewed: January 2019
Date adopted: February 2019

Table of contents:

Adult health
Infectious disease
Pediatric/adolescent health
Substance use
Women's health

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Adult health			
Alzheimer's disease/dementia	*Guideline Watch (October 2014): Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias*	American Psychiatric Association (APA)	**http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/alzheimerwatch.pdf**
Anxiety	*Anxiety Disorders* (Last revised July 2018)	National Institute of Mental Health (NIMH)	**https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml**
Asthma	*Guidelines for the Diagnosis and Management of Asthma (EPR-3)* (August 2007)	National Heart, Lung and Blood Institute (NHLBI)	**https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma**
Behavioral health screening, assessment and treatment	*The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults Third Edition* (August 2015)	APA	**https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890426760.pe02**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Bipolar disorder* * Addresses diagnosis and treatment of bipolar disorder in special populations, such as children and adolescents	*Bipolar Disorder: Assessment and Management* (Minor update April 2018)	National Institute for Health and Care Excellence (NICE)	**https://www.nice.org.uk/guidance/cg185/resources/bipolar-disorder-assessment-and-management-pdf-35109814379461**
	Evidence-based guidelines for treating bipolar disorder: Revised third edition recommendations from the British Association for Psychopharmacology (2016)	British Association for Psychopharmacology	**https://www.bap.org.uk/pdfs/BAP_Guidelines-Bipolar.pdf**
Coronary artery disease	*AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease* (2011 update)	American Heart Association (AHA)/American College of Cardiology Foundation (ACCF)	**https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e318235eb4d**
	Treatment of Hypertension in Patients With Coronary Artery Disease (March 2015)	AHA/ACCF and American Society of Hypertension	**https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000207**
	AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update (November 2011)	AHA/ACCF	**https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e318235eb4d**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Coronary artery disease (cont.)	*Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women - 2011 Update* (February 2011)	AHA	**https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31820faaf8**
Celiac disease	*ACG Clinical Guidelines: Diagnosis and Management of Celiac Disease* (April 2013)	American College of Gastroenterology	**http://gi.org/wp-content/uploads/2013/05/ACG_Guideline_CeliacDisease_May_2013.pdf**
Chronic kidney disease	*The National Kidney Foundation Kidney Disease Outcomes Quality Initiative (NKF KDOQI)™ evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD) and related complications*	National Kidney Foundation	**https://www.kidney.org/professionals/guidelines/guidelines_commentaries**
	National Chronic Kidney Disease Fact Sheet (2017)	Centers for Disease Control and Prevention (CDC)	**https://www.cdc.gov/diabetes/pubs/pdf/kidney_factsheet.pdf**
	KDIGO (Kidney Disease Improving Global Outcomes) 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease (January 2013)	International Society of Nephrology	**https://kdigo.org/wp-content/uploads/2017/02/KDIGO_2012_CKD_GL.pdf**
Chronic obstructive pulmonary disease	*Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease* (2019)	Global Initiative for Chronic Obstructive Lung Disease	**https://goldcopd.org/gold-reports**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Depression	*Depression in Adults: Screening* (January 2016)	U.S. Preventive Services Task Force (USPSTF)	**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1**
	Practice Guideline for the Treatment of Patients with Major Depressive Disorder Third Edition (October 2010)	APA	**http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf**
	Depression in adults: recognition and management Clinical Guideline CG90 (Updated April 2018)	National Collaborating Centre for Mental Health commissioned by NICE	**https://www.nice.org.uk/guidance/cg90/resources/depression-in-adults-recognition-and-management-pdf-975742638037**
Diabetes	*Standards of Medical Care in Diabetes* (January 2019)	American Diabetes Association (ADA)	**http://care.diabetesjournals.org/content/42/Supplement_1**
Gender dysphoria/ incongruence	*Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline* (September 2017) *Correction to Clinical Practice Guideline* (February 2018) *Correction to Clinical Practice Guideline* (July 2018)	The Endocrine Society	**https://academic.oup.com/jcem/article/102/11/3869/4157558** **https://academic.oup.com/jcem/article/103/2/699/4675081** **https://academic.oup.com/jcem/article/103/7/2758/5036711**
Fall risk	*Falls Prevention in Community-Dwelling Older Adults: Interventions*	USPSTF	**https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/falls-prevention-in-older-adults-interventions1**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Fall risk (cont.)	*Evidence-Based Falls Prevention Programs: Resources for Professionals and Advocates*	National Council on Aging	**https://www.ncoa.org/center-for-healthy-aging/falls-resource-center/falls-prevention-tools-and-resources/resources-for-professionals**
Heart failure	*2013 ACCF/AHA guideline for the Management of Heart Failure: a Report of the American College of Cardiology Foundation/ American Heart Association Task Force on Practice Guidelines* (October 2013) *ACCF/AHA/HFSA Guideline for the Management of Heart Failure* (Focused update 2017)	ACCF/AHA/Task Force on Practice Guidelines/Heart Failure Society of America (HFSA)	**http://www.onlinejacc.org/content/62/16/e147?ijkey=079f90818917662ed8e6c54bd132bb10bede26a1&keytype2=tf_ipsecsha** **http://www.onlinejacc.org/content/70/6/776?_ga=2.233130 85.667318568.1514996759-679389624.1511900706**
Hyperlipidemia	*2018 AHA/ACC/AACVPR/ AAPA/ABC/ACPM/ADA/ AGS/APhA/ASPC/NLA/ PCNA Guideline on the Management of Blood Cholesterol* (October 2018)	ACC/AHA/American Association of Cardiovascular and Pulmonary Rehabilitation (AAPA)/American Academy of Physician Assistants/Association of Black Cardiologists (ABC)/American College of Preventive Medicine (ACPM)/ADA/American Geriatrics Society (AGS)/American Pharmacists Association (APhA)/American Society of Preventive Cardiology (ASPC)/National Lipid Association/Preventive Cardiovascular Nurses Association (PCNA)	**http://www.onlinejacc.org/content/accj/early/2018/11/02/j.jacc.2018.11.003.full.pdf**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Hypertension	*ACC/AHA/AAPA/ABC/ ACPM/AGS/APhA/ASH/ ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults* (November 2017) *Correction to Guideline* (May 2018)	ACC/AHA/AAPA/ABC/ACPM/AGS/ APhA/American Society of Hypertension (ASH)/ASPC/National Medical Association (NMA)/PCNA	**http://www.onlinejacc.org/content/early/2017/11/04/ j.jacc.2017.11.006?sso=1&sso_redirect_count=1&access _token=** **http://www.onlinejacc.org/content/71/19/2275**
Obesity	*Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults* (September 2018)	USPSTF	**https://www.uspreventiveservicestaskforce.org/ Page/Document/UpdateSummaryFinal/obesity-in-adults-interventions1**
	AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults (November 2013)	ACC/AHA Task Force on Practice Guidelines and The Obesity Society (TOS)	**http://circ.ahajournals.org/content/early/2013/11/ 11/01.cir.0000437739.71477.ee**
Oppositional defiant disorder	*Common Questions About Oppositional Defiant Disorder* (April 2016)	American Academy of Family Physicians (AAFP)	**https://www.aafp.org/afp/2016/0401/p586.pdf**
Post-traumatic stress disorder (PTSD)	*Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults* (February 2017)	APA	**https://www.apa.org/ptsd-guideline/ptsd.pdf**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
PTSD (cont.)	*VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder (V3.2017)*	Department of Veterans Affairs Department of Defense: The Management of Posttraumatic Stress Disorder Work Group	**https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf**
	PTSD Screening Instruments	Department of Veterans Affairs: PTSD: National Center for PTSD	**https://www.ptsd.va.gov/professional/assessment/screens/index.asp**
Rheumatoid arthritis	*American College of Rheumatology: Referral Guidelines* (August 2015)	American College of Rheumatology (ACR)	**https://www.rheumatology.org/Portals/0/Files/Referral%20Guidelines.pdf**
	2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis (October 2015)		**https://www.rheumatology.org/Portals/0/Files/ACR%202015%20RA%20Guideline.pdf**
Schizophrenia	*Practice Guideline for the Treatment of Patients with Schizophrenia Guideline Watch* (September 2009)	APA	**http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf**
Sickle cell anemia	*Evidence-Based Management of Sickle Cell Disease: Expert Panel Report* (September 2014)	NHLBI	**https://www.nhlbi.nih.gov/health-topics/evidence-based-management-sickle-cell-disease**
Suicide risk	*SAFE-T: Suicide Assessment Five Step Evaluation and Triage*	Suicide Prevention Resource Center	**https://www.integration.samhsa.gov/images/res/SAFE_T.pdf**
Trauma care	*A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services* (2014)	Substance Abuse and Mental Health Services Administration (SAMHSA)	**https://store.samhsa.gov/system/files/sma14-4816_litreview.pdf**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Trauma care (cont.)	*Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series*	SAMHSA	**https://store.samhsa.gov/series/tip-series-treatment-improvement-protocols-tips**
Infectious disease			
Chlamydia/human papillomavirus (HPV)	*Sexually Transmitted Diseases Treatment Guidelines* (June 2015)	CDC	**https://www.cdc.gov/std/tg2015/tg-2015-print.pdf**
Hepatitis B	*AASLD Guidelines for Treatment of Chronic Hepatitis B* (August 2015) *Update on Prevention, Diagnosis, and Treatment of Chronic Hepatitis B: AASLD 2018 Hepatitis B Guidance* (Jan 2018)	American Association for the Study of Liver Diseases (AASLD)	**http://www.aasld.org/sites/default/files/guideline_documents/hep28156.pdf** **https://www.aasld.org/sites/default/files/HBVGuidance_Terrault_et_al-2018-Hepatology.pdf**
Hepatitis C	*HCV Guidance: Recommendations for Testing, Managing and Treating Hepatitis C*	Infectious Diseases Society of America (IDSA)/AASLD	**http://www.hcvguidelines.org**
	Guidelines for the Screening, Care and Treatment of Persons with Chronic Hepatitis C Infection (April 2016)	World Health Organization (WHO)	**http://apps.who.int/iris/bitstream/handle/10665/205035/9789241549615_eng.pdf;jsessionid=569946A6B8399B8CED0D09D7F7A9BD3C?sequence=1**
HIV/AIDS	*Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America* (November 2013)	HIV Medicine Association of the IDSA	**https://www.idsociety.org/practice-guideline/primary-care-management-of-patients-infected-with-hiv**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
HIV/AIDS (cont.)	*Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States* (December 2014)	CDC	**https://stacks.cdc.gov/view/cdc/44064**
	2017 HIVMA of IDSA Clinical Practice Guideline for the Management of Chronic Pain in Patients Living With HIV (September 2017)	IDSA	**https://www.idsociety.org/globalassets/idsa/practice-guidelines/2017-hivma-of-idsa-clinical-practice-guideline-for-the-management-of-chronic-pain-in-patients-living-with-hiv.pdf**
	HIV and Adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV (2013)	WHO	**http://apps.who.int/iris/bitstream/handle/10665/94334/9789241506168_eng.pdf?sequence=1**
Pediatric/adolescent health See **adult health** for additional resources for the following conditions: • Bipolar disorder • Oppositional defiant disorder			
ADHD	*Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents* (November 2011)	American Academy of Pediatrics (AAP)	**http://pediatrics.aappublications.org/content/128/5/1007.full.pdf**
Autism	*Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder* (February 2014)	American Academy of Child and Adolescent Psychiatry	**http://www.jaacap.com/article/S0890-8567(13)00819-8/abstract** **http://www.jaacap.com/article/S0890-8567(13)00819-8/pdf**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Celiac disease	*Guideline for the Diagnosis and Treatment of Celiac Disease in Children: Recommendations of the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition* (January 2005)	North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition	**http://www.naspghan.org/files/documents/pdfs/position-papers/celiac_guideline_2004_jpgn.pdf**
Depression	*Depression in Children and Adolescents: Screening* (February 2016)	USPSTF	**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1**
	Depression in children and young people: identification and management (Updated September 2017)	NICE	**https://www.nice.org.uk/guidance/cg28/resources/depression-in-children-and-young-people-identification-and-management-pdf-975332810437**
Hypertension in children and adolescents	*Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents* (September 2017)	AAP	**http://pediatrics.aappublications.org/content/pediatrics/140/3/e20171904.full.pdf**
Obesity	*Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report* (December 2007)	AAP	**http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full.pdf**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Obesity (cont.)	*Clinical Report: The Role of the Pediatrician in Primary Prevention of Obesity* (July 2015)	AAP	**http://pediatrics.aappublications.org/content/early/2015/06/23/peds.2015-1558**
Oppositional defiant disorder	*Fifty Years of Preventing and Treating Childhood Behavior Disorders: a Systematic Review to Inform Policy and Practice* (April 2017)	National Institute of Health PubMed	**https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5950520**
Substance use			
Substance use	*Medication-Assisted Treatment of Adolescents With Opioid Use Disorders* (September2016)	AAP	**http://pediatrics.aappublications.org/content/early/2016/08/18/peds.2016-1893**
	Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions (November 2018)	USPSTF	**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions**
	CDC Guideline for Prescribing Opioids for Chronic Pain — United States (March 2016)	CDC	**www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm**
	Resources List: Opioid Use in the Older Adult Population (May 2017)	SAMHSA	**https://www.samhsa.gov/capt/sites/default/files/resources/resources-opiod-use-older-adult-pop.pdf**
	Medication-Assisted Treatment (MAT) (Last updated February 2018)	SAMHSA	**http://dpt.samhsa.gov**
	Relearn Life Without Cigarettes	National Alliance for Tobacco Cessation	**https://www.becomeanex.org/docs/fotonovela_english.pdf**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Substance use (cont.)	*Identifying and Treating Patients Who Use Tobacco* (July 2017)	U.S. Department of Health and Human Services	**https://millionhearts.hhs.gov/files/Tobacco-Cessation-Action-Guide.pdf**
All states offer free smoking cessation telephone quit line services. Dialing 1-800-QUIT-NOW (1-800-784-8669) will connect the caller to their state quit line.			
Women's health			
Routine antepartum care	*American Academy of Pediatrics, Guidelines for Perinatal Care, Eighth Edition* (September 2017)	AAP and American Congress of Obstetrics and Gynecology (ACOG)	**https://shop.aap.org/guidelines-for-perinatal-care-8th-edition-ebook** Members only
Depression in pregnancy	*Screening for Perinatal Depression ACOG Committee Opinion 757* (November 2018)	ACOG	**https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co757.pdf?dmc=1&ts=20190102T2051356897**
Preventive care	*Women's Preventive Services Guidelines* (Last reviewed 2017)	Health Resources and Services Administration	**https://www.hrsa.gov/womens-guidelines-2016/index.html**
Cancer screening	*Women's Health Care Physicians: Cervical Cancer FAQ* (December 2015)	ACOG	**https://www.acog.org/Patients/FAQs/Cervical-Cancer**
	Cervical Cancer: Screening (August 2018)	USPSTF	**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2**
Diabetes and pregnancy	*Management of Diabetes in Pregnancy* (January 2019)	ADA	**http://care.diabetesjournals.org/content/42/Supplement_1/S165**
	Gestational Diabetes Mellitus, Screening (January2014)	USPSTF	**https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/gestational-diabetes-mellitus-screening?ds=1&s=gestational diabetes**
	Gestational Diabetes	ACOG	**http://www.acog.org/Search?Keyword=gestational+diabetes**

Condition/disease	Guideline title	Recognized source(s)	Website(s)
Diabetes and pregnancy (cont.)	*Postpartum Screening for Abnormal Glucose Tolerance in Women Who Had Gestational Diabetes Mellitus*	ACOG	**https://www.acog.org/Search?Keyword=Postpartum+Screening+for+Abnormal+Glucose+Tolerance+in+Women+Who+Had+Gestational+Diabetes+Mellitus&Topics=43d4646b-dc34-4c12-abeb-bb516387312f** Members only
Obstetrical care	*Guidelines for Antenatal Care*	ACOG	**https://www.acog.org/Search?Keyword=antenatal&Topics=906bff1e-0656-4579-a7df-4a22f9bce483**
	WHO recommendations for Prevention and treatment of pre-eclampsia and eclampsia (2011)	WHO	**http://whqlibdoc.who.int/publications/2011/9789241548335_eng.pdf**
	Committee Opinion 455. Magnesium Sulfate Before Anticipated Preterm Birth for Neuroprotection (Reaffirmed 2018)	ACOG/Society for Maternal Fetal Health	**https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Magnesium-Sulfate-Before-Anticipated-Preterm-Birth-for-Neuroprotection**
	Pre-Gestational Diabetes Mellitus Number 201 (December 2018)	ACOG	**https://www.acog.org/Search?Keyword=pregestational+diabetes** Members only
	Management of Preterm Labor Number 171 (Reaffirmed 2018)	ACOG	**https://www.acog.org/Search?Keyword=management+of+preterm+labor** Members only
	Hypertension in Pregnancy	ACOG	**https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports-List**
	Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice, Number 633 (Reaffirmed 2018)	ACOG	**https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Alcohol-Abuse-and-Other-Substance-Use-Disorders-Ethical-Issues-in-Obstetric-and-Gynecologic-Practice**

Condition/disease	*Guideline title*	Recognized source(s)	Website(s)
Obstetrical care (cont.)	*Guidelines for the identification and management of substance use and substance use disorders in pregnancy* (2014)	WHO	**http://apps.who.int/iris/bitstream/10665/107130/1/9789241548731_eng.pdf?ua=1**
Smoking cessation during pregnancy	*Smoking Cessation During Pregnancy ACOG. Number 721 (October 2017)*	ACOG	**https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Smoking-Cessation-During-Pregnancy**
	Need Help Putting Out That Cigarette?	ACOG	**http://www.tobacco-cessation.org/PDFs/NeedHelpBooklet.pdf**
	Smoking Cessation for Pregnancy and Beyond: Learn Proven Strategies to Help Your Patients Quit.	Dartmouth Medical School	**http://www.iml.dartmouth.edu/education/cme/Smoking/Linkpage/index.html**

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PREVENTIVE HEALTH GUIDELINES

As of May 2017

What is your plan for better health?

Make this year your best year for wellness. Your health plan may help pay for tests to find disease early and routine wellness exams to help you and your families stay well. Talk with your doctor about the care that is right for you.

Your plan may not pay for all services and treatments in this guide. To learn more about what your plan pays for, see your certificate of coverage or call the Member Services number on your ID card to check. You also can check **www.unicare.com/medicaid** to learn about your benefits and health topics from child care to zinc.

The content in this guide is based in part on suggestions from these independent groups and based on state-specific requirements:

- **AAFP** — American Academy of Family Physicians
- **AAP-BF** — American Academy of Pediatrics – Bright Futures
- **ACIP** — Advisory Committee on Immunization Practices
- **ACOG** — American College of Obstetrics and Gynecology
- **ACS** — American Cancer Society
- **CDC** — Centers for Disease Control and Prevention
- **USPSTF** — U.S. Preventive Services Task Force

This guide is just a learning tool for you. It is not meant to take the place of medical care or advice.

Use this guide to know when to set up visits with your doctor for you and your children. Ask your doctor which exams, tests and vaccines are right for you, when you should get them and how often. This guide does not mention every condition and treatment, so be sure to talk with your doctor.

HWV-BO-0004-17

WELL-BABY AND CHILD SCREENINGS

Well-baby exam — birth to 2 years*

Infants who leave the hospital less than two days (48 hours) after birth need to be seen by a doctor within two to four days after being born. You might talk to the doctor if you are a first-time parent, are having a high-risk pregnancy, or want to learn about feeding, circumcision or well-baby care. At the well-baby exam, you may get advice on your child's safety, dental exams and care starting at age 1 year if needed, healthy eating and development. At these exams, your baby may get vaccines and these screenings or added screenings, such as tuberculin, urine testing and/or sickle cell anemia testing, if needed.

Age (in months)

Screenings	Birth	1	2	4	6	9	12	15	18	24
Weight, length and head circumference (the length around the head)	At each visit									
Newborn metabolic, sickle cell and thyroid screening	Birth to 2 months (ideally at 3-5 days)									
Development and behavior	At each visit									
Hearing	As a newborn and when your doctor suggests									
Oral/dental health						Dental exams at each visit				
						Fluoride varnish on the teeth when your doctor suggests; fluoride prescription based on your drinking water				
Hemoglobin or hematocrit (blood count)							At 12			
Lead testing (unless you are sure the child has not been around lead)							At 12			At 24
Autism									At 18	At 24
Urine	When your doctor suggests									

Well-child exam — ages 2½ to 10 years*

You may get advice about how to keep your child safe, how to prevent injuries, counseling to reduce the risks of getting skin cancer, good health, diet and physical activity, and development, as well as annual dental referrals starting at age 3 or earlier if needed. At these well-child exams, your child may get vaccines and these screenings or added screenings such as tuberculin and urine testing, if needed.

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**Height and weight is used to find BMI. BMI is used to see if a person has the right weight for height or is under or over weight for height.

Age (in years)

Screenings	2½	3	4	5	6	7	8	9	10
Height, weight, body mass index (BMI)**	Each year								
Development and behavior	At each visit								
Vision	Each year								
Hearing	Each year								
Oral/dental health	Dental exams each year								
	Fluoride varnish on the teeth when your doctor suggests; fluoride prescription based on your drinking water								
Hemoglobin or hematocrit (blood count)	When your doctor suggests								
Blood pressure	Each year starting at 2½ years								
Urine	When your doctor suggests								

Well-child exam — ages 11 to 18 years*

The doctor may talk to you about health and wellness issues. These include:

- Diet and physical activity
- Healthy weight
- Dental health
- Dentist referral each year
- Mental health, including depression screening
- Sexual behavior and screening for sexually transmitted infections (STI)
- How to prevent injuries
- Counseling to reduce your risk of getting skin cancer; special risks you might have for cancer (such as family history) and steps you can take to reduce those risks
- Secondhand smoke
- Avoiding tobacco, alcohol and drugs

At these exams, your child may get vaccines and these screenings or added screenings such as tuberculin and urine testing, if needed.

Age (in years)

Screenings	11	12	13	14	15	16	17	18
Height, weight, BMI**	Each year							
Development and behavior	Each year							
Blood pressure	Each year							
Vision	Each year							
Hearing	Each year							
Oral/dental health	Each year							
Hemoglobin or hematocrit (blood count)	When your doctor suggests							
Chlamydia	For sexually active women age 24 and younger							
Urine	When your doctor suggests							

ADULT SCREENINGS – WOMEN*

Well-person exam

The doctor may talk with you about health and wellness issues. These include:

- Diet and physical activity
- Family planning
- Folic acid for women who are of the age to get pregnant
- Sexual behavior and screening for sexually transmitted infections
- Screening for HIV
- Screening for hepatitis B (HBV) if high risk
- Intimate partner violence
- How to prevent injuries
- Counseling to reduce your risk of getting skin cancer, special risks you might have for cancer (such as family history) and steps you can take to reduce those risks
- Misuse of drugs and alcohol
- Secondhand smoke
- How to stop using tobacco
- Dental health
- Mental health, including screening for depression

*Women should talk to their doctor and choose the best age to begin screening. Women aged 50 to 74 years may have the option to screen every year.

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At this visit, you may get vaccines and these screenings:

Screenings	Age (in years) 19-20	21-29	30	35	40	45	50	55	60	65 and older
Height, weight	Each year or as your doctor suggests									
BMI**	Each year or as your doctor suggests									
Blood pressure	Each year or as your doctor suggests. High measurements should be confirmed in the home setting.									
Breast cancer	Doctor exam every 1 to 3 years.					Each year from age 40 to 65+				
Breast cancer: mammogram	Each year from age 40 to 65+.* Biennial screening mammography for women aged 50 to 74 years.									
Cervical cancer: ages 21-29		Every 3 years								
Cervical cancer: ages 30-65	Should have a Pap test plus an HPV test (called cotesting) every 5 years. This is the preferred approach, but it is alright to have a Pap test alone every 3 years.									
Cervical cancer: ages 65+										Stop screening at age 65 if last three Pap tests or last two cotests (Pap plus HPV) within the previous 10 years were normal. If there is a history of an abnormal Pap test within the past 20 years, discuss continued screening with your doctor.
Colorectal cancer	At age 50 and continuing until age 75 years: your doctor may suggest one of these test options: ▪ FIT: fecal immunochemical test ▪ FIT-DN: multitargeted stool DNA test ▪ gFOBT: guaiac-based fecal occult blood test ▪ Colonoscopy ▪ CT colonography ▪ Flexible sigmoidoscopy									
Chlamydia	Sexually active women ages 24 and younger									
Cholesterol	Every 5 years starting at age 40 with more screenings as your doctor suggests or for women ages 20-40 if at increased risk for coronary heart disease. Statin use may be recommended for some people ages 40 to 75 years who are at increased risk for cardiovascular disease.									
Contraceptive education, methods, counseling and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes.										
Glucose screening for Type 2 diabetes	As your doctor suggests from age 40 to 70 if you are overweight or obese. Individuals with high glucose should talk to their doctor about intensive counseling interventions to promote a healthful diet and physical activity.									
Hepatitis C						Screen once if born between 1945-1965				
Osteoporosis						The test to check how dense your bones are should start no later than age 65.; women at menopause should talk to their doctor about osteoporosis and have the test when at risk.				

*This guide is for people enrolled in the UniCare Health Plan of West Virginia, Inc. plan.

PREGNANT WOMEN*

Pregnant women should see their doctor or OB/GYN in their first three months of pregnancy for a first visit and to set up a prenatal care plan. At this visit, your doctor will check your health and the health of your baby.

Based on your past health, your doctor may want you to have these tests, screenings or vaccines:

- **Depression** — screening during or after pregnancy
- **Diabetes** — during pregnancy
- **Hematocrit/hemoglobin (blood count)**
- **Hepatitis B**
- **HIV**
- **Rubella immunity** — to find out which women need the rubella vaccine after giving birth
- **Rh(D) blood type and antibody testing** — if Rh(D) negative, repeat test at 26 to 28 weeks
- **Syphilis**
- **Urinalysis** — when your doctor wants it

The doctor may talk to you about what to eat and how to be active when pregnant as well as staying away from tobacco, drugs, alcohol and other substances. Your doctor will provide interventions during pregnancy and after birth to support breastfeeding, lactation supplies and counseling.

Other tests and screenings:
Some tests given alone or with other tests can be used to check the baby for health concerns. These tests are done at certain times while you are pregnant. The best test to use and the best time to do it depends on many things. These include your age as well as your medical and family history. Talk to your doctor about what these tests can tell you about your baby, the risks of the tests and which tests may be best for you.

- **Amniocentesis**
- **Chorionic villus sampling**
- **Special blood tests**
- **Ultrasound tests**, including special tests (used with blood tests during the first three months for chromosomal abnormality risk) and routine two-dimensional tests to check on the baby

Medications:
If you are high risk for a condition called preeclampsia, your doctor may recommend the use of low-dose aspirin as preventive medication.

Vaccines:
If you are pregnant in flu season (October to March), your doctor may want you to have the inactivated flu vaccine. Pregnant adolescents and adults should be vaccinated with the Tdap vaccine with each pregnancy.

Tdap should be administered between 27 and 36 weeks gestation, although it may be given at any time during pregnancy. Currently available data suggest that vaccinating earlier in the 27 through 36 week window will maximize passive antibody transfer to the infant.

You should get the Tdap vaccine (to help protect against whooping cough), during your pregnancy. Other vaccines, like the flu shot, can be given before or during pregnancy, depending on whether or not it is flu season when you're pregnant."

While other vaccines may be given in special cases, it is best to get the vaccines you need before you get pregnant. Women should always check with their doctor about their own needs.

You should NOT get these vaccines while you are pregnant:

- **Measles, mumps, rubella (MMR)**
- **Varicella**



ADULT SCREENINGS – MEN*

Well-person exam

The doctor may talk with you about health and wellness issues. These include:

- Diet and physical activity
- Family planning
- How to prevent injuries
- Misuse of drugs and alcohol
- How to stop using tobacco
- Secondhand smoke
- Sexual behavior and screening for sexually transmitted infections
- Screening for HIV
- Screening for Hepatitis B (HBV) if high risk
- Counseling to reduce your risk of getting skin cancer; special risks you might have for cancer (such as family history) and steps you can take to reduce those risks
- Dental health
- Mental health, including screening for depression

At this visit, you may get vaccines and these screenings:

Age (in years)

Screenings	19	20	25	30	35	40	45	50	55	60	65 and older
Height, weight	Each year or as your doctor suggests										
BMI**	Each year or as your doctor suggests										
Abdominal aortic aneurysm											One time for ages 65-75 for those who have ever smoked
Blood pressure	Each year or as your doctor suggests.							High measurements should be confirmed in the home setting.			
Cholesterol	Every 5 years starting at age 40 with more screenings Statin use may be recommended for some people ages							as your doctor suggests or for men ages 20-40 if at increased risk for coronary heart disease. 40 to 75 years who are at increased risk for cardiovascular disease			
Colorectal cancer	At age 50 and continuing until age 75 years; your doctor may suggest one of these test options: • FIT: fecal immunochemical test • FIT-DN: multitargeted stool DNA test • gFOBT: guaiac-based fecal occult blood test • Colonoscopy • CT colonography • Flexible sigmoidoscopy										
Glucose screening for Type 2 diabetes	As your doctor suggests from age 40 to 70 if you are overweight or obese. Individuals with high glucose should talk to their doctors about intensive counseling interventions to promote a healthful diet and physical activity.										
Hepatitis C	Screen once if born between 1945-1965										
Prostate cancer	If you are 50 or older, discuss with your doctor the risks and benefits of the prostate cancer tests										

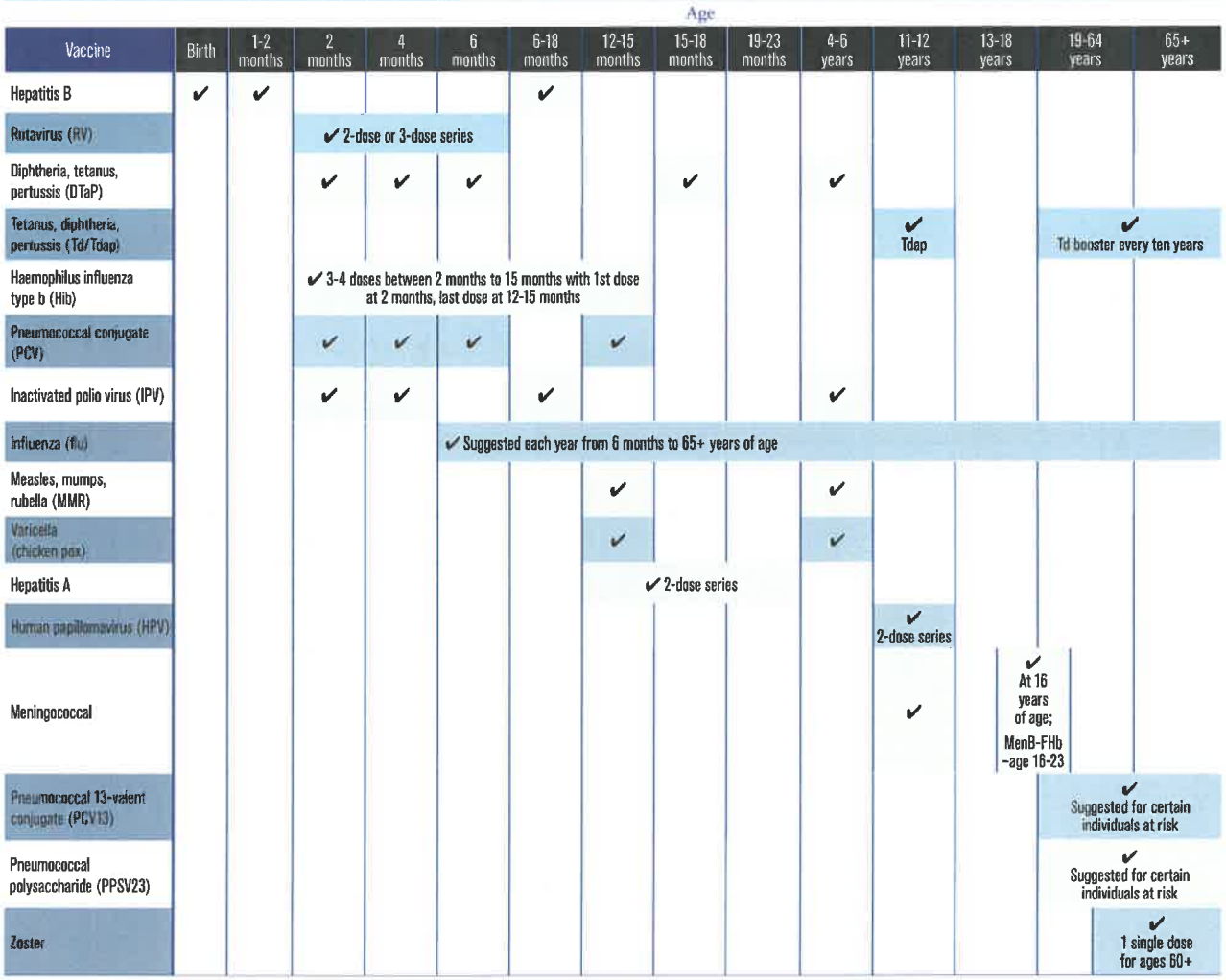
*This guide is for people enrolled in the UniCare Health Plan of West Virginia, Inc. plan. Talk to your doctor if you have concerns about your health.

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SUGGESTED VACCINE SCHEDULE*

For more information about vaccinations, visit www.cdc.gov/vaccines.

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Hepatitis B — The first dose should be administered within 24 hours of birth to address births outside of the hospital. You may get an extra dose (four-dose series) at four months if the combination vaccine is used after the birth dose.

Rotavirus (RV) — Get two-dose or three-dose series (Depends on brand of vaccine used).

Tdap (teens) — If you are 13 to 18 years of age and have not had this vaccine before, talk to your doctor about a catch-up vaccine.

Tdap (adults) — If you are 19 years of age or older and have not gotten a dose of Tdap before, you should get a single dose.

Haemophilus influenza type b (Hib) — Get three-dose or four-dose series (Depends on brand of vaccine used).

Pneumococcal conjugate (PCV) — Children aged 14 months through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), get a single supplemental dose of 13-valent PCV (PCV13).

Influenza (flu) — Refer to www.flu.gov or www.cdc.gov to learn more about this vaccine. (Note: Children 6 months to 8 years of age having the vaccine for the first time should have two doses separated by four weeks.)

Measles, mumps, rubella (MMR) and varicella (chicken pox) — If you were born after 1957, you should have records of one or more doses of MMR vaccine unless you have a medical reason not to have the vaccine, or laboratory records of immunity to these diseases.

Human papillomavirus (HPV) — Eleven to 12-year-olds receive two doses of HPV vaccine at least six months apart. Teens and young adults who start the series later, at ages 15 through 26 years, will continue to need three doses of HPV vaccine to protect against cancer-causing HPV infection.**

Meningococcal — When given to healthy adolescents who are not at increased risk for meningococcal disease, 2 doses of MenB-FHbp should be administered at 0 and 6 months. If the second dose is given at an interval of 6 months a third dose should be given at least 6 months after the first dose. For persons at increased risk for meningococcal disease and for use during serogroup B outbreaks, 3 doses of MenB-FHbp should be administered at 0, 1-2 and 6 months.

Pneumococcal 13-valent conjugate (PCV13)/Pneumococcal polysaccharide (PPSV23) — Adults 65 years and older and certain adults younger than 65 who are considered at risk are recommended to receive both a PCV13 and PPSV23. Ask your doctor about the dosing recommendation that is right for you.

**For more information on the updated recommendations, see Centers for Disease Control website: *Use of a 2-Dose Schedule for Human Papillomavirus Vaccination — Updated Recommendations of the Advisory Committee on Immunization Practices* (December 16, 2016): cdc.gov/mmwr/volumes/65/wr/mm6549a5.htm.

TO LEARN MORE ABOUT YOUR PLAN, PLEASE SEE UNICARE.COM/MEDICAID

To learn more about vaccines, please see the Centers for Disease Control and Prevention (CDC) website: www.cdc.gov.

We can translate this for you at no cost. Call the Customer Care Center at 1-800-782-0095.
If you have speech or hearing loss, call the TTY line at 1-866-368-1634.

Podemos traducirle este texto sin costo. Llame al Centro de Atención al Cliente al 1-800-782-0095.
Si tiene impedimentos auditivos o del habla, puede llamarnos a través de una máquina de TTY/TDD al 1-866-368-1634.

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2. CARE MANAGEMENT

The Vendor should refer to the relevant specifications located in **Appendix 1: Detailed Specifications** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in **Section 4: Project Specifications** in this RFP, and then describe its approach to Care Management below. The Vendor's narrative response should not exceed 75 pages.

CM001	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated care plan for all children.	The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.
CM002	The Vendor should share information required for continuity of care with the member and their family or caregiver(s).	The Vendor should describe how it will meet this specification, including, but not limited to, communication paths, methods, and/or frequency.
CM003	The Vendor should provide training to ensure an integrated care plan is jointly developed and shared among the primary care provider (PCP) and/or specialist serving as a principalcoordinating physician, and the child and caregiver(s).	The Vendor should describe how it will meet this specification and who will participate in training.
CM004	The Vendor should evaluate and report member progress in meeting goals identified in the individualized service plan (ISP).	The Vendor should describe how it will meet this specification.
CM005	The Vendor should collaborate with the Department's pharmacy program to help provide coordinated care for the member, including, but not limited to, those members accessing psychotropic medications, for applicable populations.	The Vendor should describe how it will meet this specification.
CM006	The Vendor should establish and maintain patient-centered medical homes for its members (in applicable populations) in alignment with the American Academy of Pediatrics (AAP) guidelines in the Health Care Issues for Children and Adolescents in Foster Care and Kinship Care manual, including, but not limited to, the following:	The Vendor should describe in detail how it will meet these specifications.
CM007	The application process for providers	See the parent specification.
CM008	Assessment of whether foster care members can continue to receive healthcare in their medical home of origin, and if not, how best to establish and maintain new medical homes	See the parent specification.

CM009	Communication with members and/or their caregivers/families, as appropriate, about patient-centered medical homes for applicable populations	See the parent specification.
CM010	Annual reporting processes	See the parent specification.
CM011	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others on discharge planning needs of a member leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM012	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others to ensure outpatient services have been established prior to the member leaving an Inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM013	The Vendor should coordinate with the Department to ensure that all needed medication is available to the member after leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM014	The Vendor should engage in the Individualized Care Planning process for foster care members.	The Vendor should describe how it will meet this specification.
CM015	The Vendor should collaborate with caseworkers to support members experiencing home removals and changes in placement based on Department foster care requirements.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM016	The Vendor should collaborate with caseworkers to minimize the need for removals and changes in placement.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM017	The Vendor should identify and track new members with high physical or behavioral health needs to assure continuity of care, for applicable populations.	The Vendor should describe how it will meet this specification.
CM018	The Vendor should monitor members' physical or behavioral health needs and respond to changes in acuity over time, for applicable populations.	The Vendor should describe how it will meet this specification.

CM019	The Vendor should use telemedicine, telehealth, and telemonitoring services to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.
CM020	The Vendor should use internet and/or web-based services to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.
CM021	The Vendor should identify and Implement opportunities to use video conferencing to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.
CM022	The Vendor should identify members for participation in Intensive Care Management (ICM) teams for individuals with one or more chronic conditions, for applicable populations.	The Vendor should describe how it will meet this specification.
CM023	The Vendor should determine the composition of the Intensive Care Management (ICM) team for participating members, for applicable populations.	The Vendor should describe how it will meet this specification.
CM024	The Vendor should develop plans specific to each case for members participating in Intensive Care Management (ICM) teams, for applicable populations .	The Vendor should describe how it will meet this specification.
CM025	The Vendor should conduct ongoing gap analyses to determine the types of services and resources not available in the State.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM026	The Vendor should work with the Department and community partners to increase capacity for those services and resources identified as not available in the State.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM027	The Vendor should leverage population health management risk stratification tools to support stratification of members into risk tiers for care coordination services.	The Vendor should provide a detailed description of its approach to meeting this specification.
CM028	The Vendor should capture data related to social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC).	The Vendor should describe how it will meet this specification.
CM029	The Vendor should incorporate data about social determinants of health into its care coordination services.	The Vendor should describe how it will meet this specification.

CM030	The Vendor should establish committees with family members, the member, providers, the care coordinator, and a Department lead to help develop the most appropriate care plans for the member.	The Vendor should: 1) Describe how it will meet this specification. 2) Explain how it proposes to define the "most appropriate" care plans.
CM031	The Vendor should develop and implement access to care standards and methodology.	The Vendor should describe how it will meet this specification, including, but not limited, to proposed standards and methodology.
CM032	The Vendor should develop and Implement care guidelines for working with youth who may have been exposed to adverse childhood experiences (ACEs).	The Vendor should: 1) Provide proposed guidelines. 2) Describe direct experience working with youth who may have been exposed to adverse childhood experiences (ACEs).
CM033	The Vendor should establish an organizational structure and treatment framework to recognize, understand, and respond to the effects of all types of trauma per American Academy of Pediatrics (AAP) guidelines for a trauma-informed practice.	The Vendor should describe how it will meet this specification.
CM034	The Vendor should facilitate coordination of care between primary care providers (PCPs) and children's dental providers for applicable populations, including, but not limited to, for children with special healthcare needs.	The Vendor should escribe how it will meet his specification.
CM035	The Vendor should provide a care coordination model with stratified services for eligible members according to clinical, social, or other criteria.	1) The Vendor should provide a detailed description of its care coordination model. 2) The Vendor should describe how the care coordination department is organized and the integration of the service types. 3) The Vendor should describe its proposed clinical, social, or other criteria. 4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy.
CM036	The Vendor should screen members for stratification into care coordination services upon enrollment.	The Vendor should describe how it will meet this specification.
CM037	The Vendor should monitor screening timelines for member care coordination stratification.	The Vendor should describe how it will meet this specification.

CM038	The Vendor should assign members to an appropriate healthcare professional who is formally responsible for coordinating the member's overall healthcare, including, but not limited to, behavioral health, for applicable populations.	The Vendor should: 1) Describe its protocol for assigning members. 2) Explain how the Vendor proposes to define an "appropriate" healthcare professional. 3) Specify whether services are coordinated by the member's primary care provider (PCP) or through some other means, including, but not limited to, a care coordinator.
CM039	The Vendor should use clinical, social, or other criteria to assign members to a care coordinator within a timeframe that the Department approves.	The Vendor should: 1) Describe its protocol for assigning members. 2) Describe its proposed clinical, social, or criteria 3) Provide the expected timeframe for care coordinator assignment to the identified member.
CM040	The Vendor should develop education, member materials, and outreach strategies that are appropriate for adults and children and adhere to federal and State marketing regulations.	The Vendor should: 1) Describe any differences in how it will approach adults versus children. 2) Describe any internal processes that may vary between approaching adults and children, including, but not limited to, education, member materials, and outreach. 3) Explain how it proposes to define "appropriate for adults and children."
CM041	The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals.	The Vendor should describe how it will meet this specification. This description should reflect an understanding of the West Virginia (WV) Children with Special Health Care needs program.
CM042	The Vendor should perform screening, assessment, and/or utilization analysis to identify and provide services for members with special needs.	1) The Vendor should describe its methods for meeting this specification. 2) The Vendor should describe any additional screening tools used in this process. 3) If the Vendor proposes to conduct its own health risk assessment, the Vendor should provide a template for the form or protocol.
CM043	The Vendor should perform screening and assessment to identify and provide services for members with behavioral health needs.	1) The Vendor should describe its methods for meeting this specification.

		2) The Vendor should describe any additional screening tools used in this process. 3) If the Vendor proposes to conduct its own health risk assessment, the Vendor should provide a template for the form or protocol.
CM044	The Vendor should complete health risk assessments that will be made available upon enrollment to members In applicable populations and/or their caregiver(s), including, but not limited to, assessments specific to members with special healthcare needs.	The Vendor should describe how it will meet this specification.
CM045	The Vendor should provide targeted education programs and identify who will receive these programs.	The Vendor should: 1) Describe its approach to targeted member or medical management education programs. 2) Identify the audience for these programs. 3) Provide the timeframe for creating education materials and educating community engagement and care coordination staff.
CM046	The Vendor should use specialized care coordinators for certain conditions, including, but not limited to, experienced pediatric or cardiac nurses and behavioral health specialists.	The Vendor should indicate whether the Vendor will use specialized care coordinators for certain conditions, and describe the rationale behind its approach.
CM047	The Vendor should develop and maintain qualifications and training for Vendor staff who will be involved in coordinating care.	The Vendor should describe: 1) Qualifications and training for Vendor staff who will be involved in coordinating care 2) The Vendor's plan for hiring care coordination staff, including, but not limited to, timeframes, number of care coordinators, and maximum case load Note: Care coordinators should be dually trained in both Bureau for Children and Families (BCF) and Bureau for Medical Services (BMS) policies.
CM048	The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.	The Vendor should describe in detail: 1) Steps care coordinators will take to establish relationships with their assigned members. 2) A protocol for addressing a member who

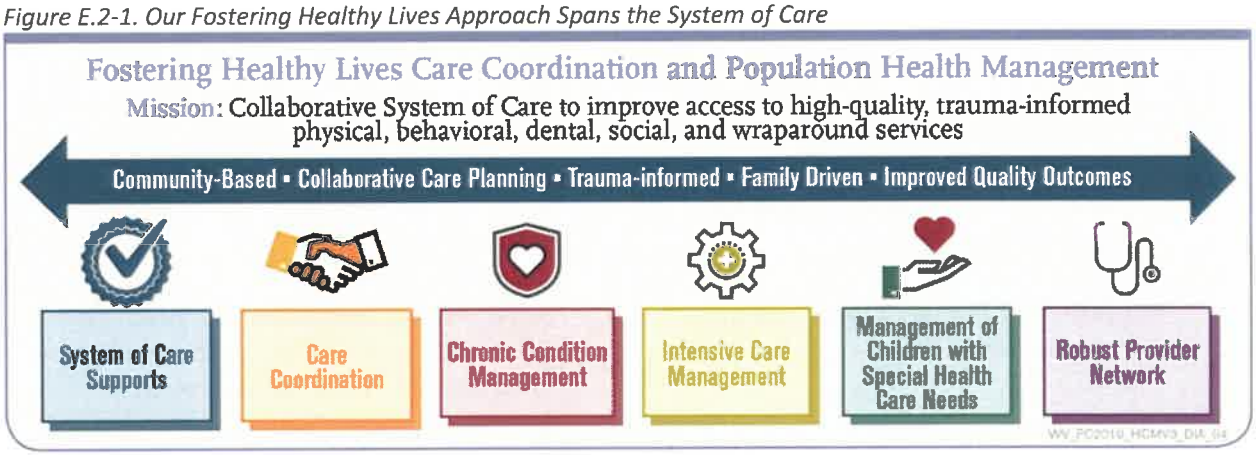
		does not want a care coordinator or cannot be reached once a care coordinator has been assigned.
CM049	The Vendor should establish and implement guidelines for when care coordinators should have face-to-face contact with their assigned members, including, but not limited to, when requested by a Department worker.	The Vendor should describe its approach to care coordinators' face-to-face contact with assigned members, including, but not limited to: 1. Frequency 2. Circumstances resulting in a need for face-to-face contact 3. Goal of face-to-face contact at this frequency and/or in these circumstances
CM050	The Vendor should develop and implement standards for how often the care coordinators will contact members after the initial care coordination contact, based on the member's acuity level.	The Vendor should provide and describe proposed standards for this specification.
CM051	The Vendor should collect statistics, according to a set frequency, on care coordinators' progress toward establishing relationships with members.	The Vendor should describe what statistics it proposes to collect and how often.
CM052	The Vendor should monitor and evaluate care coordinators in regards to establishing relationships with members.	The Vendor should describe how it will meet this specification.
CM053	The Vendor should identify members in need of treatment plans.	The Vendor should describe the process and/or mechanisms for identifying members in need of such a plan.
CM054	The Vendor should develop, update, and use clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, community and social support, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.	The Vendor should develop, update, and use clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, community and social support, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.
CM055	The Vendor should share care plans with a member's primary care provider (PCP) at a set frequency.	The Vendor should: 1) Provide the frequency with which care plans will be shared with primary care providers (PCPs) and other providers. 2) Describe the manner (including, but not limited to, letters or phone calls) in which care plans will be shared with PCPs or other providers. 3) Describe who is responsible for sharing care plans with a member's PCP.

CM056	The Vendor should share care plans with a member's primary care provider (PCP) outside of the established schedule according to guidelines developed by the Vendor and approved by the Department.	The Vendor should describe what events or circumstances will prompt the Vendor to share care plans outside of the established schedule.
CM057	The Vendor should track the completion of care plans	The Vendor should describe how it will meet this specification.
CM058	The Vendor should provide episodic and/or catastrophic care coordination interventions.	The Vendor should describe how it will meet this specification.
CM059	The Vendor should identify providers that do not perform coordination activities and take action to improve coordination.	The Vendor should identify providers that do not perform coordination activities and take action to improve coordination.
CM060	The Vendor should coordinate services with community resources and social services for members in the area served by the Vendor, including, but not limited to, those with special healthcare needs.	The Vendor should describe: 1) Procedures that will be in place for coordination with community resources and social services for members, including those with special health needs 2) Timeframes for identification of such resources and services

Care Coordination Model (CM035)

The UniCare Health Plan of West Virginia, Inc. (UniCare) Fostering Healthy Lives model supports safety, permanency, and well-being through a comprehensive and integrated care coordination approach for children and youth in the child welfare system. Our Fostering Healthy Lives approach (Figure E.2-1) incorporates population health management (PHM) and care coordination interventions to bring a fully integrated approach to meeting physical health (PH), behavioral health (BH), dental, and social support needs of children and youth in child welfare.

Figure E.2-1. Our Fostering Healthy Lives Approach Spans the System of Care



As a current West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) MCO, we have been supporting members through a fully integrated care coordination program for over 16 years. Our Fostering Healthy Lives model is informed by our experience in West Virginia as well as the experiences of 13 of our affiliates serving members involved in the child welfare system. Our approach is guided by system of care principles that are strength-based, family and person-centered, youth-driven, evidence-based, trauma-informed, collaborative, and community-focused. It is also sensitive to members' experiences; for example, we seek ways to minimize duplication when gathering historical and assessment information to avoid inadvertently re-traumatizing children and youth. Our model will build on our extensive West Virginia knowledge and relationships, as well as our affiliates' experience to implement a comprehensive program defined by the following core values.



- **Systems-based.** Children and youth in the child welfare system have multi-system involvement and coordinating care must account for the different systems and stakeholders that engage the child. This includes Department of Health and Human Resources (DHHR) and the Bureau for Children and Families (BCF), the West Virginia Judiciary Division of Children's Services, educational system, community and health care providers, child-placing agencies, foster parents, adoptive parents, and kinship caregivers, biological parents, and others.
- **Trauma-informed.** Children and youth in child welfare are at increased risk of multiple issues due to Adverse Childhood Experiences (ACEs), which strongly correlate to the development and prevalence of a wide range of health problems throughout a person's life, including those associated with substance use. Our Fostering Healthy Lives model promotes resiliency and the understanding that children, youth, and young adults in child welfare have experienced trauma and must be approached using a trauma-informed lens.
- **Evidence-informed.** An evidence-informed model incorporates research but also considers a person's needs, values, and preferences, as well as the experience and knowledge of a practitioner in decision-making. Evidence-informed approaches are more person-centered and flexible than entirely research-centered.
- **Focused on self-determination, independence, and autonomy.** Care coordination focuses on helping members achieve independence, self-reliance, and autonomy. Care Coordinators work to foster self-determination through supports for both the child and youth, as well as caregiver.

Our Fostering Healthy Lives model is consistent with the well-established triple aim of improving health outcomes, improving satisfaction with care, and decreasing cost of care. It focuses on four areas consistent with NCQA's PHM program:

- Keeping members healthy
- Managing members with emerging risk
- Maintaining member safety and outcomes across settings
- Managing members' multiple chronic illnesses

Care Coordination Department Organization

Our Care Coordination department will be organized cross-functionally, integrating PH, BH, dental, and social support services in close collaboration with utilization management (UM), member services, and other supporting staff. The Care Coordination department will include:

- **Care Coordination Manager**
- **Fostering Healthy Lives Care Coordinators** who will offer field-based support and serve as the child's single point-of-contact

- **Fostering Healthy Lives Concierge team** of dedicated, non-clinical representatives who will be specially trained to provide assistance and serve as a central contact point for children, caregivers, providers, Department caseworkers, and court representatives
- **Fostering Independence Coordinators** dedicated to helping transition age youth (TAY) successfully move into adulthood by teaching self-management skills for independence
- **Pharmacist** who will analyze pharmacy data provided by DHHR and work closely with the Care Coordination team to address children's medication coordination and management
- **Dental Liaison** who will work with a variety of stakeholders to assure children and youth receive appropriate preventive dental services

Key features of our care coordination model include:

- Regionally aligned care coordination teams
- Care Coordinator co-location at BCF offices and high-volume inpatient, psychiatric residential treatment facilities (PRTFs), and residential settings, (including Qualified Residential Treatment Programs [QRTPs]), based on regional and member needs
- Assignment of each child to a Care Coordinator who remains the single point-of-contact for the child and caregiver
- Access to our multidisciplinary team of subject matter experts, including BH clinicians, Medical Directors, Pharmacist, Social Services Directors, Socially Necessary Services (SNS) liaisons, Dental Liaisons, and other professionals with expertise applicable to members' needs

Screening and Assessment for Stratification (CM036, CM039)

Immediately following notification of a new enrollment from the daily supplemental enrollment file of foster children, a Concierge Representative, as an extension of our overall Care Coordination team, will outreach to all members within five business days, with the goal of contacting members within two business days to identify any urgent needs for rapid follow-up by a Care Coordinator. The representative will complete the Fostering Healthy Lives Health Risk Screener (HRS) during this call if the caregiver or Authorized Representative consents, or schedules completion of the HRS by phone no later than 14 days following the child's enrollment. They will also gather any additional information the caregiver or member wishes to share.



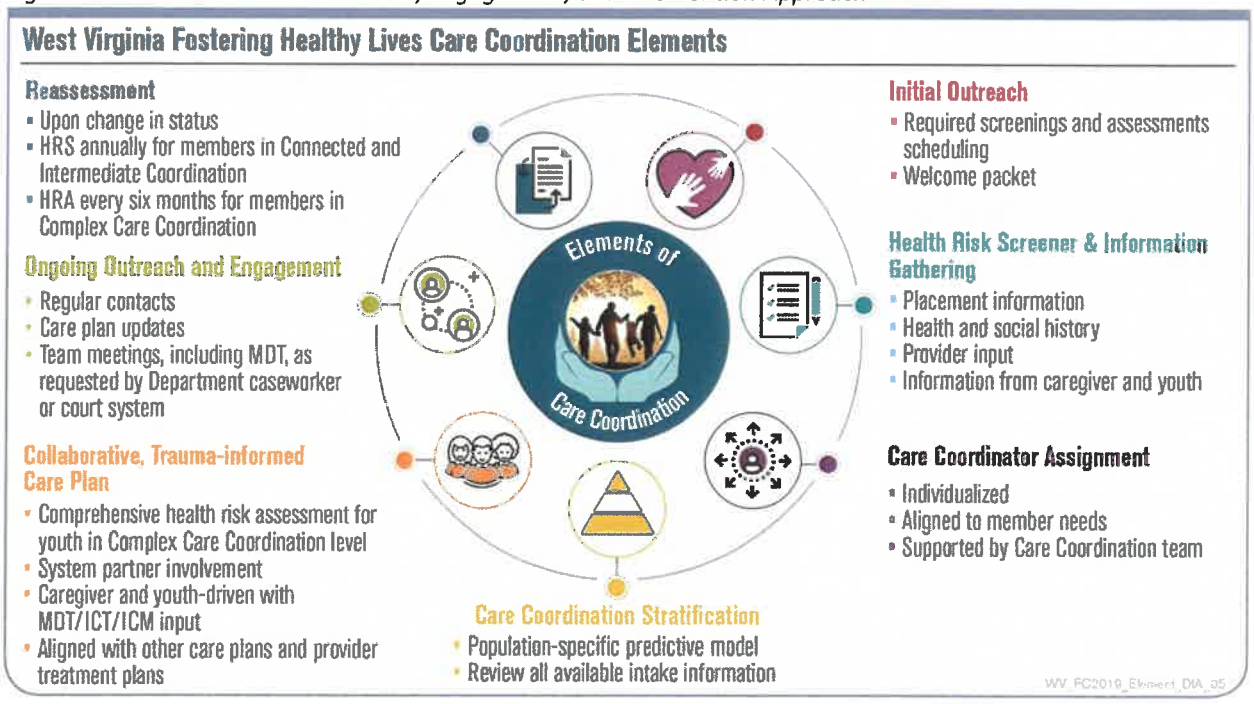
Initial Outreach



Health Risk Screener & Information Gathering

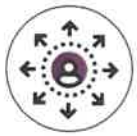
Our HRS includes questions about member demographics; information about who is completing the screening on behalf of a child (if under 18 years old); current health status and services; mental health and substance use disorder (SUD) status; social determinants of health (SDOH); education; and caregiver strain. The Concierge Representative will also contact the child's Department caseworker and providers to gather other available clinical information, including assessments, as well as care and treatment plans (including the individualized service plan [ISP] and family service plan [FSP]). All information gathered will be entered into Health Insight, our care management system, where it is available for review by the Care Coordination team to support member stratification. ***Our rapid intake and information gathering process is essential to identifying children's care coordination needs and quickly connecting them to a qualified and experienced Care Coordinator.*** Figure E.2-2 provides an overview of our care coordination approach.

Figure E.2-2. Care Coordination Intake, Engagement, and Intervention Approach



Timely Assignment to a Qualified Care Coordinator (CM046)

We recognize children may be enrolled in the program shortly after removal from their parents who have faced trauma. We will train all Care Coordinators in trauma-informed care practices and make sure they have expertise relevant to the population.



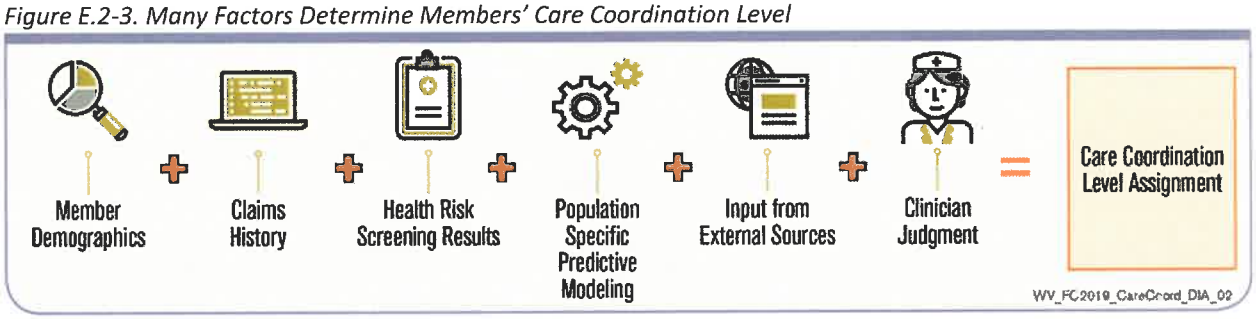
We will assign each child a Care Coordinator with experience applicable to their needs. For example, we will assign Children with Special Health Care Needs (CSHCN) with complex PH needs to a registered nurse (RN) and children with identified complex BH needs to a BH clinician. Care Coordinators will include pediatric and OB nurses, BH specialists with experience working with children and youth who have a serious emotional disturbance, mental illness, or SUD, and social workers with child welfare experience. The Care Coordination Manager will review the child's compiled information in Health Insight, our care management system, and, within two business days of enrollment, assign a Care Coordinator, considering the child's location and primary diagnosis. The Care Coordination Manager will work with each Care Coordinator to identify the child's initial care coordination stratification level.

All Care Coordinators will be cross-trained as part of our fully integrated care coordination model, recognizing members typically have multifaceted needs. In addition, Care Coordinators will have access to our multidisciplinary team of subject matter experts to help coordinate services and treatment for children with the most complex needs.

Care Coordination Stratification (CM027, CM035, and CM036)

Our approach to care coordination stratification is much more comprehensive than models based solely on clinical indicators. We will review all available information, including information learned from discussion with the caregiver, child, and Department caseworker, to identify an appropriate care coordination level — Connected, Intermediate, or Complex. Figure E.2-3 displays the many factors considered during stratification.

Figure E.2-3. Many Factors Determine Members' Care Coordination Level



The review encompasses:

- The results of the HRS
- Member transition data (historical paid claims and service authorization data when available)
- Other assessments such as the West Virginia Child and Adolescent Needs and Strengths Assessment (CANS)
- Care Plans, including the Child Welfare Safety Plan, DHHR case plan, ISP, and FSP
- Results from the Health Check preventive screening completed by the provider
- Verbal and written reports from the caregiver, Department caseworker, and providers
- Enrollment information from the 834 file, including enrollment in the CSHCN program
- When claims data become available, our child welfare-specific predictive modeling results

Population-specific Predictive Modeling

Our Chronic Illness Intensity Index (CI^3) is a predictive model developed by our ultimate parent company, Anthem, Inc. (Anthem), from claims data aggregated from a 12-month look-back period, identifying member complexity, from low to high, and assigning a risk score. This helps us identify children and youth with emergency room (ER) use, who are inpatient, have complex and comorbid PH and BH needs, substance use, and other indicators of special needs. We also complete a Likelihood of Inpatient Admission Score (predicting a PH or BH inpatient admission within the next 60 days). We use all available sources of data, such as claims, inpatient and ER utilization data, and available State reporting data to identify known PH and BH issues, medications, and other relevant health information. Our ***Child Welfare-specific Predictive Model*** generates a risk level sensitive to the unique population characteristics, further refining stratification. This model was built and tested against a broad segment of members with child welfare involvement, and is more predictive for children in lower levels of need, helping more reliably predict who may benefit from more extensive care coordination.

After reviewing available information, the Care Coordinator, in consultation with the Care Coordination Manager, applies our stratification guidelines (Figure E.2-4) to identify a recommended stratification level. Factors include:



- Number of placements and reasons for changes
- Designation as a CSHCN, resulting in assignment to Complex care coordination
- Risk level derived from our population-specific predictive modeling tool
- Legal and justice involvement (outside of child welfare-related proceedings)
- Frequency of inpatient and PRTF admissions
- Medication use and management
- Suicidal ideation or attempts
- Level of involvement with State agencies

- PH and BH conditions, including substance use
- Risk of runaway behavior
- History of human trafficking, domestic violence, or other trauma

Figure E.2-4. Our Approach Informs Care Coordination Stratification

Fostering Healthy Lives Stratification

Connected	Intermediate	Complex
Increasing Intensity →		
• Low predictive modeling score	• Low to mid-range predictive modeling score	• Higher predictive modeling score
• Minimal changes in placements	• More than one placement in conjunction with other characteristics	• Multiple placements resulting from difficulty in managing the child
• Minimal involvement with State agencies	• Legal involvement outside of foster care proceedings	• Involvement of many State agencies • Recent legal involvement
• No medication, or stable on current medication	• Prescribed medications, including psychotropic or medications for multiple conditions	• High medication use, indications of non-adherence
• No PH/BH conditions or stable PH/BH conditions	• One or more chronic conditions (medical or behavioral) requiring management	• Children with Special Health Care Needs • Comorbid conditions not successfully managed • Pregnant
• No recent admission	• May have had a recent admission but stable	• Recent or current PRTF admission • Multiple inpatient admissions
• Individualized Care Team (ICT)	• Intensive Care Management (ICM) Team	• Intensive Care Management (ICM) Team

While the guidelines suggest a stratification level, the Care Coordinator and Care Coordination Manager will use their clinical judgement to make the final determination. Our experienced staff recognizes every child is different, every child's circumstances are different, and every child has different levels of resiliency. The care coordination level also drives the intensity of interdisciplinary planning, through an interdisciplinary care team (ICT) for children stratified as Connected, or an Intensive Care Management (ICM) team, for those stratified as needing Intermediate or Complex care coordination. ***As members' needs change, they may move in and out of specific care coordination levels, but will remain assigned to a single Care Coordinator. This helps reduce fragmentation and offers seamless continuity of care.***

Care Coordinators continually identify members' needs through ongoing care coordination contacts and monthly review of their risk score to assess care coordination level and identify those with emerging risk. In addition, Care Coordinators complete the comprehensive health risk assessment (HRA) for members stratified into Complex care coordination, as described below.

From this initial review, and working with the member, caregiver, primary care provider (PCP), Department caseworker, and other key stakeholders, the assigned Care Coordinator reviews the member's and caregiver's strengths, identified concerns, barriers to health, or other specific needs, helps them identify personal goals, and develops a Care Plan.

Health Risk Assessments (CM044)

We will complete our comprehensive HRA for members stratified into Complex care coordination, and for any child or youth upon referral or request by the caregiver, Department caseworker, or court system. The Care Coordinator will complete it telephonically or in person at

a location meeting the member's and caregiver's needs, then complete a reassessment using the same tool every six months. They may also complete as-needed specialized or condition-specific assessments (i.e., our pediatric BH assessment) based on HRS or HRA outcomes.

The Care Coordinator will contact the caregiver of each child stratified as Complex within 30 days of assignment to complete the HRA and develop the child's Fostering Healthy Lives Care Plan (Care Plan), and include a trauma assessment for those not previously assessed. They will also contact the member's Department caseworker to review each child's risk factors and needs. For example, a child's clinical data may reveal no pressing or significant needs; however, we may learn from a Department caseworker that the child was removed from the home after witnessing a violent act or has experienced severe abuse.



Our Health Risk Assessment Tool

Our HRA, provided as Supplemental Document E.2-2 and Supplemental Document E.2-3 includes a hierarchy with branching logic that probes more than 20 potential clinical areas for risk factors. We do not duplicate existing, available assessments during completion of the HRA, but incorporate and confirm findings from recent assessments. A thorough assessment is fundamental to developing a Care Plan and includes:

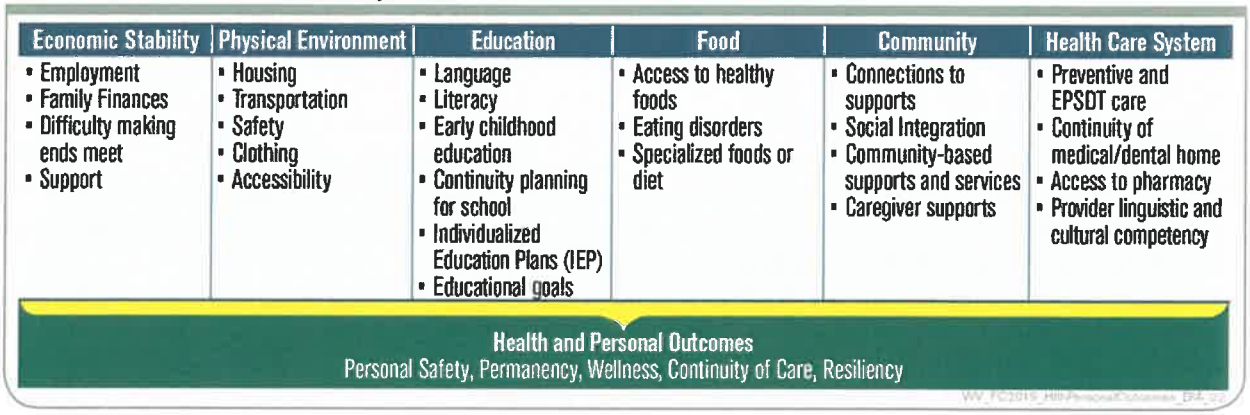
- An initial assessment of the member's health and functional status, including appropriate developmental milestones; biopsychosocial status, including cognitive functions, mental health conditions, and substance use disorders (for example, alcohol or recreational drug use); and SDOH that may affect the member's and caregiver's ability to adhere to their Care Plan
- Documentation of the member's clinical and treatment history; key events such as acute phases and inpatient stays; treatment plan; current and past medications and medication knowledge; and therapies or procedures that address the health condition(s)
- Evaluation of cultural and linguistic needs, preferences, or limitations; visual and hearing needs, preferences, or limitations; and assessing and accounting for any difficulties that may affect communicating with the member
- Caregiver resources such as family involvement in Care Plan decision-making and adequacy of caregiver support for the member during the initial evaluation
- Available services and supports, community and natural resources
- Member's self-management capabilities; family/caregiver capabilities; willingness to change
- Member safety concerns or issues, including social support and environmental issues
- Care coordination needs, including support for transitions of care and aging out of children's systems into adult systems of care
- Identification of barriers to a member meeting goals or complying with the Care Plan

Care Coordinators will conduct specialized, evidence-based assessment modules for specific conditions and populations as applicable (i.e., OB, Pediatric, or BH assessments for children).

Capturing Social Determinants of Health Data (CM028)

UniCare leverages SDOH data in our care coordination and UM processes, gathering information about members' SDOH needs and resources during screening, assessment, and outreach; and from a review of other available information, including a child's ISP. In addition, we will use our ***SDOH Assessment tool*** with TAY, their caregivers, and family of origin. It has been specifically designed to identify unmet SDOH in key areas such as housing, education, employment, health literacy, and food. Our SDOH components are derived from generally accepted factors displayed in Figure E.2-5, including those recognized by the Centers for Disease Control and Prevention.

Figure E.2-5. Social Determinants of Health Factors



SDOH Assessment Tool

Our assessment tool solicits information regarding employment and education history, interests and strengths, and any potential SDOH barriers, including food and housing insecurity, lack of transportation, lack of childcare, and literacy issues. To facilitate care coordination, the SDOH Assessment tool has been configured into Health Insight and is stored as part of the member's record. Once the SDOH Assessment is complete, the Care Coordinator begins working with the youth and caregiver to remove barriers, immediately addressing those that may be putting the child at risk or that may compromise placement stability. The Care Coordinator connects to local resources such as emergency housing, food assistance, or other supports needed to address urgent needs. They will also incorporate the TAY life goals such as starting technical school, obtaining full-time employment, or finding an affordable apartment into the youth's Care Plan. Care Coordinators will document community resource referrals, mutually agreed next steps, and follow-up intervals in the Care Plan.

The Care Coordinator continually identifies, updates, and documents SDOH-related interventions as a component of ongoing care planning review and update.

Providers and SDOH

We encourage providers to identify and document members' social needs as part of the overall approach to improving member health outcomes. UniCare currently offers an incentive program to Preferred Community Health Partners (PCHPs) for completion of SDOH assessments for members in case management using a 10-question screening tool. For 2020, we will expand our SDOH incentive program to additional PCPs participating in our Provider Quality Incentive Programs (described in QU011). It will include an incentive tied to a provider's assessment of their patients' SDOH and connection to community resources.

Incorporating Social Determinants of Health Data into Care Coordination (CM029)

SDOH data is readily available to the clinical team through Health Insight and to network providers through the provider portal. We will also make SDOH data available to Department caseworkers and other authorized users through role-based access to the Youth Access Record Portal (YouthRAP). YouthRAP is a member portal providing access to health record information for assigned members including Care Plans and health information, integrating internal and clinical data collected from other program participants, and serving as a portable health record for members and caregivers.

The Care Coordinator will incorporate SDOH data into the care planning process during development of the child's or youth's Care Plan, which includes goals and interventions designed to support and meet a member's SDOH needs. Working with the caregiver and member in collaboration with the Department caseworker, the Care Coordinator will include Medicaid-covered services, community-based supports, and our Value-Added Services (VAS) that can help meet identified SDOH needs. Examples of these services include:

- Medicaid-covered services, such as non-emergency medical transportation (NEMT)
- SNS, such as tutoring, intensive therapeutic recreation experience, and transportation services as authorized by the Department caseworker
- VAS, such as Youth Club Memberships (Boys & Girls Clubs of America, Boys & Girls Clubs summer camps, National FFA Organization, and 4-H), Jump Start Program that supports health and financial literacy, and a Home Essentials Kit for youth moving to independent living arrangements (described in Attachment E.8)
- Community-based supports, such as West Virginia Birth to Three, West Virginia Home Visitation Program (WVHVP), or Mission WV, as well as resources that support self-management, such as Community Resource Link (offered as a VAS), West Virginia 2-1-1, and the West Virginia Tobacco Quitline
- SNS authorized by the Department caseworker through the multidisciplinary team

The Care Coordinator, with support from the Social Services Director, will link the child and caregiver to these services and supports, coordinating authorization and referrals, and providing self-management education. For example, they will educate the family about the use of West Virginia 2-1-1 and Community Resource Link, assist with transportation arrangements, and make direct referrals to community-based resources upon families' request. The Social Services Director will serve as a resource to the Care Coordination team, maintaining an inventory of available community resources and social service agencies, and helping identify additional or unique resources in a child's community at the request of the Care Coordinator.

The Care Coordinator will check in periodically to confirm the child and caregivers are accessing identified resources, troubleshoot and resolve barriers, and update the member's Care Plan.

Fostering Independence Model

We recognize the importance of SDOH to youth transitioning from child welfare, and begin early planning for this transition through our Fostering Independence model. When a child reaches 14 years of age, our Fostering Independence Coordinator, who has a specialized understanding of the issues facing TAY, will be assigned to partner with the primary Care Coordinator to address TAY-specific needs. They will support the child's Department caseworker as we learn about barriers to independence and services needed to support transition. The Care Coordinator will reinforce the learning and transition plan developed by the Department caseworker during regular contacts with the child, and provide coordinated assistance, such as family planning education when they identify as sexually active; linking them to available housing, educational, training, employment and other community supports; and offering them our VAS. Care Coordinators will provide guidance about health care coverage and related processes that change during transition, such as moving from pediatric to adult providers; continuing coverage beyond age 18; and communicating with providers about medical needs. Our Career Development Specialist will collaborate with external stakeholders to assure foster youth have prioritized access to career development resources.

Identifying Opportunities to Collaborate and Complement Children with Special Health Care Needs (Title V) Program Clinics, Providers, or Other Professionals (CM041)

Stronger Together We serve members who are also members of the CSHCN program. We have a history of collaborating with CSHCN to address unique member needs and provide smooth transitions between the programs. Our close partnership with CSHCN started as a joint effort with multiple health plans, with the particular purpose of coordinating medical food services. We have made adjustments to our approach over time to become more effective as we focus on individual CSHCN members, their needs, and customized approaches to assist. We have received positive feedback regarding our leadership role in developing and modifying UM protocols to effectively coordinate care and facilitate access to referral and treatment for children in the CSHCN program. We continue to meet with CSHCN staff:

- **Daily.** Our Care Coordination team collaborates directly with CSHCN nurses and enrollment coordinator daily via phone and email for care coordination and to provide member updates. This has helped us identify with our members on a more personal level.
- **Monthly.** We meet at least monthly as a broader team to coordinate the services we deliver. Our staff and the Office of Maternal, Child and Family Health (OMCFH) staff meet in order to discuss individual member needs and systemic processes that could enhance and improve coordination.
- **As Needed.** We meet directly with Donna Pauley-Wilson from the CSHCN department to discuss each individual's identified needs.

Our regular communication with CSHCN staff has resulted in better information-sharing, identifying, and referring our members who may qualify for CSHCN that are not already enrolled, and working together to improve member outcomes.

Going forward, we will continue the close working relationship between DHHR, the Bureau for Public Health, OMCFH, and UniCare, working toward our common goal of improving the health and outcomes for individuals engaged with the child welfare system and addressing the needs of the population. As a part of the partnership, we will:

- Set up collaborative treatment team meetings to discuss member needs and service delivery and coordinate strategies to better serve members under age 21, including those individuals with special health care needs who are eligible for Medicaid managed care services.
- Work closely with OMCFH to develop and implement quality improvement activities, education, and other initiatives targeted at improving the care and health outcomes for CSHCN.
- Designate an individual to accept and coordinate all data and information requests and limit the use of personally identifiable information to only what is necessary to render Medicaid services, aligning with data-sharing requirements and best practices; all shared data will be subject to all applicable requirements regarding privacy and confidentiality and will be consistent with all State and Federal statutory requirements around the electronic submission of identifiable information.
- Collaborate with OMCFH Care Coordinators to share Care Plans for CSHCN and ensure that we do not duplicate services provided by OMCFH, leveraging our YouthRAP portal to share information as permissions allow.

Barbara Wessels, UniCare Associate

My son has special health care needs. He was seriously ill and required a transplant, is on the autism spectrum scale, and needs multiple medications every day. Navigating the health care system on his behalf is challenging, even for me, who is especially knowledgeable about the nuances of the system. The care coordinators and the case managers with our health plan are a lifeline for us.

I recently heard about child in foster care, the same age as my 15 year old son, who had transitioned between 50+ placements. I know that children in foster care also have special health care challenges, and adding multiple placements and transitions in and out of the child welfare system makes keeping track of health care needs overwhelming. What if this were my son with special health care needs moving from place to place? Who is ensuring that this child has his/her physical and behavioral health care needs met? How many vaccinations have been missed? What about a significant health issue? What if a diagnosis was missed or not followed up on? **This is MY WHY. I want to be a part of doing better for this child and every child whose life have been socially disrupted, and ensure that the system works for them, by giving them easy access to the services they need to be healthy citizens within our West Virginia communities.**

WV_FC2019_MyWhy_Wessels_COB_02

Identifying Members with Special Healthcare Needs (CM042)

We will identify members with special needs from the CSHCN indicator on the 834 enrollment file and immediately assign these members to Complex care coordination with an RN Care Coordinator trained to work with children and youth with special health care needs. The Care Coordinator will work with the CSHCN program's care coordinators to avoid duplication of care and services. We will also refer members to the program when appropriate.

We work closely with the CSHCN Program in the Office of Maternal, Child and Family Health (OMCFH) and have identified and referred 62 additional members to the agency in 2019. We will build on this relationship to support children and youth with special needs enrolled in Specialized Managed Care.

WV_FC2019_CM042_OMCFH_13_COB_02

We will identify members with special needs for referral to the CSHCN program — from review of the results of the HRS, HRA, available clinical and claims information, our risk stratification process, and as identified by the Department caseworker and multidisciplinary treatment team (MDT).

Our HRA and supplemental assessment tools are provided as Supplemental Document E.2-2. Members with special needs include:

- Members stratified as having complex needs
- Members with disabilities or developmental delays
- Members with emerging risks

As paid claims history becomes available, the Care Coordinator will review the member's risk score monthly and identify indicators of service over- and under-utilization to continually identify those with special needs. On a continuing basis, Care Coordinators will outreach to these members to identify why they may have gaps in care or high service use and identify solutions, including needed services or engagement in special programs, such as Fostering Independence, described previously (CM029). We also accept referrals of members who may have special needs from any source.

Screening and Assessment for Members with Behavioral Health Needs (CM043)

Our information gathering, screening, and assessment process is designed to identify the child's total needs, including BH needs and existing services and supports. Both the HRS and HRA include questions designed to identify a member's total PH, BH, and social support needs. Please refer to Supplemental Document E.2-3 for our BH-specific assessments.

Because those in the child welfare system may be transient or have had a recent change in placement, the Care Coordinator's conversation with the caregiver (foster family, kinship caregiver, or Authorized Representative) and Department caseworker is key to making sure we have identified all of the child's BH needs and prior services. Screenings and assessments include:

- **The HRS.** Includes questions designed to identify BH diagnoses or indicators of BH needs (such as questions about the child's mood and functioning) that trigger completion of the HRA.
- **The HRA.** Supports further identification of BH needs, including the child's BH status, cognitive functions (for example: ability to communicate, understand instructions, and process information), mental health conditions, and substance use disorders (for example, alcohol and recreational drug use). It includes branching logic that directs the Care Coordinator to additional assessment tools, such as our pediatric BH assessment, to obtain more in-depth information when indicated.
- **Initial state-required screenings.** Includes the child's or youth's initial state PH screening; the medical, dental, and vision exams; as well as the child's mental health screening.
- **Other available screenings and assessments completed as part of the Comprehensive Assessment and Planning System.** If we identify a child or youth whom we believe would benefit from an additional BH assessment, such as the West Virginia CANs, the Care Coordinator will collaborate with the member's Department caseworker and seek concurrence from the MDT for referral to a West Virginia Comprehensive Assessment and Planning System provider. We will facilitate completion of the assessment, identify qualified providers, authorize the applicable SNS, and complete a referral for services, assisting with transportation when needed, and providing the results of the assessment to the MDT.

Following assessment and identification, the Care Coordinator will determine the child's specific BH service needs through the care planning process with input from ICT/ICM team participants, including the child, caregiver, Department caseworker, PCP, specialists, other existing service providers, and other key stakeholders. The Care Coordinator will help the child and caregiver identify personal goals and desired outcomes, specific service needs and preferences, and available resources to meet these needs, including covered services, available fee-for-service benefits, and resources funded by other agencies and programs, as well as community resources.



The Care Coordinator will also assess and review the caregiver's needs to promote placement stability and help make sure the caregiver can meet the child's BH needs in the home environment. By working closely with the Department caseworker, they will help caregiver's access SNS and community supports, including family training and respite.

Care Coordinators will complete reassessments as scheduled based on the child's care coordination level and when needed, for example:

- Following a change in the child's needs, placement, or level of care
- From review of indicators of increasing risk or potential unmet needs, including gaps in care data, calls to the BH crisis line, or internal and external referrals
- Upon request from the child, caregiver, Department caseworker, or court

Care Coordinators will proactively identify changes in members' BH needs through ongoing discussions with members, families, caregivers, and Department caseworkers; during the care planning process; through review of the member's data maintained in Health Insight; and through periodic, scheduled, and as-need reassessment when indicated. For a detailed description of the care planning process, please refer to CM001, CM004, CM014, CM023, CM024, and CM030 for our full detail on ISP and Care Plan Collaboration.

Identifying and Tracking Members with High Physical or Behavioral Health Needs (CM017, CM022)

UniCare's Fostering Healthy Lives model relies on stratification and information sharing to assure members receive the right level of services and appropriate support. ***Members with high PH or BH needs, one or more chronic conditions, or who are CSHCN will be identified through our comprehensive process (described previously in CM001), assigned to the Intermediate or Complex care coordination level, and have an ICM team.***

Since our staff will have experience in a wide variety of specialties, members engaged with the ICM team will be matched with a Care Coordinator with specialized skills, such as pediatric nursing, BH clinical licensure, or specialization in SUD. The ICM team will work closely with UniCare's team of subject matter experts, available to Care Coordinators upon request, to address members' unique needs. In addition, we hold daily PH and BH support rounds and brainstorm ways to meet the needs of members with complex or especially challenging needs through weekly interdisciplinary rounds.

At a minimum, Care Coordinators will make contact in-person and by phone at least twice monthly with members stratified as Complex, and monthly for those stratified as Intermediate. In addition, we will require that Care Coordinators:

- Complete the HRA every six months (Complex level) and when a member experiences a significant change in health, level of care, or setting
- Complete the HRS annually (Connected or Intermediate levels) and when a member experiences a significant change in health, level of care, or setting
- Review and update the member's Care Plan every 30 days (Complex level), six months (Intermediate level), when a member experiences a significant change in health, level of care, or setting, and annually for children stratified as Connected

Care Coordinators will also contact members and caregivers whenever their needs change significantly, based on monitoring of claims data, review of the monthly risk level from predictive modeling, notification of admissions, changes in placement, ER visits, or when the child's placement is at risk (as communicated by the caregiver or Department caseworker), and when the member needs crisis stabilization.

Episodic and Catastrophic Care Coordination Interventions (CM058)

Our stratification approach considers management of a member's chronic conditions or illnesses and assigns all who need episodic or catastrophic care coordination interventions to the Intermediate or Complex care coordination level and an ICM team. These members are at the greatest risk because of the combination of PH and BH health conditions, multiple placements, frequent intensive service use, multi-agency involvement, and previous or current indications of non-adherence to treatment plans. This includes children with cancer diagnoses, who are technology dependent, have complex and comorbid conditions such as anorexia, or who are transitioning from an inpatient, PRTF, or other residential facility stay, who need intensive coordination of services and support, including frequent cross-system collaboration, to avoid a readmission or change in placement. Also included are children recovering from a traumatic injury, serious acute illness, or post-surgical complications. The child's level may change once the acute episode resolves and their health is stable.

The ICM team will focus their activities through close cross-system coordination and collaboration, with the Care Coordinator serving as the contact point to simplify health care management and make sure the member's health and social support needs are met. Interventions will also include targeted education to make sure caregivers are equipped and connected to the resources they

need to provide care to the member. As the child's or youth's needs change, we will adjust the intensity of services and provide immediate and frequent communication to the Department caseworker to help assess the impact on the goals previously outlined in the ISP. We will also participate in the MDT as requested by the Department caseworker.

Figure E.2-6. Interdisciplinary Teams Support Care Planning



Specialized Programs

One of our strengths is development of evidence-based programs for members who are high risk through the combined resources of our local and national subject matter experts. For example, Anthem's Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS) program is an episodic care coordination program that incorporates evidence-based approaches that seek to avoid child welfare engagement through early identification and resolution of the mother's and baby's needs. It includes:

- Advanced analytics and predictive modeling
- Peer support for the mom and Intensive Care Management, including facility and home-based in-person visits for six months post-delivery
- An OB Practice Consultant who conducts outreach to high-volume family practice, obstetrics, and pediatric providers
- A primary care toolkit that incorporates screening, brief intervention, and referral to treatment (SBIRT), and prevention and care of NAS and NOWS

ISP and Care Plan Collaboration

Care Planning

UniCare will develop a Care Plan for each child within 30 calendar days of enrollment. Using the results of all assessments and screenings, the assigned Care Coordinator will work with the member, caregiver, and other interdisciplinary team participants to develop the Care Plan. The Care Plan will be comprehensive, individualized, and include covered Medicaid services, SNS, Children with Serious Emotional Disorder Waiver (CSEDW) services (when they become part of the program), and community-based supports to meet the child's PH, BH, dental, and SDOH needs. Through the person-centered care planning process, we will help children and caregivers identify goals that are a priority for them, as well as those important for the child's overall health and well-being. The Care Plan will also support the goals of the child's ISP, FSP, other Care Plans, such as Individualized Education Plans (IEPs) as applicable, and providers' treatment plans.

Interdisciplinary Teams (CM030)

Each child will have an interdisciplinary team to support development of the Care Plan (as displayed in Figure E.2-6), including:

- An ICT for children stratified as Connected
- An ICM team for those stratified as having Intermediate or Complex care coordination needs

Stratification is determined from a review of all available information, including our predictive modeling risk score, and the Care Coordinator's clinical judgement. Please refer to CM027 and CM036 for a detailed description of the stratification process.

Interdisciplinary team participants will vary based on the child's needs, expanding to include additional providers and involved agencies for members with more complex needs. The Care Coordinator will engage:

- The child and caregiver
- The child's PCP
- The child's Department caseworker
- Other service providers, including SNS providers
- Other key stakeholders, including any of the member's natural supports, a court representative, or others as identified and requested by DHHR, the child, or caregiver
- The family of origin as appropriate
- UniCare subject matter experts, such as the health plan pharmacist, BH clinician, Dental Liaison, Social Services Director, SNS Liaison, Career Development Specialist, and other professionals with relevant expertise to assist with care planning

Members' Care Coordinators are the single point-of-contact for interdisciplinary team participants; they support the team with information gathering, organization, communication, information sharing, and make sure the team employs a person-centered, trauma-informed approach to care planning in alignment with evidence-based care.

The ICT/ICM team, led by the Care Coordinator in partnership with the child and caregiver, will work together to assure development of an appropriate Care Plan, which will be:

- Specific to the child's and caregiver's identified needs
- Strengths-based, person-centered, family-focused, and trauma-informed
- Developmentally appropriate
- Focused on promoting improved health and functional outcomes, as well as placement stability
- Comprehensive but also realistic — identifying priorities, short- and long-term goals, and strategies
- Inclusive of care coordination interventions that support the goals and priorities specified in the child's ISP; FSP; Department case plan; other care, service, and treatment plans; and court orders

Care Plan Development (CM014)

The Care Coordinator will lead development of the Care Plan using the results of the HRS, HRA, and other available screening and assessment information to guide discussion, with a focus on identifying the member's strengths, goals, and preferences. The Care Coordinator will help the child and caregiver develop a Care Plan that documents the combination of health plan benefits, fee-for-service benefits, services and supports from other programs, and community resources that combine to meet the member's PH, BH, dental, and social support needs. To make sure services are closely coordinated, the Care Coordinator will participate in MDT meetings as requested by the Department caseworker or court system and adjust the Care Plan accordingly.

Safety and Crisis Plans

The Care Plan may also include a safety and crisis plan designed to make sure the caregiver and member know whom to contact if they have urgent needs or the child exhibits self-harming,

aggressive, or other behavior that requires rapid intervention. The crisis and safety plan identifies resources, including our BH hotline, available to the caregiver and member to help meet urgent or crisis needs. For example, when a caregiver or youth contacts the BH hotline, they will reach a representative trained in recognizing members in crisis who will screen and triage their needs. Members will be warm transferred to a BH clinician when appropriate or to their assigned Care Coordinator for follow-up.

Engaging Children and Caregivers in Care Planning

Using motivational interviewing, Care Coordinators will engage members and families to determine their desire for change, and encourage them to identify strengths and needs from their own perspectives. They promote a family-driven, youth-guided Care Plan that supports the caregiver's primary decision-making role for the child or youth. In addition, a child's or youth's concerns and choices are essential in helping craft an effective Care Plan. Consistent with Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines, we promote a youth's active involvement in the care planning process, giving them a decision-making role appropriate to their age, and providing support and education to help them identify their desired outcomes. The Care Coordinator will work to engage the caregiver and member at whatever level they are able to participate.

Care Coordinators will use a strengths-based approach, engaging in a discussion of the member's and caregiver's strengths, abilities, hopes, and aspirations for the future, rather than their circumstances and diagnosis. Our fully integrated model takes every aspect of a member's life into account, including unmet SDOH needs, service and support needs, and preferences. The Care Coordinator, with the caregiver and child, will lead a review of the member's ISP or other care or service plans and providers' treatment plans, identifying, with input from interdisciplinary team participants, the services that support but do not duplicate these plans.

The Care Coordinator will then document the member's and caregiver's strengths, needs, goals, and preferences, and the services and supports, providers, community resources, and natural supports that will meet the identified needs.

Care Plan Updates

The Care Plan is a living document; the Care Coordinator will review and update it regularly and when the member and caregiver experiences a significant change in needs. At a minimum, they will review and update the Care Plan:

- Every 30 days, for children stratified as Complex
- Every six months, for children stratified as Intermediate
- Annually, for children stratified as Connected

Reassessments and updates to the Care Plan will be coordinated with ICT/ICM team participants and made available to the member and caregiver, PCP, other providers, the Department caseworker, and others involved in the child's care.

Intensive Care Management (CM023 and CM024)

Children stratified as needing Intermediate or Complex care coordination will be matched with a Care Coordinator with specialized skills applicable to the child's needs, (such as an experienced pediatric nurse or BH specialist), and engaged in an ICM team. The Care Coordinator, in collaboration with the member's PCP and Department caseworker, will offer the appropriate level of support to the child and caregiver based on their identified needs, providing more intensive support and specialized resources and programs for children with the most complex needs. The ICM team participants will expand as needed to support cross-system, agency, and provider coordination. For example, for children or youth in a PRTF, the PRTF provider, in

addition to the child, caregiver, PCP, and Department caseworker, will be a key member of the ICM team. The ICM team will be convened at a minimum every six months, when the member's needs change, or upon request of the Department caseworker or court system.

The Care Coordinator will participate in the MDT as requested by the Department caseworker or court system. For example, for members at risk of out-of-state placement, the Care Coordinator will be available to the MDT and Regional Clinical Coordinator from the System of Care Regional Clinical Review Team to assist with service authorization and coordination care.

Care Management Resources for Members with Intensive Needs

The ICM team will have access to UniCare subject matter experts, described previously in this section, to address members' unique needs. In addition, Care Coordinators will solicit feedback and expertise through our interdisciplinary rounds. We currently hold daily PH and BH planning meetings and weekly rounds with subject matter experts from a variety of disciplines, including PH and BH Medical Directors, UM Clinicians, and psychiatrists, and will use this approach for the Specialized Managed Care for Children and Youth Program (the Program). We will bring additional dedicated positions to this process, including a Pharmacist, Social Services Director, and SNS Liaison. During these meetings, we will work together to resolve challenging coordination of care issues and break down barriers to care. We brainstorm ways to intervene most effectively with members with high-risk PH, BH, and SUD conditions, and complex, multi-agency involvement.

Ongoing Contact and Updates


Reassessment

Because members engaged in the ICM team have more intensive needs, the Care Coordinator will contact the member and family frequently and as needed. We require Care Coordinators to make contact in-person and by phone at least twice monthly for members stratified as Complex and monthly for members stratified as Intermediate. In addition, we require Care Coordinators to:

- Complete the HRA every six months (Complex level) and when a member experiences a significant change in health, level of care, or setting
- Complete the HRS annually (Intermediate level) and when a member experiences a significant change in health, level of care, or setting
- Review and update the member's Care Plan every 30 days (Complex level) or six months (Intermediate level), when a member experiences a significant change in health, level of care, or setting, and annually for children stratified as Connected

Care Coordinators will also conduct in-person visits, reassessments, and Care Plan updates as requested by the Department caseworker or the court, and as needed by request from the caregiver or member.

Coordinating the Care Plan with the Individualized Service Plan (CM004)

The overarching goals of safety, permanency, and well-being result from members' progress in meeting their individual goals. Care Coordinators will proactively share members' screenings, assessments, Care Plans, and Care Plan updates with the Department caseworkers and other key system partners, including to child-placing agencies, West Virginia Supreme Court Division of Children/Juvenile Services, West Virginia Judiciary, and the Department of Education with appropriate authorizations, to support coordinated planning.

Within one business day of the child's enrollment notification, our Concierge Representatives will contact the child's Department caseworker to request the member's ISP so the Care Coordinator may incorporate ISP goals into the Care Plan. They will also request copies of other applicable Care Plans such as the FSP, Department case plan, and IEP. We additionally

propose developing an electronic interface that would enable our Care Coordinators and UM Clinicians access to information in the ISP. This will streamline data sharing processes while simultaneously reducing the administrative burden on the Department caseworker. Should an occasion arise where we do not have access to this information, we will work with the Department caseworker to confirm that the Care Plan aligns to ISP goals.

During each contact with the child and caregiver, the Care Coordinator will review the child's progress toward their identified goals, including goals in support of the ISP. Care Coordinators will provide updates on the child's progress and any changes in needs during MDT meetings in-person or via a teleconference with the child's Department caseworker, or by secure email. We will also measure a child's progress towards ISP goal attainment in the previous quarter and on an ongoing basis to identify opportunities to contribute to attainment through adjustments to the Care Plan and through care coordination activities.

We will make member information available to Department caseworkers and other authorized users through the YouthRAP portal. This will provide Department caseworkers as-needed access to the most up-to-date assessment, care planning, and service information for their assigned members.

Coordinating Continuity of Care with an Integrated Care Plan (CM001)

The member's Care Plan will support and integrate the ISP developed by the MDT, FSP, and DHHR case plan, and align them with providers' treatment plans gathered by the Concierge Representatives during intake and initial information gathering. In addition, the Care Coordinator will review all other available information, including available claims and service authorization information, as well as the results of the HRS and HRA, to support development of a fully integrated Care Plan. Our SNS Liaison will assist the Care Coordinator with gathering information and coordinating continuity of care with existing SNS providers.

We will also implement special programs with procedures for continuity of care during transition of care, including:

- Transitions across settings and levels of care through our Discharge Planning and Transitional Care Management program, described in CM011 through 013
- The member's transition to adulthood and independence, through our Fostering Independence model described in CM029
- Placement changes described in CM015 and CM016

The member's Care Coordinator will support continuity of care and reduce fragmentation through cross-system outreach and interactions with various components of the system as needed, such as the Department caseworker, child's school, health care and SNS providers, the court system, and local child welfare agencies, updating the Care Plan as needed.

Sharing Care Plans with Providers (CM055, CM056)

The Care Coordinator will support the PCP's role as an essential interdisciplinary team participant, providing a copy of the member's Care Plan following development and at a minimum annually. In addition, when the member has a significant change in needs or change in placement or level of care, the Care Coordinator will notify the PCP by phone or email, depending on the child's needs and circumstances, and provide the updated Care Plan upon completion.



Care Plans will also be shared with other providers as applicable to support coordinated service delivery, including following ICT/ICM team participation and completion or revision; when the provider begins providing services to the member, if not already provided; and when the child's needs change and the change directly impacts the

providers' services. PCPs and other authorized providers and users may also access the member's current Care Plan on-demand through the provider portal.

Principal Coordinating Physician Care Planning Training (CM003)

Our approach to training PCPs and specialists serving as a principal coordinating physician promotes holistic, person-centered, and trauma-informed care for members and their families and caregivers. All network providers will have access to expert-developed, clinically appropriate, population-specific, and culturally competent education that focuses on our overall family-centered model. Our subject matter experts will educate providers about the contents of an integrated Care Plan, how it will be developed and shared across the ICT/ICM team, how it will be monitored, and what to do if a change is needed. We will include this information in our provider education and materials describing the coordination process and the responsibilities of the principal coordinating physician.

Targeted Training

Training will be available to all new PCPs upon enrollment and to specialists functioning as the principal coordinating physician. We will identify these providers from our provider assignment file and identification by our Concierge Representatives and Care Coordinators, who will confirm who the member's principal coordinating physician is during the initial member outreach and engagement process. As part of the care coordination process, Care Coordinators will orient office staff to the Care Plan development and information sharing process. If the staff indicate the provider would like a personalized training session, this will be coordinated with a Network Relations Consultant.

Ongoing Assistance

To help providers carry out this role, Care Coordinators will proactively seek input from them during development of the integrated Care Plan through conference calls, secure email exchange, and inclusion of information from provided treatment plans. They will incorporate the provider's assessments and treatment plan into the member's record, reviewing this with the child and family, and include related health care goals and interventions in the integrated Care Plan. The provider may view the Care Plan in Health Insight and will also have this capability through YouthRAP, if authorized, and we will email or fax initial and revised Care Plans to the principal coordinating physician, making a copy available to the child and caregiver as requested.

Assigning Members to an Appropriate Health Care Professional (CM038)

We recognize the critical importance of making sure every child has a medical home consistent with guidance from the American Academy of Pediatrics. The fact that those in child welfare often have complex health care issues is well documented, and includes the presence of chronic PH and BH problems and dental care issues, compounded by the children's exposure to trauma and their often sporadic and fragmented care. Given the complex health issues faced by this population and the multiple stakeholders involved, it is critical that their care be integrated and well-coordinated. ***We promote this coordination through the combination of the children's medical home (PCP) and Care Coordinator working together to make sure they receive needed health care services.*** The Care Coordinator will help coordinate all of the child's health care services, and provide needed assistance to help the PCP make referrals for medically necessary specialty, secondary, and tertiary care, including BH and SNS services. Care Coordinators will also educate children and caregivers on emergency care, non-covered services, and use of out-of-network providers, and coordinate and facilitate access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

To make sure providers have the information and resources needed to carry out their responsibilities, we will deliver training on critical issues and care delivery approaches for this

population. These include the roles and responsibilities of the Department caseworker, MDT, court, Care Coordinator, and ICT and ICM team participants, as well as training in trauma-informed care and (ACES). Attachment E.2 describes our provider training and education approach.

The provider manual for the Program will describe the PCP's roles and responsibilities, as well as the supporting role of the Care Coordinator. UniCare Network Relations Consultants will work with specialists choosing to assume this responsibility to make sure they understand exactly what is required. They will also be available to provide specialized training related to children and youth in the child welfare system when needed. ND032 through ND035 provide additional details about oversight of specialists serving as PCPs.

Identifying and Improving Providers' Coordination Activities (CM059)

Care Coordinators will have responsibility for confirming providers, including a specialist serving as a member's primary coordinating provider, render appropriate primary care services to the member on an ongoing basis. We will also offer providers opportunities for recognition as ACEs Provider Champions, Gold Star Providers, and Foster Care PCMHs. Provider recognition requires providers to demonstrate an understanding of their care coordination responsibilities and the importance of integrated care (described in PS013, PS015, and PS017).

Care Coordinators will identify providers who are not performing required coordination activities:

- During periodic discussion with the family and member concerning adequacy and satisfaction with providers and services
- From data analysis, including a review of gaps in care and under- and over-utilization data; UniCare's Quality team will provide specific data for review such as relevant HEDIS® measures, EPSDT visit data, and a list of children without a primary care visit in the preceding six months
- From review and analysis of complaints concerning a provider's availability or services rendered
- From review of provider profiling reports, described in QU038 through QU043
- From review of information obtained through the Stakeholder Advisory Group and the Parent and Caregiver Advisory Group

In addition, our Quality Management (QM) Practice Consultants may identify opportunities to improve a provider's coordination activities during chart audits. Once identified, the Care Coordinator works with our Network Relations Consultant to identify actions to improve the provider's coordination activities, beginning with education that includes a review of coordination responsibilities and resources available to support coordination, including care coordination and system resources. Providers with ongoing quality issues will be required to develop a written corrective action plan and to demonstrate compliance within a specified time frame. The provider may also be referred to our Medical Directors for peer consultation as needed. In addition, our Care Coordinators will advise the Community Engagement and Training team when they identify a need to reinforce this requirement so that this responsibility can be emphasized during provider training.

Identifying Members in Need of Treatment Plans (CM053, CM054)

We identify members in need of treatment plans through a review of information gathered during the intake, screening, assessment, care planning, and ongoing contact process described previously. The Care Coordinator will develop the member's Care Plan in consultation with the PCP and other providers and confirm that all treatment plans address all of the member's needs.

Care Coordinators will coordinate access to treating health care professionals for members with disabilities (or at risk of developing a disabling condition); chronic or complex PH and BH conditions, including CSHCN; and collaborating with the member's PCP to make sure the member has access to needed treatment, including specialty care. They will work collaboratively with the member's PCP, specialist(s), as well as ancillary and non-medical providers to make sure members have access to and appropriately utilize medically necessary and covered SNS, fee-for-service benefits such as NEMT, and other services and supports identified in the member's Care Plan. The Care Coordinator will also work closely with our UM Clinicians to complete determinations for requested services requiring UniCare authorization.

If Care Coordinators identify an unmet need or the need for a treatment plan from assessment, conversation with members, caregivers, or Department caseworkers, or by referral from the MDT or court order, they will work with the PCPs and providers of the needed services to coordinate access to care. They will support development of the treatment plans and align the members' Care Plans. They will also assist with needed authorizations and help the members or caregivers arrange services such as transportation to access the needed services or treatment.

To promote proactive care planning and treatment plan development, Care Coordinators, Network Relations Consultants, and the Community Engagement and Training team will collaborate to deliver education to health care professionals, including PCPs and specialists. Education will cover topics such as care coordination overview, covered and coordinated services, services available through or coordinated by BCF, continuity of care requirements, and quality of care.

We will continuously assess, plan, implement, monitor, coordinate, and evaluate members' Care Plans, which are developed in collaboration with their PCPs, specialists and other providers, members and caregivers, Department caseworkers, and in consultation with other key stakeholders. When Care Coordinators attend MDT meetings at the request of the Department caseworkers or court system, they will support collaboration by serving as the single point-of-contact for coordination of all covered benefits, and communication with and between members' providers. See Supplemental Document E.2-4 for an example of our treatment plan.

Qualifications and Training for Care Coordination Staff (CM047)

We designed our comprehensive staffing approach to support recruitment, hiring, and retention of a highly qualified, experienced, and trained care coordination teams who can successfully perform all required Contract functions and provide the best possible services to our members, providers, and DHHR.

Care Coordination Staff Qualifications

Our Care Coordinators will be licensed BH clinicians, social workers, and nurses, supported by Concierge Representatives, non-clinical staff trained to provide a range of supporting functions, including intake and information gathering and HRS completion. They will be supported by UM Clinicians who work closely with Care Coordinators when evaluating the need for services requiring UniCare authorization. We will require care coordination staff to have the following qualifications:

- **Social Workers.** A bachelor's degree in social work and at least two years of experience working with a social work agency or in child welfare (including lived experience)
- **Licensed BH Clinicians.** Current licensure as an LGSW, LCSW, LICSW, LPC or Clinical Psychologist, or a master's degree in social work, counseling, or a related BH field or nursing; the clinician must have at least three years of BH experience or combined equivalent education or experience

- **Nurses.** Actively licensed in West Virginia as an RN with experience in pediatrics, BH, or chronic condition management; a bachelor's degree in a health-related field, and at least three years of clinical experience or an equivalent combination of education and experience
- **Concierge Representatives.** A high-school education or GED and at least five years' experience supporting member services
- **UM Clinicians.** RNs, clinical Psychologists, or master's-level licensed clinicians with case management, dual diagnosis, and BH experience, including with individuals who have severe and persistent mental illness, serious emotional disturbance, and SUD

Care Coordination Staff Training

Our recruitment plan emphasizes hiring qualified, experienced, and local staff whenever possible, and leveraging local resources to train clinical staff so they are fully prepared to provide the best support and resources to members. From their first day and throughout their tenure with us, we support our staff, making sure they have the resources, tools, training, and assistance they need to successfully fulfill their roles. Ongoing training across the organization is integral to UniCare's success and foundational for improving outcomes for the children, youth, and families we serve. Our UniCare Training Academy (the Academy) will support all initial and ongoing training for staff.

Our clinical team represents the core of what we do. All clinical employees undergo a 90-day orientation and training period where they learn the basic functions of their jobs, and the policies and procedures that will govern the Program operations. We make sure they are well-versed in contract requirements and fully understand their roles and responsibilities.

We will draw on our extensive West Virginia experience, and leverage internal and external subject matter experts who have child welfare experience and expertise in such areas as trauma-informed care, ACEs, and evidence-based practices for this population as we develop the training plan. Employees will receive classroom training, job shadowing, and mentorship to foster opportunities for discussion and questions.

The center of our comprehensive curriculum is the system of care approach based upon full integration of physical, behavioral, functional, and social health. All of our clinical employees must master the requisite skills to oversee and coordinate care for members with co-occurring disorders. Training supports the intake, stratification, and Care Coordination team in the multidisciplinary development of an individual's Care Plan. It is the foundation for effective communication across the member's system of care. This initial training includes skills practice sessions throughout to reinforce the information taught. Figure E.2-7 summarizes initial training topics.

Beyond standard employee and job-specific training, our Fostering Healthy Lives staff will be required to engage in extensive training focused on specific program orientation topics, as well as topics related to the child welfare and juvenile justice systems and issues. We tailor staff training requirements to employees' roles. For instance, all staff will be required to take foundational courses on trauma-informed Care, but our Care Coordinators will receive more in-depth and expansive training on topics such as:

- Working with Parents Involved in the Child Welfare System
- Addressing Transition Issues for Young Foster Care Children
- Mental Health First Aid and Zero Suicide

From the Center on the Developing Child at Harvard University

- The Impact of Early Adversity on Children's Development
- InBrief: The Science of Resilience
- Persistent Fear and Anxiety Can Affect Young Children's Learning and Development

Additionally, our care coordination and member-facing teams will receive in-person training on Person Centered Thinking© by the Learning Community for Person Centered Practices. Several of our West Virginia health plan team members already received this training last year. Following classroom instruction and skills practice, trainees receive continual on-the-job training for at least the remainder of the 90-day training period from our clinical leadership team.

Figure E.2-7. Fostering Healthy Lives Clinical Staff Training Topics



Training specific to the child welfare system will occur at the beginning of the program and will include training in both BCF and BMS policies. This training will be provided during new employee on-boarding, and at periodic intervals as appropriate, but no less than annually. Following orientation, each Care Coordinator will receive monthly quality assurance audits and feedback on their performance and program compliance.

Plan for Hiring Care Coordination Staff

We anticipate hiring at least 59 Care Coordinators across the State, ideally at least three months prior to Contract implementation to provide sufficient time for extensive training. ***Our Fostering Healthy Lives person-centered methodology for assigning and maintaining optimal care coordination caseloads takes into account a number of case-mix factors to assure each member's health, safety, and permanency*** such as:

- Level of care coordination required
- Acuity and complexity of the population, including overlap among various populations; for example, a child in foster care who is also enrolled in the CSEDW, when these services are added
- Language and cultural preferences
- Geography and population distribution
- Contact frequency, and modalities
- Amount, scope, and duration of service needs
- Care Coordinator qualifications, experience, access to supportive staff, and proximity to the member

All members will be assigned a Care Coordinator with experience that best meets their needs and this relationship will be aligned throughout their time in the program. We recommend a case-mix methodology that uses a weighting system to assist in determining average Care Coordinator-to-member ratios, and look forward to working with DHHR to develop these upon award. Based on this methodology, our suggested ratio for our members in our highest level of care coordination, the Complex level, is one Care Coordinator per 50 members (1:50). Our proposed maximum caseload is 350, assuming that we will have a high volume of members that are stable and will be in our Connected level of care coordination. Our maximum caseload includes the expected levels of member engagement based on our experience in West Virginia and our affiliate experience serving members engaged with the child welfare system.

Care Coordination Approach to Establish Relationships with Members (CM048, CM049, and CM050)

Care Coordinators' primary responsibility is to connect with and develop trusting relationships with children and caregivers working collaboratively with the child's Department caseworker. They will collaborate to make sure children receive the most appropriate quality care that is holistic, trauma-responsive, and tailored to each child's strengths and needs. We will accomplish this through processes and procedures that are both standardized and adaptable. Effective relationships between Care Coordinators, children, youth, families, and caregivers are foundational to the values and guiding principles of the Fostering Healthy Lives model. Our model provides a single Care Coordinator who works with the child for as long as they remain enrolled, regardless of transitions in placement or changes in care coordination level. The relationship begins with the first outreach and continues, uninterrupted, until the child transitions out of the program, promoting development of a trusting relationship and continuity of care.



Ongoing Outreach and Engagement

Steps to Establishing a Relationship with the Member (CM048)

During the first telephonic outreach, Care Coordinators will introduce themselves, review the results of the HRS, and identify the member's and caregivers' immediate needs. They will also educate member and caregivers about care coordination services and contact frequency, and identify their preferred method of contact. Care Coordinators will use motivational interviewing techniques throughout the program to support and sustain member and caregiver engagement. Members and caregivers engaged in care become partners with their care teams, setting goals and finding solutions that best meet their individual needs and circumstances. After the initial contact, the Care Coordinator will mail a welcome letter that includes their contact information and alternative methods of contact, including teleconferencing and video calls.

Care Coordinator Contact Frequency (CM049 and CM050)

Our Care Coordinators understand and respect the challenges experienced by those in the child welfare system and their caregivers, including what can be an overwhelming number of contacts from agencies, providers, schools, and others involved in members' care. They will coordinate in-person contact with the Department caseworker to avoid overwhelming families, such as a joint visit, or visiting on alternate weeks. Care Coordinators will use their clinical judgement when determining contact method, frequency, and scheduling, guided by the child's assigned care coordination level, information compiled in the intake and assessment process, changes in status, and requests from the member or caregiver. ***Care coordination staff will also be able to use video technology, given member or caregiver choice, for ongoing care coordination contacts, supporting readily available and more personal access to the Care Coordinator.***

Table E.2-1 displays UniCare's standards for Care Coordinator contacts.

Table E.2-1. Standards for Contact with Members and Caregivers

Care Coordination Level	Contact Requirements
All levels	Ongoing contact as needed, including: • When child has identified care gaps, change in placement or level of care, ER visit, or new diagnosis • As recommended by the ICT/ICM team • As requested by Department caseworker or court
Complex	• At least two contacts a month, minimum one face-to-face contact • HRA completed with member and caregiver at least every six months • Care Plan reviewed and updated every 30 days
Intermediate	• At least monthly contact • Minimum quarterly face-to-face contact • HRS completed with member and caregiver annually • Care Plan reviewed and updated every six months
Connected	• At least an annual face-to-face contact • HRS completed with member and caregiver annually • Care Plan reviewed and updated annually

Other Outreach Triggers

Specific events will also trigger outreach to children and their caregivers. For example, a Care Coordinator will make an in-person visit to a child or youth while inpatient, in a PRTF, or other residential facility setting at least once for short-term stays, at least every 30 days for longer-term stays, and as requested. For a child in an out-of-state placement, we will visit or use appropriate technology, such as video-conferencing, if needed. Care Coordinators will also contact the caregiver and member by phone within 24 hours post-discharge for those with in-home services and durable medical equipment (DME), and two business days post-discharge for all other members, to confirm satisfactory transition and access to needed services and supports. The Care Coordinator may also make an in-person visit as needed and within 14 calendar days of discharge. Care Coordinators will contact the child and caregiver within 48 hours of an ER visit to identify any preventable events leading to the visit and develop a plan to avoid future visits that can be mitigated through access to additional services or supports. If needed, they will make an in-person visit to make sure they have a complete picture of the child's and caregiver's needs and the services and supports that can be put in place to improve stability.

Members Who Decline Care Coordination or Who Cannot Be Reached After Initial Contact

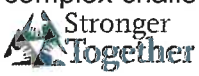
Our protocol for members who decline care coordination, or who we cannot reach after a Care Coordinator is assigned, respects member and caregiver choice, and recognizes effective care coordination is collaborative. If a member, caregiver, Authorized Representative (on behalf of the member) declines care coordination, we will offer to check in at set intervals (such as every six months) as an alternative to ongoing care coordination, then notify the child's Department caseworker, as applicable, and their PCP. The Care Coordinator will remain in contact with the child's PCP and help coordinate services through the PCP; and for children in foster care, with the Department caseworker and MDT. In addition, the Care Coordination team will monitor specific events, such as an ER visit or inpatient admission, or evidence of increasing risk such as rapidly increasing service use or gaps in care, and contact the child and caregiver to offer help related to the specific event or risk and any other needs.

If we cannot reach a child in foster care or their caregiver after Care Coordinator assignment, the Care Coordinator will contact the member's Department caseworker to obtain the member's most up-to-date contact information and initiate contact. If the member still cannot be reached, we will alert the Department caseworker and monitor claims data to identify a member's visits to new providers or their PCP, hospital, clinic, or other outpatient provider; obtain updated contact information; and coordinate follow-up in collaboration with the Department caseworker.

Some individuals may be especially difficult to locate and engage, including Adoption Assistance members and former foster care children who are not actively engaged with the child welfare system. Our Concierge Representatives will work collaboratively with providers and community partners who may have had recent contact with these individuals to try and locate them. If we learn a family or youth is experiencing homelessness, a member of the Care Coordination team will contact the local agencies and providers who typically deliver services to this population and may make in-person visits to shelters or housing sites when needed to locate and engage the member.

Coordination with Community Resources (CM060)

We know children and youth in the child welfare system and their caregivers face multiple and complex challenges, and have proven solutions to address and improve their health and well-being. Because we are an experienced West Virginia Medicaid MCO and hire from the local community, we have well-established relationships with community resources, social service agencies, and programs supporting effective service coordination and communications with members and caregivers. Our responses to CM026 and CS001 describe our extensive outreach to community partners, such as community and faith-based organizations, government agencies, and schools. We value these relationships and will work hard to continue to develop community collaborations, helping create the best possible outcomes for members and their caregivers. Our Community Engagement team and SSD will continue to grow our outreach, engagement, and community support initiatives, coordinating their efforts with the Care Coordination team to benefit both members and caregivers, and the communities where they live.



Coordination Procedures and Time Frames

The SSD will maintain and share information with Care Coordinators about available community resources and social services to support identification and timely referral to resources that promote placement stability, health education and self-management, and improved health outcomes. This information will help the Care Coordinator, member, and family identify beneficial resources and social services during development of the member's Care Plan with input from ICT/ICM team participants.

Resources and services identified in the Care Plan will be authorized or coordinated by the Care Coordinator through referral, removal of barriers to access (such as helping coordinate transportation), and member and caregiver education. Some members with special needs will require access to specialized community resources and social service programs, such as the OMCFH CSHCN program; Healthy Grandfamilies, and other programs described in CS001.

When we identify a community or agency resource that will benefit a member, we will complete a referral within 48 hours of identification or sooner when feasible, to promote timely access and document this in the Care Plan. The Care Coordinator will:

- Identify the contact person
- Contact this person by secure email or by phone to discuss the member's needs, specific services available, and timeline for access
- Share member information necessary to support the referral

- Upon agreement to serve the member, update the Care Plan and contact the member and caregiver to help them arrange the first contact with the community resource provider or social service agency
- Follow up with the member and caregiver to confirm service receipt and satisfaction with services
- Document all contacts in the member's record in Health Insight
- Provide updates to the Department caseworker and court as applicable
- Other activities may include:
  - When there are multiple resources available, provide information and help arrange a visit or appointment to promote member and caregiver choice
  - Assist with any needed paperwork to access the service or resource
  - Help arrange ancillary supports such as transportation
  - Consult with the SSD to identify additional resources when needed

Value-Added Services

UniCare will offer 22 VAS specifically for West Virginia's children, youth, and families engaged in the Program. We designed age-appropriate VAS to improve health and social outcomes. For example, our Jump Start learning curriculum engages members in individualized learning to support their transitions out of foster care. English- and Spanish-speaking members can access Jump Start any time for GED preparation, vocational education, or to search for jobs, advancing financial and health literacy without having to find transportation or child care.

Collaborative and Integrated Care Coordination

Our Fostering Healthy Lives model coordinates with all entities in the system of care, assisting in establishing and implementing services and meeting youth and family goals to help stabilize and strengthen families and promote permanency. We will coordinate continuity of care between health care providers, child welfare providers, BH providers, and Care Coordinators through a collaborative care planning process and development of an integrated Care Plan.

Ongoing Monitoring and Response to Changing Physical or Behavioral Health Needs (CM018)

We recognize that a member's health status is highly fluid and close monitoring, communication, and collaboration are essential to identifying changing needs. Care Coordinators will identify children's changing PH and BH health needs through scheduled and as-needed outreach and completion of key activities, including reassessment and ongoing review of available member-specific information. Our Health Insight Platform integrates Care Plans and claims data, enabling our Care Coordinators to receive continuous updates on claims activity and service authorizations. This includes:

- Inpatient census and ER reports
- Monthly risk stratification data
- Under- and over-utilization and gaps in care data

Care Coordinators will also work across systems and teams to obtain up-to-date information from a variety of sources, including the Department caseworker. They will review claims data, service authorizations and denials, call logs, newly completed screenings and assessments, updated Care Plans received from the Department caseworker, such as the ISP and FSP, and other information as it becomes available, to identify any items of concern.

To proactively identify children's changing needs, Care Coordinators will adhere to our schedule of minimum contacts and required activities, previously summarized in Table E.2-1.

Responding to Children's Changing Needs

Through review of all available information, the Care Coordinator, working with the PCP and other ICT/ICM team participants, may adjust the child's care coordination level, complete a reassessment, and update the Care Plan. Review may trigger member and caregiver outreach and follow-up, as well as engagement in specialized programs, such as our Psychotropic Pharmacy Care Program (described in CM005), or High-risk OB Case Management through our Taking Care of Baby and Me® Program (described in BA077 and BA078).

Care Coordinators will contact the caregiver and member, and as applicable the Department caseworkers, as they identify changes or potential issues from their reviews. Through discussion, troubleshooting, and planning, and in concert with the UM team, the Care Coordinator will make sure the child's Care Plan remains current and relevant. The assigned care coordination level and the Care Coordinator's activities are fluid; we constantly adapt to respond to changes in member's needs. Reassessments and Care Plan updates will be coordinated with, and made available to, the member and caregiver, PCP, treating providers, the Department caseworker, and other applicable system partners.

Information Sharing for Continuity of Care with Member and Caregiver(s) (CM002)

The success of our Fostering Healthy Lives model relies on the inclusion of the members and their caregivers in every aspect of care planning. Core components of this inclusion are education and information sharing that support continuity of care. Only through true inclusion of members and their caregivers will we realize our goal of connecting children to the right level of services and help both them and their caregivers receive the support they need to succeed. Our communication path will begin with proactive outreach and information sharing to members and their caregivers through calls and letters, reinforced through information included in the member handbook and welcome letter. In addition, we will educate Department caseworkers and providers about our policies and procedures to support ongoing continuity of care across the system of care and among providers.

Communication Methods

We will inform members and caregivers orally and in writing of the DHHR-approved process used to obtain authorization and claims data from the member's previous Medicaid provider. We will also inform members and providers that we will accept documentation of existing service authorizations from the member and caregiver, providers, placement agents, Department caseworkers, or any other third party to support continuity of care, incorporating this information into the member's record. Care Coordinators will educate the member and caregiver on accessing health information in the child's record through YouthRAP to support self-management and continuity of care. For example, caregivers will be able to view, as allowed by DHHR, Care Plans and authorized services and the date through which the service is authorized, as well as service notifications regarding services that should be scheduled or alerts for the child's or youth's identified care gaps. Caregivers and youth may also check on continued services through secure messaging with the Concierge Representatives and Care Coordinators, and they are encouraged to contact the Care Coordination team with any needs or questions regarding services for support and continuity of care. We will also provide information to support continuity of care when the member transitions to a new provider or transitions out of the program or our health plan.

Frequency of Communication with Members and Caregivers

We will share information about our continuity of care requirements and procedures with the member and caregiver when newly enrolled, annually, and as needed, providing information in the member handbook, online, and through the Care Coordinator. We will inform members and caregivers of continuity of care requirements specified in Section 6.4.1 of the Service Provider Agreement (SPA), and the Care Coordinator will assist members and caregivers as needed to make sure they have continued access to needed services.

The Care Coordinator monitors continuity of care, taking proactive action to make sure services continue uninterrupted, including during required service reauthorization. For example, at least 10 days prior to the expiration of an authorization for continuing services, the Care Coordinator will work with a UM Clinician to complete the review. Together they will consider any additional or new information the Care Coordinator identifies to support continuation, as well as alternatives that may be of benefit in supporting a child's transition to alternative services (especially transition from inpatient and residential services). If continuation is authorized and a qualified network provider is not available, or we determine it is in the member's best interest to continue access to an out-of-network provider, we will authorize the continued services following consultation with that provider. We will continue to reassess the member's need for services from an out-of-network provider every 90 days thereafter.

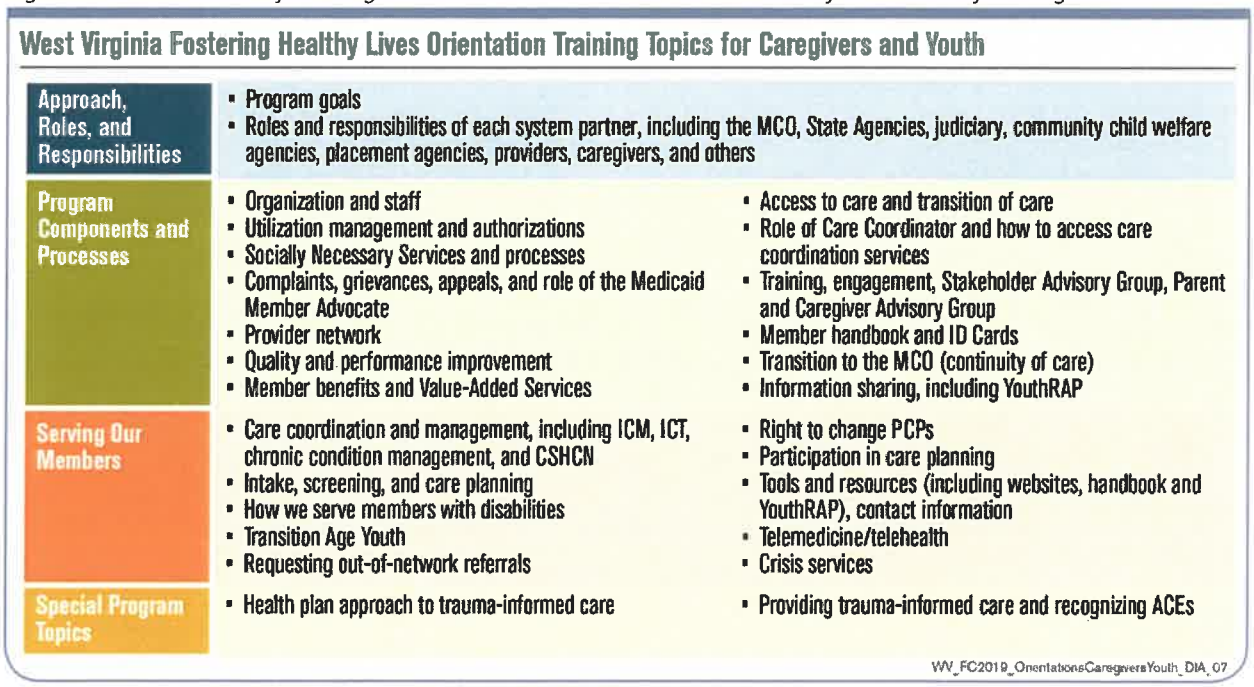
In the event a provider exits our network, we will provide written advance notice when possible to the member and caregiver, and the Care Coordinator will help identify and share information with a new provider to support continuity of care.

Targeted Education Programs (CM045)

We will implement targeted education programs that promote a comprehensive understanding of the Program, our Fostering Healthy Lives model, and our approach to member and caregiver health education. We will provide general program, health, and community resource information in the member handbook, on our website, and delivered through member blogs. ***We will also develop educational videos designed specifically for children with child welfare involvement and their caregivers,*** explaining covered benefits, how to access social supports, care coordination, medication management, and other health-related content that promotes self-management.

We will also offer ***targeted orientation programs*** that include program-specific materials and web-based training content for children, caregivers, and staff. Figure E.2-8 summarizes the training topics for caregivers and youth. Our response to CM047 describes staff training, including training topics. ***We will create training and education materials and webinars upon notification of award and staff will be trained 60 days prior to implementation.***

Figure E.2-8. Orientation for Caregivers and Youths Promotes Coordination of Care and Self-management



Care Coordinator-led Education

The member's assigned Care Coordinator will have a significant role in providing education to the member and the caregiver. This includes providing them with general health information related to chronic disease management, medications, choosing a provider, accessing health care services, as well as age-appropriate health topics (pregnancy, contraception, sexually transmitted infection screenings, and others.) Individualized education regarding a member's specific needs and Care Plan will also occur as part of the ongoing care coordination relationship. Care Coordinators will educate members and caregivers on a wide range of topics relevant to their needs and connect them to UniCare programs and community resources.

Care Coordinators will use ***our existing educational programs and materials*** designed for use with Medicaid-enrolled members and their families to support education, including:

- Teen long-acting reversible contraception (LARC) education for female teens who identify themselves as sexually active
- Our Taking Care of Baby and Me program for pregnant members
- Tobacco cessation for children indicating tobacco use
- Family planning services, including specialized approaches for youth receiving SUD services
- Asthma Medication Management Program, an education and outreach program for members with asthma and their families (BA085-87, BA041)
- NAS education programs for teen mothers with substance exposed infants or caregivers with foster children with NAS/NOWS

Overdose Lifeline Inc. supports Anthem's interest to provide services to the West Virginian Foster Care services. Our partnership with UniCare helps train educators and providers to facilitate a universal opioid misuse prevention educational program and a selective (for at-risk youth) evidence-based program for youth substance use prevention. We believe this project is important because of the real difference it can make in the lives of the children of West Virginia and help build the foundation as they move through their developmental years into adulthood.
— Justin Phillips, Executive Director Overdose Lifeline Inc.

Care Coordinators will also provide condition-specific education, offering individualized instruction and informative materials and tools to help members and their caregivers learn about condition management. They will leverage our disease management program's educational strategies and materials that address:

- Asthma
- Bipolar Disorder
- Coronary Artery Disease
- Congestive Heart Failure
- COPD
- Diabetes
- HIV/AIDS
- Hypertension
- Major Depressive Disorder
- Schizophrenia
- Substance Use Disorder

As a current MHT MCO, UniCare has developed relationships with community organizations and programs throughout the State that offer local opportunities for health education. Care Coordinators will connect members and caregivers to these resources in their communities, such as Healthy Grandfamilies education groups, Stepping Stones health and wellness program, university extension programs such as 4-H, WW® (formerly known as Weight Watchers®), and classes offered by local hospitals, health departments, and schools.



Our ***Fostering Independence model, described in CM029, provides targeted education to TAY*** about critical issues they face as they approach adulthood. The Care Coordinator supports and educates the youth about the transition from pediatric to adult providers, the coverage redetermination processes and how to continue coverage beyond age 18, guidance on how to communicate with providers about their medical needs.

Independent Self-directed Learning

UniCare is committed to caring for the mind, body, and spirit of our members and caregivers because being healthy is about more than just the body. Our VAS, described in Attachment E.8, include resources and tools for independent learning.

- For transition age youth, we offer the **Jump Start Program**, an online learning platform that engages members in individualized learning to support their transition out of foster care by providing a curriculum that focuses on a variety of topics. Members receive live one-on-one coaching to help determine next steps, such as obtaining a GED, attending trade school, or obtaining necessary certification. The program also offers exam preparation for various certifications and a personalized job search tool so members can find job openings in their area.
- Our **Online Well-being program** is a convenient tool that can be accessed via a computer, tablet, or mobile app that helps members manage stress anxiety, depression, substance use, chronic pain, sleep disruption, and other challenges. It includes a suite of self-help resources that incorporate cognitive behavioral therapy (CBT), motivational interviewing, positive psychology, and mindfulness.
- The **Toddler Development Kit** includes growth and development educational information and resources, as well as the First 100 Words board book, Oball toy, and a baby play mat. We also offer a Child Welfare and Kinship Care Toolkit that includes educational information for new caregivers.
- Our **Foster Care and Kinship Care Toolkits** for caregivers will contain informational resources, including how to access our web-based training modules, contact information for the Care Coordination and Concierge teams, and other educational materials.

Collaboration with the Department's Pharmacy Program to Improve Coordinated Care (CM005)

Evidence shows medication for BH conditions is overprescribed to children enrolled in Medicaid.[1] In addition, in September 2018, the U.S. Department of Health and Human Services, Office of the Inspector General, further reported that children and youth in foster care who are prescribed psychotropic medications were not receiving appropriate treatment planning or medication monitoring.[2] To help assure comprehensive, coordinated care, including pharmacy needs, and promote optimal health outcomes, we will work collaboratively through information exchange with the Department's pharmacy program, leveraging pharmacy data to inform and support member and caregiver education, provider consultations, and integrated care planning with all system partners. To support these activities, we will hire a Pharmacist who will work closely with the Department's pharmacy program staff, our Care Coordinators, Medical Directors, and, at the request of our clinical staff, with members' MDTs. Should pharmacy be carved-in in the future, we will augment this work with the full array of pharmacy management programs offered by IngenioRx, a fully owned subsidiary of our parent company Anthem, Inc. (Anthem). Our response to BA083 through BA087 describes these programs and capabilities in detail.

Sources and Use of Pharmacy Information

We will obtain pharmacy and prescription drug information for members provided by the DHHR's pharmacy program via the daily National Council for Prescriptions Drug Programs (NCPDP) ANSI-accredited file format. We will incorporate this into Health Insight and the data will become an integral component of member records. It will be readily available to the clinical team and network providers for ongoing reviews of a member's needs, changes in health status or treatment plans. Secondary sources of pharmacy and prescription information will include the HRS, HRA, member transition data, State required health assessments, and verbal reports from members, caregivers, Department caseworkers, and providers.

We will additionally use this pharmacy information to support BCF's overarching goal of safe, appropriate, and effective use of psychotropic medication through the development of programs, processes, and policies that align with American Academy of Child and Adolescent Psychiatry (AACAP) recommendations.

- Implementing education, engagement, and collaboration strategies to impact clinical practice by:
  - Providing trauma-informed and system of care principles to enhance provider understanding of root cause issues
  - Coordinating BH assessments and sharing them among the team to inform decisions prior to psychotropic prescription
  - Promoting active engagement with children and youth, their caregivers, and other professionals (internal and external to UniCare) in making medication decisions
  - Promoting and authorizing evidence-based psychosocial interventions in tandem with psychotropic medications
  - Enhancing awareness of potential adverse effects among members and their caregivers and monitoring for such side effects through ongoing care coordination

[1] U.S. Department of Health and Human Services, Office of the Inspector General. *Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns* (March 2015).

[2] U.S. Department of Health and Human Services, Office of the Inspector General. *Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication* (September 2018).

- Developing medication monitoring and oversight, collaborative care coordination, and planning by:
  - Providing initial and ongoing training to Care Coordinators and system partners, as appropriate, regarding relevant use of psychotropic medication to enhanced knowledge of non-physician staff working with children in the program
  - Collaborating with providers, DHHR, Department caseworkers, and child-placing agencies to monitor and review psychotropic utilization in MDTs as requested and through data sharing via our YouthRAP platform
  - Coordinating psychotropic medication monitoring and oversight efforts with DHHR, BCF, and other system partners to develop opportunities for improvement and additional collaboration
  - Increasing availability of relevant evidence-based psychosocial interventions by qualified staff through network development efforts

Medication Risk Assessment and Consultation

The Care Coordinator may complete a Medication Risk Assessment (MRA) to assess the level of medication complexity and risk to a member due to polypharmacy, medication errors, and high-risk medications, such as psychotropics, in consultation with subject matter experts such as the health plan Pharmacist, Medical Director, and BH Medical Director. The MRA will include a review of the total number of medications the member takes, complexity of medication regimens, frequent changes in medications, prescribed "high-risk" medications, cognitive or physical limitations impacting medication administration, and the caregiver's ability to assist with or administer medications as prescribed. Once completed, the tool provides a medication risk stratification of low, medium, or high based on an embedded algorithm.

Members at low to medium risk stratification will receive necessary education on medication risks from the Care Coordinator, who will refer the member to the prescribing physician. Members determined to have high medication risk will be evaluated by our pharmacist for a variety of issues, including drug-drug interactions, inappropriate medications, and untreated conditions. If there are pharmacy recommendations, the Pharmacist will engage with the Care Coordinator, providing a MRA Letter they can share with the member, caregiver, Department caseworker, or other members of the MDT as appropriate. If necessary and appropriate, we will also provide a copy of the letter to the prescriber. The Care Coordinator will review and monitor medications on an ongoing basis to assess the efficacy of these strategies in reducing medication risk and to identify additional supports, as needed.

Safe Prescribing Program

As part of our program, we will implement our Safe Prescribing Program, which includes a portfolio of prescriber-fax messaging regarding appropriate use and prescribing of psychotropic medications. This program includes 20 rules that will prompt messaging to the prescriber regarding antipsychotic prescribing practices. Members selected for inclusion will include those prescribed at least one antipsychotic medication with no blood glucose or lipid test in the past six months; those who filled an antipsychotic medication, but did not receive psychosocial care in the 90 days before or 30 days after filling that prescription; and children of a very young age prescribed psychotropic medications.

In 2018, 42% of providers serving children in foster care or child welfare across our affiliate plans in 13 markets and engaged in this program had a positive change in behavior: they discontinued inappropriate psychotropic medication in 38% of identified children under age six, and discontinued one or more of the multiple psychotropic medications for 57% of children.

The Pharmacist will analyze pharmacy data provided by DHHR loaded into Health Insight, identify providers and members for the interventions, and inform the Care Coordinator and member's ICT or ICM team of the interventions for inclusion in the member's Care Plan. Targeted providers will receive fax messages and the Care Coordinator will educate the member and caregiver about the program, including we identified the member and provider for inclusion, the program interventions, and impact to the member's medication regimen. Care Coordinators will consult with the pharmacist when the member or caregiver has questions about the program or concerns about the impact to the medication regimen and will coordinate authorization of needed psychosocial services to promote more effective treatment.

Primary Care and Oral Health Coordination (CM034)

The Care Coordinator plays a pivotal role in supporting coordination of primary care and dental care. They will promote and coordinate preventive dental care and encourage members and caregivers to select a consistent dental provider. They will also serve as the liaison between providers, helping identify the member's unmet dental needs, including preventive dental care needs, through screening, assessment, and discussion with the member and caregiver. Care Coordinators will be supported by the UniCare Dental Liaison — a dental hygienist, who will be available to assist in identifying individual dental needs and coordinating with SKYGEN USA, LLC (SKYGEN) to assist in locating appropriate dental providers as needed. Care Coordinators document these needs in the member's Care Plan and help coordinate access to needed services, sharing the member's Care Plan with the PCP and dental provider.

To support the Care Coordinator, we will provide them with monthly lists of members due for dental screenings, with upcoming appointments, or who have missed appointments. Care Coordinators will also receive a weekly electronic feed of routine or scheduled follow-up care from SKYGEN. Based on this information, members or caregivers will receive reminders of upcoming dental visits through several methods, including telephone, email, and text messages 48 hours in advance of the appointment from the Care Coordinator. Care Coordinators will:

- Identify new members' continuity of care needs and coordinate dental screenings
- Assist members and their caregivers in selecting dental providers, scheduling regular visits and follow-ups, and with transportation arrangements
- Coordinate access to medical services needed for dental management, including anesthesia, outpatient surgical care, and emergency dental services, as necessary
- Coordinate screening for babies on an established schedule
- Complete telephonic screening about initial and regular check-up
- Reinforce messages about the importance of regular dental check-up by PCPs and dentists during discussion with the member and caregiver
- Make new caregivers aware of the ongoing preventive dental care schedules and a member's dental needs during any change in placement

The Care Coordinator will help make sure up-to-date medical and dental records and history are incorporated into the member's record in Health Insight, which provides on-demand access for PCPs and dental providers. Members, caregivers, Department caseworkers, and other authorized users will be able to access this information through role-based access to YouthRAP.

Care Coordinator Monitoring and Oversight

UniCare understands the critical importance of making sure our Care Coordinators establish effective and supportive relationships with children and their caregivers and demonstrate competency in all aspects of their performance. We will leverage our quality oversight and improvement infrastructure and resources to help make sure Care Coordinators complete

essential care coordination activities and employ a trauma-informed approach that is sensitive to children's unique needs and experiences. We have designed our approach to enhance the child's quality of care though comprehensive care coordination and an integrated Care Plan that reduces fragmentation, promotes family-centered care and placement stability, and leads to improved health and social outcomes for children and their families.

UniCare has extensive experience developing, implementing, evaluating, and reporting an array of quality measures, including those measuring care management performance and satisfaction. We assess case managers' performance of key activities, such as notification to the PCP of a member's engagement in complex care management. In 2018, case managers notified the PCP 98.9% of the time for members with a primary PH diagnosis and 100% of the time for members with a primary BH diagnosis.

Our Georgia affiliate's adoption assistance members have high rates of satisfaction with Care Coordination:
- **94% were satisfied overall**
- **91% were likely to recommend the program to others**

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UniCare's quarterly complex care management survey evaluates members' satisfaction with our current case managers. ***Ninety percent or more of surveyed members consistently express satisfaction with our case managers across multiple measures.***

For calendar year 2018:
- 93% were satisfied with their case managers
- 98% agreed their case manager treated them with courtesy and respect
- 92% agreed their case manager helped meet their needs and helped make their lives better
- 94% agreed case managers provided timely assistance in meeting their needs
- 96% agreed case managers knew about their health care needs, provided information about resources and services they could use, and helped them get the care they needed

Approach to Quality Oversight (CM037, CM051, CM052, CM057)

Our quality oversight process assures Care Coordinators have experience, qualifications, training, and resources to meet internal and State-defined quality goals. We daily track Care Coordinator performance and gather monthly, quarterly, and annual data on key performance measures, generating statistical analyses to drive care coordination enhancements.

Care Management Oversight

We establish goals annually for our Care Management department and for each Care Coordinator that support completion of required activities and adherence to established timeframes. Monitoring is supported by Health Insight, through key indicators, alerts, and manager level dashboards that provide an easy-to-review summary of activities and milestones for ongoing tracking. We proactively track performance through alerts in Health Insight, which we require case managers and supervisors to review daily to make sure they meet required or internally defined timelines, and through ongoing oversight by the supervisor. We also use audit results to identify the need for individual training and feedback, resolve identified issues, and conduct necessary performance management. We may also identify broader, systemic issues that require re-training or process changes. We will use these methods to monitor and address Care Coordinators' performance.

Collecting Statistics and Tracking Performance

We will establish key performance indicators for Care Coordinators based on contract requirements and internally defined quality benchmarks and assess Care Coordinator performance against these indicators. Each indicator includes a measurable standard, monitoring frequency, information gathering procedure to support monitoring, a method of

evaluation, and expected compliance rate (which is 95%). Table E.2-2 displays examples of our proposed measures, data sources, and monitoring frequency incorporating requirements CM037, CM051, CM052, and CM057.

Table E.2-2. Sample Care Coordination Performance Measures

Standard	Data Sources	Monitoring Frequency
Screening Timeliness for Care Coordination Stratification (CM037)		
Initial outreach within 48 hours of enrollment	Health Insight	Daily
Completion of HRS within 14 days of enrollment and annually	Health Insight	Daily
Care Coordinator assignment and member stratification within two business days of enrollment	Health Insight	Daily
Care Coordinators Relationships with Members (CM051, CM052)		
Satisfaction with Care Coordinator	Member Experience Survey	Annually
Engagement rate	Health Insight	Monthly
Number of completed outreach attempts by phone/in-person	Health Insight	Monthly
Care Plan Completion (CM057)		
Completion of initial Care Plan within 30 days of enrollment	Health Insight	Monthly
Update to Care Plan within five business days of a change in placement or level of care	Health Insight	Monthly

We will also develop measures to assess a child's progress towards ISP goal attainment in the previous quarter and on an ongoing basis to identify opportunities to contribute to attainment through adjustments to the Care Plan and through care coordination activities.

Care Coordination Member Experience Survey

One of the most important components of our Quality Improvement program is feedback from members to help UniCare support them in having a positive healthcare experience. Since all members will have an assigned Care Coordinator who will play such a critical role in coordinating services throughout the system of care, we will conduct a Care Coordination Member Experience Survey. UniCare will administer the survey at least annually, via a partnership between the Fostering Healthy Lives Clinical team and Quality team. The results of the surveys will provide us with detailed data on the more complex service needs and care experience for members and their caregivers.

We will survey children 18 years of age or older and, for children under 18, their caregiver or person representing the member who participates in care coordination on their behalf. We anticipate fielding the survey through a combination of phone and mailed surveys administered by an NCQA-certified survey subcontractor. In partnership with this subcontractor, we will work to maximize participation and achieve a representative sample each year.

We are also exploring the possible use of text messaging to field a short, five-question satisfaction survey. As part of our EPSDT outreach efforts, we currently partner with HealthCrowd to make automated IVR calls to alert members to needed visits and assist with appointment and transportation scheduling. More than 88% of UniCare's member phone numbers are mobile, supporting text communications for consistent member outreach success.

Person-centered and Trauma-informed Care (CM032, CM033)

UniCare's Fostering Healthy Lives model is founded on the principle of trauma-informed care and a shared understanding of the impact of trauma across the system of care. Trauma affects children's bodies, brains, and behavior. We are committed to identifying and building resiliency, reducing consequences of trauma and addressing the challenges that children face as a result of traumatic events to improve outcomes for the families we serve. Due to the potential impact

of trauma on the children and youth served through the Program, the core of the UniCare philosophy for members in child welfare is our commitment to reflect the concepts of trauma-informed care, ACEs, and trauma-responsive care throughout our training program.

We have organized our services and business processes to support these members, recognizing that due to exposure to ACEs, many members may have complex needs requiring a coordinated, thoughtful approach. As described more fully in Attachment C: Project Organization and Staffing Approach, our organizational structure for the Program will be based our integrated, trauma-informed, family-centered and person-centered approaches upon our West Virginia experience managing and coordinating care for children, youth, and individuals with complex care needs and our experience gained through our affiliates in other markets.

We will help connect the entire system of care across the many agencies, providers and community organizations involved in child welfare through well-trained, qualified, and fully dedicated staff who live in these same communities, fully understand the nuances of effective services and supports for children and youth, and bring stakeholders together to work collaboratively toward the same goals. We will employ staff with child welfare and juvenile justice experience, along with strong community ties, and we will offer them the specialized training necessary to appropriately serve the children and youth who will be our members in West Virginia.

Treatment Framework Supports Children Exposed to ACEs

Focusing on the goals of safety, permanency, and resiliency, we employ a trauma-informed approach to care coordination for our members in the Program. Our integrated and multifaceted care coordination model includes engaging and coordinating care with the caregiver, current providers and when appropriate, and the member's school. When a Program member is identified, we conduct a comprehensive screening to determine their level of care and immediate and current needs. Where indicated, we involve our UM staff to assess for medical necessity for any levels of care that require prior authorization. ***The Program is built to minimize disruptions and assure responsiveness, to provide needed consistency, reduce crises, and assist members when challenges occur.***

Strength-based Approach

Our Care Coordination team uses a strength-based approach when working with Program members and their caregivers. The team gathers multiple stakeholders, including BMS and BCF representatives, physical and BH providers, educational supports, family members as appropriate, the member and their caregivers to understand and assess the areas of greatest needs and to create a Care Plan and multiple supports that promote resiliency. This includes sharing the Care Plan and gaining input from all stakeholders and engaging the participants in meetings. On an ongoing basis, the team helps to foster an environment and relationships that provide consistency in the member's life.

Preparing Staff to Incorporate Trauma-informed Care and Promote Member and Caretaker Resiliency

Through the Academy, we support member and family resiliency by training and educating our Care Coordinators on:

- Trauma and ways in which members respond to ACEs, supporting members to access developmentally appropriate BH services and supports
- How to foster resilience by supporting, connecting with, and developing trusting relationships with our members and their families of origin, caregivers, and natural supports
- Encouragement of voice and choice in the decisions that affect members' lives

- Available and accessible effective, evidence-informed, community-based services and supports that can be individualized for members and their caregivers
- Person-centered, strengths-based care coordination in accordance with the unique needs of each member and their caregivers
- Cross-system collaboration with child agencies and programs, including traditional and nontraditional services, informal and natural supports
- Protecting the rights of members, families of origin, and caregivers and supporting the delivery of services and supports within the least restrictive environments

Appropriate Assessment that Limits Duplication and Member Trauma

Using established intake policies and procedures, the Care Coordination team will document communications with BCF staff, information collected, and assessments scheduled for the member. Good communication with DHHR and West Virginia Supreme Court Division of Children/Juvenile Services will prepare the Care Coordination team to develop a Care Plan based on assessment results. Collecting existing information can help us confirm appropriate screening and assessments without unnecessarily repeating assessments or re-traumatizing a child who has experienced potentially traumatic events or ACEs. Toward that end, we will continue to engage in partnerships with providers leading the way on trauma assessments.

Addressing life circumstances and ACEs works best when coordinated in a team approach, to identify interventions to address the member's needs and build resiliency. To achieve this, we gather data on the member's needs and adverse experiences from all available sources including BMS, BCF and Child Protective Services (CPS), child welfare agencies, and providers, and identify unmet needs.

Our Care Coordination team works closely with community-based organizations, public health departments, and resources to meet members' and families' specific needs. In working with our partners, we work to limit the number of staff in direct contact with Program members, in order to provide a consistent and clear connection to the Care Coordination team.

Care Guidelines for Youth Exposed to Trauma and Other ACEs



UniCare clinical practice guidelines educate providers about serving members with ACEs and using trauma-informed care. We are developing child welfare-specific guidelines and toolkits to support providers' ACEs responsiveness and trauma-informed care that is tied to the American Academy of Pediatrics (AAP) guidance on caring for children. We are also partnering with our ACEs Provider Champions who have shown expertise and leadership in ACEs and trauma-responsive care. Our level of care guidelines that support determinations of medical necessity are supplemented by products developed by organizations such as the AAP and American Psychiatric Association, including the best practices for ACEs and treatment. For example, the AAP has developed toolbox guides for trauma. Our trauma-informed care guide, the *Provider Specialist Guide to Assessing And Supporting Trauma-Informed Into Provider Practices* is based on the AAP principals of building a trauma-informed practice and is used by our Provider Collaboration Specialist to support all types of providers. This guide, along with UniCare's other clinical practice guidelines, are made available to clinicians through multiple channels. The ACEs toolkit includes:

- Definition of ACEs
- Background on ACEs study objective, goals, findings
- Information on the lasting impact of ACEs
- Assessment tools to identify ACEs and trauma

- Current research and efforts to impact ACEs and trauma
- Online links to additional resources, including Centers for Disease Prevention and Control ACEs resources, AAP ACEs and Toxic Stress, and the Resilience Project, and childwelfare.org ACEs portal

Training that Promotes Best Practices

To address the unique needs of our members, we will staff our Fostering Healthy Lives team with professionals who have extensive expertise recognizing and treating trauma in children, youth, and young adults. UniCare has sought out local and national experts to support and train staff, providers, and stakeholders to increase knowledge of emerging research and evidence-based approaches and practices. The Academy will provide trauma-informed education and information about the unique needs of our members in the child welfare program to all stakeholders involved in a member's care, including families, caregivers, providers, law enforcement, judges, advocates, and agency partners throughout West Virginia. The trainings will include education about the types of externalized responses to trauma that can lead to inaccurate diagnoses (such as ADHD, oppositional defiant disorder, and attachment disorder) and the misuse of medical resources (such as inappropriate prescribing of psychotropic medications). The Academy provides information and interventions that can prevent inappropriate or excessive use of medical resources.

Ongoing training focuses on engagement; outreach; promoting and providing information and training on system transformation and capacity building; PHM principles; evidence-based practices, including the appropriate utilization of psychotropic medications; crisis intervention services; the impact of ACEs; and other critical topics to improve the quality of services, as well as special provider programs such as the ACEs Provider Champions program.

Creating Cultures of Trauma-informed Care Toolkit

Our Creating Cultures of Trauma-informed Care (CCTIC) toolkit:

- Outlines evidence-based tools to assess specific needs and goals of a variety of practice types
- Gives guidance for best monitoring tools of implementation performance to understand continued training needs and barriers
- Supports the Provider's practice through the AAP trauma toolkit for PCPs

Using the CCTIC, the Child Welfare Provider Partner will work with a provider to assess trauma-informed care goals and develop a plan to best implement and support the practice. The Child Welfare Provider Partner will be focused on going beyond training to support Providers in assessing their ability to provide, and help them implement tools to improve their delivery of trauma-informed care. Once the provider implements trauma-informed practices, the Child Welfare Provider Partner will follow up with the practice to complete follow-up assessments to ensure optimal integration.

Table E.2-3 describes the contents of the CCTIC toolkit.

Table E.2-3. CCTIC Toolkit Elements

Creating Cultures of Trauma-informed Care Toolkit Includes:	
Performance Monitoring Tools	• Trauma-informed Care Performance Monitoring Tool • TICOMETER Assessment Tool
Comprehensive Assessment and Strategy Building Tools	• Risking Connections Training Program • The Sanctuary Model • Trauma-informed Organizational Capacity Scale

Creating Cultures of Trauma-informed Care Toolkit Includes:	
Self-assessment Tools	• Agency Self-assessment for Trauma-informed Care • Trauma-informed Care – Organizational Self-assessment Tool • Scale Attitudes Related to Trauma-informed Care
Training Modules	• National Traumatic Stress Network
Specialized Training/Assessment Modules	• Secondary Traumatic Stress Informed Organization Assessment • Professional Quality of Life Measure • National Center on Family Homelessness Toolkit

Trauma-informed certified providers, who hold a qualifying license such as a Trauma-Focused Cognitive Behavioral Therapist (TF-CBT) are identified in the UniCare system. Providers who have received training but are not certified are identified as trauma-responsive. Based on member need, we help members and caregivers connect with trauma-responsive and certified providers.

Recognizing Adverse Childhood Experiences Provider Champions

UniCare will recognize as ACEs Provider Champions the organizations throughout West Virginia that are already successfully addressing ACEs. To receive this recognition, organizations must currently deliver high quality, culturally sensitive care to our members and be ready and willing to serve as mentors for their peers by taking on projects that address disparities in care, further SDOH, and increase the resiliency of their communities. ACEs Provider Champions may receive grants from UniCare to help offset one-time startup or other costs to expand their project reach and member impact. ACEs Provider Champions will share their unique knowledge, experiences, recommendations for best practices, and lessons learned at regional summits and in UniCare Provider communications. These mentors are accessible for providers who seek informal guidance and insight into how best to care for their Medicaid patients.

For example, in North Carolina, our affiliate's health plan alliance recognizes Mountain Area Health Education Center for its success in incubating and organizing the Buncombe County ACE Learning Collaborative. The Collaborative has established a speaker's bureau and implemented trauma-informed curriculum in area schools.

Establishing Foster Care Patient-centered Medical Homes (CM006, CM007, CM008, CM009, CM010)

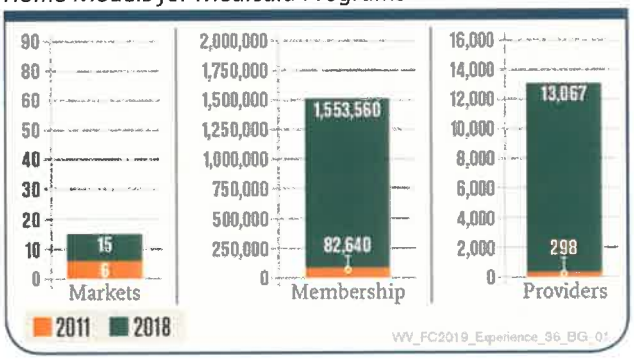
UniCare supports DHHR's efforts to assure West Virginia's children and youth are aligned with a medical home experienced in and knowledgeable of the unique needs of children and youth in the child welfare system. We believe the patient-centered medical home (PCMH) model will best assure our members receive care that is accessible, continuous, comprehensive, patient and family-centered, coordinated, compassionate, and culturally effective.

UniCare and our affiliates have long-supported the growth and expansion of PCMHs to promote delivery of services and follow-up care using evidence-based medical and clinical decision supports. We will leverage our own experience in West Virginia, along with the experience of our affiliates' PCMH programs as we design and develop a foster care-focused PCMH model for West Virginia.

As shown in Figure E.2-9, ***UniCare and our affiliates' support of PCMHs has increased more than 4,200% since 2011 — from 298 PCMH providers at inception of PCMH models to more than 13,060 PCMH providers today.*** Together, our PCMH support strategies have evolved from purely working with providers to help them achieve NCQA PCMH recognition, to our current focus on PHM and practice transformation to drive improvements in quality outcomes and better management of medical spend.

We believe NCQA-recognized PCMHs that are already practicing team-based care provide a solid foundation for our West Virginia Foster Care PCMH (FC-PCMH) program. ***In West Virginia, we have identified over 100 participating PCP practices that are already NCQA-recognized PCMHs, and 68 who currently participate in our Provider Quality Incentive Program (PQIP) alternative payment model (APM).*** We will also target PCMH practices that are Federally Qualified Health Centers (FQHCs) and have established relationships with West Virginia Comprehensive Behavioral Health Providers (COMPs) and Licensed Behavioral Health Centers (LBHCs) as potential candidates for our FC-PCMH program.

Figure E.2-9. UniCare Affiliate Patient-centered Medical Home Models for Medicaid Programs



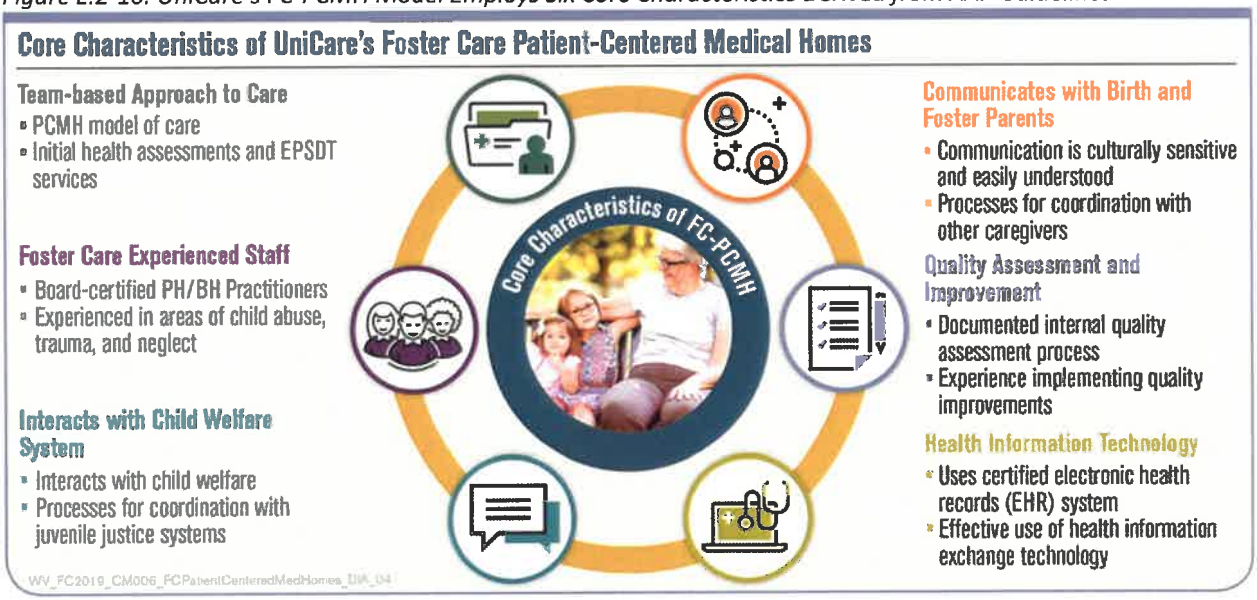
Establishing a Foster Care PCMH Model in West Virginia in Alignment with American Academy of Pediatrics Guidelines (CM006)

UniCare's FC-PCMH model will be based on AAP guidelines for children and youth in foster care and kinship care, and can help address health care disparities; improve population health; improve patient care experience, including quality and satisfaction; and reduce cost of care.

Core Characteristics of Our Foster Care PCMH Model

Figure E.2-10 provides an overview of the characteristics of our FC-PCMH model.

Figure E.2-10. UniCare's FC-PCMH Model Employs Six Core Characteristics Derived from AAP Guidelines



Our FC-PCMHs will be defined by the following ***core characteristics*** derived from AAP guidelines:

- Practices in accordance with PCMH principles using a team-based approach to delivery of comprehensive care, including initial assessments and EPSDT services
- Staffed by qualified physical and/or BH professionals that demonstrate an understanding of the impacts of ACEs and issues of child physical abuse, sexual abuse, neglect on children and youth in child welfare
- Demonstrated training, competence, experience, and expertise in evidence-based practices, including providing trauma-informed care
- Demonstrated understanding of processes for interaction with the child welfare and juvenile justice systems
- Demonstrated ability to effectively communicate with birth and foster parents
- Systems and infrastructure for quality assessment and improvement, and effective use of health information technology, including effective use of electronic health records (EHRs)

Our QM Practice Consultants will collaborate with our Patient Centered Care Consultants to lead the development of our FC-PCMH program. Our FC-PCMHs will be supported by our Care Coordinators. Additionally, our integrated care teams will be designed to complement our FC-PCMH and coordinate with state resources. Our FC-PCMHs will receive specialized training related to the child welfare system, trauma, abuse and neglect, and behavioral and psychiatric disorders so that they are well-prepared to address the increased intensity of encounters and complex conditions of our Fostering Healthy Lives members.

Provider Application Process and Implementation Strategy (CM007)

UniCare has begun development of our FC-PCMH program by incorporating the practice parameters and core characteristics defined by the AAP into the development of our FC-PCMH provider application. Our application will capture key information related to the prospective FC-PCMH's experience and capabilities to serve as FC-PCMH on key criteria identified by the AAP, including but not limited to:

- How the practice interacts with and communicates with child welfare personnel, birth, and foster parents
- The practice's processes for identification of and treatment related to child abuse and neglect
- The qualifications and specialized training and experience of the practice's primary care, BH and other professional providers in areas related to the needs of foster care members and treating CSHCN
- The practice's processes and procedures for complying with West Virginia foster care initial health assessments, EPSDT visits, and trauma assessments
- The practice's process for quality assessment and improvement and foster-care-specific quality indicators
- The practice's use of certified EHR systems
- The types of health education and wellness promotion the practice provides to staff, foster and birth parents, and foster children

Implementation Strategy

Our high-level implementation strategy is detailed in Figure E.2-11. We will begin implementation of our FC-PCMH program upon contract award, and expect to implement an initial FC-PCMH pilot program in West Virginia with at least one approved FC-PCMH provider in year two of the Program. Beginning upon award:

- We will publish and communicate information to providers about our FC-PCMH program and participation criteria
- Our QM Practice Consultants, in collaboration with our Patient Centered Care Consultants, will reach out to potential FC-PCMH providers (targeted PCMHs, PCPs, FQHCs, RHCs) to garner their interest and capability to becoming a FC-PCMH
- We will establish a FC-PCMH reimbursement model that incorporates value-based care mechanisms to address the specific needs of our children and youth enrollees in foster care and kinship care
- We will use our Medical Advisory Committee and Provider Advisory Group to evaluate prospective FC-PCMH provider applications and qualifications
- We will establish a FC-PCMH designation on our member and provider websites and provider directories
- We will review our FC-PCMH network at least annually to assess and develop reporting tools, and determine annual reporting requirements

Figure E.2-11. UniCare's High-level FC-PCMH Implementation Schedule

Implementation Step	Phased Timeline
Draft FC-PCMH Model criteria and application requirements	Prior to RFP Response Submission
Engage prospective FC-PCMHs and stakeholder advisory groups to obtain feedback on FC-PCMH model design	Beginning Upon Award through Program Year One
Finalize FC-PCMH program criteria, application requirements and obtain applicable State approvals	During Program Implementation through Program Year One
Inform and educate prospective FC-PCMH providers on program and application process	During Program Year One
Evaluate submitted applications against FC-PCMH program requirements and select qualified providers for initial FC-PCMH pilot	During Program Year One
Develop FC-PCMH member communication materials and member attribution criteria for FC-PCMH pilot	During Program Year One
Obtain applicable approvals and communicate availability of FC-PCMH pilot to eligible members and other stakeholders	Program Year Two
Implementation and ongoing monitoring and evaluation of FC-PCMH pilot program	Program Year Two
Expand FC-PCMH pilot program as new FC-PCMH providers and members	Program Year Two and Beyond

Supporting Our FC-PCMHs

Recognizing the additional time, resources, and expertise needed for a practice to serve as a FC-PCMH, we will develop a reimbursement structure aligned with our APM strategy (as described in QU001, Provider Incentives and Value-Based Payment Models) that will encourage providers to seek FC-PCMH designation.

Over time, we expect to grow our FC-PCMH program across the state. We will encourage additional West Virginia providers to apply for FC-PCMH designation, as well as NCQA recognition or Joint Commission PCMH certification. We will inform providers individually about the benefits of PCMH recognition and how we can help them achieve recognition, including our financial incentives. We will promote recognition using various communication channels and media, including fliers and postcards that clearly outline the benefits and support we offer, frequently asked questions, and how to contact us for more information. We will discuss the benefits of PCMHs at West Virginia Medicaid Fair presentations, PCMH/Health Information Technology Conferences, and meetings with local and national medical chapters. Our Provider website will include a link to NCQA's PCMH recognition website.

Our support available to prospective FC-PCMH practices will include:

- Working with them to evaluate FC-PCMH application questionnaire responses, determine their qualification and ability to serve as FC-PCMHs, and develop a transformation plan to move toward FC-PCMH recognition
- Orienting and delivering a suite of utilization, quality, and medical cost management reports specific to their UniCare members
- Providing regular interaction with UniCare's Medical Directors, who will be integral throughout the transformation process and on an as-needed basis when the provider needs additional assistance
- Synchronizing our care management activities with the practice, including Care Coordinators who will work alongside the practice
- Providing QM Practice Consultants who will inform and support each practice to build systems for measuring and improving its quality measures as part of a continual quality improvement program

Communication to Members (CM009)

Following development and implementation, we will develop and include educational member materials about our FC-PCMH program on our member and provider websites. On an ongoing basis, we will distribute information to providers, Care Coordinators, Department caseworkers, members, and caregivers about the availability of approved FC-PCMH providers and the services they offer. Our intention is that our members will be offered the opportunity to select an available FC-PCMH provider as their PCP, subject to availability within geographic access and other PCP selection criteria.

Assessment of Whether Members Can Continue With Their Original Medical Home and/or How Best to Establish New Medical Homes (CM008)

UniCare will employ a person-centered approach to assessing and attributing members to the most appropriate medical home provider to meet the member's needs. Our Care Coordinators will assist members and their Authorized Representatives in the selection of the most appropriate medical home. Our individualized assessment process will evaluate the care needs of the member and advise member on the best medical home to meet their needs. Regardless of which medical home the member is chooses or is attributed to, our Care Coordinator will assure that all required primary and preventive services are being provided and documented properly.

Annual Reporting Process (CM010)

We will review our PCMH network at least annually to assess its effectiveness and compliance with applicable reporting requirements prescribed by DHHR. Working with DHHR, we will develop performance reporting criteria and other measures to assess and monitor the performance of the FC-PCMH program. Additionally, we will provide practices with the tools necessary to drive improved outcomes and quality.

Supporting Effective Transitions of Care

Our Fostering Healthy Lives model focuses on children as they enter the foster care program, ensuring completion of timely and urgent screenings and assessments to identify those who experience placement disruption or change, like discharge from an inpatient hospital or PRTF or changes in placement. We minimize the disruptive effects associated with these transitions through a direct approach to discharge and continuity of care planning at the start of admission.

Our collaborative efforts focus on early and meaningful discharge planning with the treating facility, Department caseworkers and welfare agencies and community providers as members discharge from levels of care. Our discharge planning process is designed to assure the safety, well-being, and permanency for our members through the provision of the most appropriate services, supports, and resources and application of our well-established and successful transition of care process.

Supporting Timely Discharge Planning and Outpatient Connections (CM011, CM012)

We recognize that our members' needs change frequently and supporting them during critical transitions between care settings is one of the most crucial care coordination functions; therefore, our Care Coordinators are dedicated to facilitating safe and successful discharge planning from health care settings for our members. A member's Care Coordinator will follow them throughout their enrollment with the Program, including during inpatient and residential facility stays, supporting highly coordinated care and minimizing the risk of member readmission or placement disruption. Our integrated approach between the UM Clinician and Care Coordinator ensures we begin discharge planning prior to admission for planned admissions, immediately upon notification of admission, or upon a new member's enrollment notification to our health plan when inpatient or in a residential facility. We prioritize the safe and timely completion of transition of care activities in a way that minimizes potential trauma triggers and nurtures the member and caregiver's resilience.

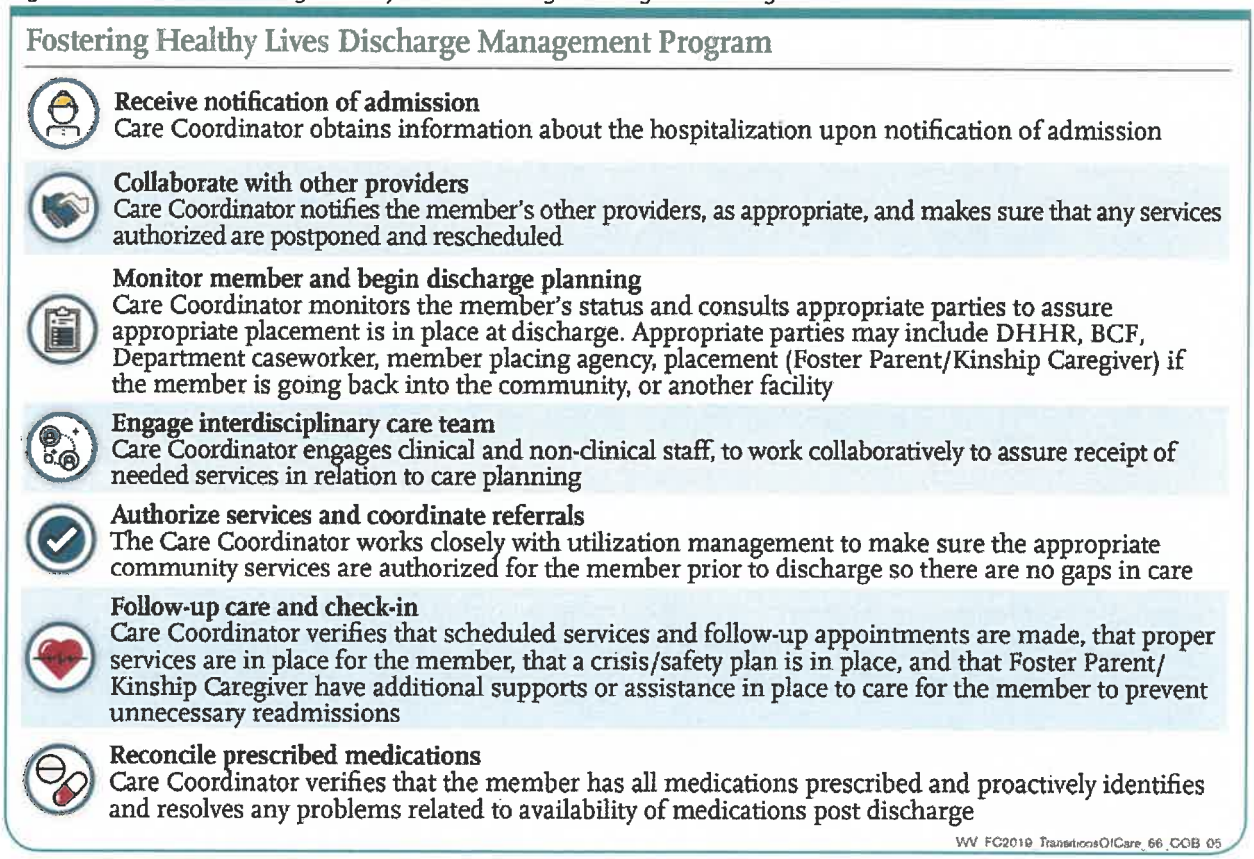
Throughout the member's stay, their Care Coordinator works alongside the UM Clinician and participates in rounds and meetings, as requested, with the member's Department caseworker and facility discharge planner, identifying any needed resources to support a successful transition back to the community or next level of care and a stable placement.

Our integrated team will work closely with the Department caseworkers, providers, and members and their caregivers to support effective communication between all parties and to collaborate on a discharge plan that addresses any barriers to a successful reintegration into the community. Through this close coordination with the member's support system, including the court, as applicable, and the State's pharmacy benefit manager (PBM), we will assure the support necessary for transition planning. Care Coordinators will promote, coordinate, and help members and caregivers access essential services prior to and following discharge, as well as during level of care changes.

The Care Coordinator will also arrange in-person visits, when indicated, with the member and caregiver, coordinated through the Department caseworker and facility staff to gain a more in-depth understanding of the member's and caregiver's needs, precipitating factors that led to admission or placement, and to closely coordinate our discharge and transition support activities with the entire treatment team.

To facilitate in-person collaboration with members and caregivers, DHHR, and the provider team, we also plan to have co-located staff in high-volume hospital, PRTF, and residential settings, including QRTPs. Our UM Clinicians will be aligned to facilities for consistency in communication. Our Fostering Healthy Lives discharge management program is summarized in Figure E.2-12.

Figure E.2-12. Our Fostering Healthy Lives Discharge Management Program



We realize that this population may have additional needs for safe discharge planning and placement, to include community integration and wraparound supports. We will work closely with the member and their Department caseworker, caregiver and residential or inpatient provider to identify and as applicable authorize and coordinate alternative services and supports that promote a return to home or lower levels of care. This includes collaboration during a Department caseworker's activities to connect eligible families to the ***Safe at Home Program*** that provides wraparound services. The integrated team assures all service options are considered with the child and caregiver and confirms with them the best options that align with the member's personal goals and optimize a healing environment. ***The goal of our discharge planning process is to assure the safety, well-being, and permanency for our members through the provision of the most appropriate services, supports, and resources that maximize the member's success in the community and minimize the risk of member readmission or placement disruption.***

Care Coordinators' Pre-discharge Planning Activities

In support of coordinated discharge planning, Care Coordinators will:

- Collaborate, share information and obtain input from the care team including the member, caregivers, the Department caseworker and other State agencies
- Work with UM Clinicians to make sure necessary aftercare services are authorized, providers identified, and in place upon discharge, including SNS services, outpatient BH and primary care visits

- Align the Care Plan with the provider's treatment plan, DHHR case plan, member's ISP and FSP
- Complete or update the member's HRA (for complex members) and Care Plan to ensure adjustments to services and goals are reflective of current status
- Identify services covered or coordinated by UniCare that can help avoid a higher-level placement by maintaining the member in their current placement or moving them to a lower level of care
- Assure authorization as needed for in-home therapies including physical, occupational, and speech therapy; DME providers; and peer and family support partners
- Contact treating providers to share the member's updated Care Plan and crisis plan and confirm they understand the member's needs, the timeline for the member's discharge and transition, and are ready to serve the member upon discharge and throughout the transition
- Collaborate with the discharge planner to support medication reconciliation and access to medications post-discharge
- Establish a home visit plan for members who have day or weekend passes prior to discharge
- Provide feedback and education to caregivers about needed services or medications upon discharge
- Assess key transition components, including nutrition, adequacy of the Care Plan, and physician follow-up after the transition is completed to provide additional support and education based on their evaluation of the member's health status, and identified gaps in care
- Coordinate with a member's PCP, specialist, or FC-PCMH, if applicable
- Align members to the right BH providers, including those who are TF-CBT providers, where necessary

Care Coordinator Post-discharge Support

During the transition period, our Care Coordinators provide one-on-one support, coaching, and education for members and caregivers on strategies for successful transition. The Care Coordinator:

- Calls the caregiver and member within 48 hours of discharge to confirm transition and that necessary services, supports, and equipment are in place and satisfactory; for complex members or those receiving in-home services or DME, contact will be within 24 hours.
- Visits the caregiver and member prior to discharge to assess the member's status and any need for service adjustment.
- Reviews the crisis plan with the member and caregiver, which delineates other alternatives to hospitalization and resources to bolster family and caregiver support.
- Confirms post-discharge appointments are scheduled and needed transportation arranged.
- Confirms completion of the first post-discharge BH outpatient visit within seven days from the date of discharge.

We will also assure BH service providers contact members who have missed an appointment within 24 hours to reschedule appointments.

If the member is discharging from a facility stay to a new foster care placement, we will work with the Department caseworker and treatment team to prepare the new foster parent to address the member's PH and BH needs, medication use, and crisis plan.

Members in an Inpatient or Residential Setting at the Time of Enrollment

If the child or youth is in an inpatient setting, PRTF, or other residential facility placement (like a QRTP) at the time of transition to managed care or child welfare, we will immediately implement discharge planning as described previously. We will assign a Care Coordinator matched to the member's needs, contact the member's Department caseworker and facility discharge staff, and identify all necessary transition activities and responsibilities. Essential activities will include completing initial screenings, confirming the child's or youth's placement following discharge, identifying providers for post-discharge visits coordinated with the Department caseworker and caregiver, authorizing necessary outpatient visits, and coordinating access to prescribed drugs and other necessary services and supports for which we are responsible.

Out-of-state Placements

We understand that sometimes it is necessary for members to get needed treatment in facilities in other states. In these situations, the integrated team continues to work closely with the Department caseworker and provider to continuously identify and authorize, as applicable, alternative services and in-state placements that would meet the member's needs to support the shortest stay possible in an out-of-state facility.

Success Reducing Lengths of Stay

We recognize that many members with the greatest acuity often languish in facility settings due to a lack of safe or appropriate placement options. We have found that close collaboration and frequent meetings facilitate reduced stay in placements for members with the most complex needs.

As an example, in 2015 when we began managing the BH benefits, many UniCare-enrolled children needing PRTF placement were placed in out-of-state facilities in six other states, often for extended periods of time, with a nine- to 12-month stay being typical. To address this challenge, we redesigned our PRTF placement coordination process. We implemented bi-monthly integrated team calls with each PRTF facility, active monitoring of progress towards treatment goals, and bi-monthly medical necessity review. All PRTF admissions required Medical Director authorization and case managers reviewed progress towards treatment goals, family visits, and home visits weekly with parental guardians. We also developed a comprehensive geographic list of alternative in-home providers and intensive in-state programs to assist the team during discussions with providers to assure members were accessing the least restrictive level of care inclusive of community options. We also developed a pre-certification and concurrent review process based on clearly defined standards for extended stays. We will leverage our proven process to improve care for members in the Program.

Proven Success Reducing Lengths of Stay

At the start of our intervention, there were 21 children in out of state placements. As a result of our combined efforts, by 2017, only three members remained out-of-state and our members are now being discharged three to five months sooner than the initial discharge plan indicated. Members are returning to West Virginia faster, with in-home services, intensive services, or outpatient treatment to support their lives and development in the community. These interventions have sustained success; as of July 2019, there were only two members receiving out-of-state care.

Coordinating Access to Medication During Discharge or a Change in Level of Care (CM013)

Assistance with medication reconciliation immediately before and after discharge or a change in level of care is a critically important step in supporting the member's stability and treatment goals. We include medication management as part of our discharge or transition planning through close coordination with the discharging provider, PCP, child and caregiver, and, for changes among levels of care, the receiving provider. Our approach is to provide members and caregivers education about the importance of medication adherence, confirm the caregiver's understanding of the discharge medication regimen, and serve as a point of collaboration across settings and providers.

Real Stories

Care coordination helped assure that a young member in our affiliate health plan had the medication he needed to remain healthy. Sam, a 13-year-old foster care member, had a diagnosis of autism and PTSD, regularly presented with mood dysregulation and impulsivity, and is non-verbal with a history of aggression, destruction of property, elopement, and acting out sexually. After being newly enrolled with our affiliate plan, Sam was about to run out of his medication, Geodon. The prescribing provider's office was closed until Tuesday of the following week, and Sam was in need of a refill of his medication. Sam's Care Coordinator stepped in quickly and spoke with his DCBS Social Service Worker and confirmed Sam's history of being on this medication, despite his age being outside of the FDA limits. The Care Coordinator was able to get an over-ride approved to fill this medication until Sam could be seen by his provider the following week. The Care Coordinator followed up with Sam's provider to arrange for an appointment and to make sure the physician completed the prior authorization that following week.

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Discharge and transition planning for medication include:

- A review of the member's discharge medication regimen
- Discussion with the discharge planner to confirm the member will have a short-term supply of prescriptions, or the prescriptions will be transmitted to the outpatient pharmacy before discharge
- Discussion with the caregiver to make sure the member has a pharmacy of their choice available to fill prescriptions following discharge and has transportation available to obtain the medication
- Identification of other needed support post-discharge to continue the medication regimen, including helping coordinate transportation, and the first follow-up outpatient visit with the prescribing provider
- Our Pharmacist will review and track the member's prescribed medications, work closely with the Care Coordinator to reinforce knowledge on medication safety, adherence, frequency, and dosage. Our pharmacist will serve as a ready resource to conduct medication reconciliation throughout a member's enrollment

Following discharge, the Care Coordinator will call the caregiver and member as part of the first post-discharge contact and confirm they have required medications, walking through the discharge medication list and confirming the caregiver is administering them (or for a youth, taking them) as prescribed, answer medication related questions, and resolve any issues. If the caregiver experienced trouble filling a new or refill prescription, the Care Coordinator will contact the pharmacy to identify the barriers and work with the Pharmacist and prescribing provider. A health plan pharmacist will also be available to the Care Coordinator to coordinate medication authorization with the State's PBM when needed.

Value-Added Services

The Care Coordinator will also offer our ***Medicine Safety Kit,*** available as appropriate, as a VAS that includes a lockable medicine box, prescription destroyer gel, childproof prescription caps, and pill case covers that reset when opened — all of which helps the caregiver maintain control over medications.

If the caregiver seems unsure or is having difficulty with medication compliance, the Care Coordinator will work with our pharmacist to schedule a call or in-person visit to provide caregiver and member education.

Depending on the member's situation and complexity of their medication regime, the Care Coordinator, in consultation with the health plan pharmacist (for members with complex medication use), will complete an MRA to assess the level of medication complexity and risk to the member due to polypharmacy, medication errors, and high-risk medications. The MRA will include, but is not limited to, a review of the total number of medications the member takes, complexity of medication regimens, frequent changes in medications, prescribed high-risk medications, cognitive or physical limitations impacting medication administration, and the caregiver's ability to assist with or administer medications as prescribed.

Care Coordinators will review and monitor medications on an ongoing basis to assess the efficacy of these strategies in reducing medication risk and to identify additional supports, as needed. Additional description of coordination with the Department pharmacy program is outlined in CM005.

Minimizing Child Welfare Placement Changes

Collaborating with Department Caseworkers to Minimize Removals and Changes in Placement (CM015 and CM016)

As of June 2019, West Virginia had 6,509 children and youth in out-of-home placements, per the Foster Care Placement Report data. We know these children and youth have diverse and unique needs and may have recurring changes in living environments. To effectively and compassionately address these changes in placement, we will leverage our experience supporting West Virginia youth populations, including CSHCN.

STABILIZING and STRENGTHENING FAMILIES

Our approach emphasizes stabilizing and strengthening families so that we can avoid the need for placement changes or removals, thereby minimizing additional trauma. We will work to ensure that appropriate supports and services are in place, and provide training, education, and support to existing foster parents and caregivers to better prepare them to foster children with complex needs. In alignment with the Family First Prevention Services Act, our focus is on family foster care, with other placements only when necessary. We will also provide training and support to children and youth to assist them in transitioning to foster care and throughout their placement to help them navigate the system.

UniCare will collaborate with Department caseworkers to minimize removals and support members experiencing placement changes by strategically placing a member of our Care Coordination team in regional locations. Locations for our field Care Coordinators may include BCF offices, select inpatient hospitals, PRTF, QRTF, and other residential settings. Co-locations will be selected based on member utilization and regional needs. Our Care Coordinators will also align our assignments with Department caseworkers in large group home settings, promoting communication and coordination of Care Plans and improving member engagement.

When it is not possible to maintain a member in a placement, our team rapidly responds to facilitate a seamless transition of services that mitigates the risk of increased, compounded trauma and promotes continuity for the member.

Promoting Placement Stability

Placement permanency is a key pillar of our approach to working with children, caregivers, and Department caseworkers. Core features of our program designed to promote placement permanency and minimize disruptions during removal or a change in placement include:

- Assignment of each member to a single Care Coordinator who supports and follows the member for as long as they remain enrolled
- Promotion of a trauma-informed approach to meeting children's needs through education and training for our staff and network providers
- Access to a comprehensive network of providers who are trained to deliver evidence-based services to support members and families and reduce the risk of removal, such as Parent-child Interaction Therapy (PCIT) and TF-CBT
- An expedited service authorization process to make sure members and their families receive intensive community-based services quickly, minimizing the need for removal from the home or transition to a higher level of care
- Flexible service options, as permitted by DHHR and agreed to by the member and caregiver, that enable us to offer a member a service we might not ordinarily cover because it helps maintain placement stability and avoid a higher level of care
- Connection to community resources that promote member and caregiver engagement and reduce the risk of removal, such as the WVHVP (discussed in more detail in CS010)
- Promotion of community-based services such as SNS, and ancillary services in a residential setting to reduce the need to transfer to a higher level of care

The Care Coordinator will work with the member, caregiver, and Department caseworker to promote access to community options, including Family Resource Networks, during care planning and before any placement decision. Additionally, we will continue to pursue collaborative agreements with state-operated or state-contracted facilities and cover inpatient stays in Institutions for Mental Disease (IMDs) as defined and permitted by CMS for members age 21 to 64. The Care Coordinator will help address identified gaps and continue to engage the member and caregiver to verify scheduled services and follow-up appointments are made, assist with arranging transportation, provide appointment reminders, follow up to see that proper services are in place and concerns are addressed, perform medication reconciliation, and identify new or emerging needs for rapid resolution.

Responding to Urgent Needs

When a member urgently needs services beyond what they currently receive to support continued placement, our team will authorize services, such as crisis respite and crisis stabilization, and include SNS, to quickly respond to these needs and provide alternatives to hospitalization. Following service initiation, the Care Coordinator will conference with the Department caseworker, provider, member, caregiver, and others involved in the situation to make sure authorized services are meeting or expected to meet the child's or youth's needs, and identify any additional service needs to prevent removal. The Care Coordinator will also identify an agreed-to schedule for follow-up calls and visits in collaboration with the Department caseworker to monitor the member's progress and changing needs. The Care Coordinator will update the member's Care Plan, including safety plan/crisis plan, sharing this with the caregiver, member, providers, and Department caseworker.

Responding to Caregiver Needs

In order to support a member's placement, it is important to care for the caregivers as well as the enrolled member. The support we offer to caregivers is informed by an assessment of their needs and preferences and can include:

- Training to understand the behavioral impacts of trauma, BH conditions, and parenting styles
- Referring to community-based support groups and recreational activities
- Addressing SDOH barriers
- Educating the caregiver and member how SNS, such as individualized parenting and respite services, are authorized
- Educating on VAS, such as our Online Well-being program (self-help resources for stress, anxiety and other challenges) and Foster Care and Kinship Care Toolkits, filled with helpful educational resources for new foster and kinship parents
- Training on caregiver self-care
- Providing advocacy and support during educational or court-related meetings or hearings, in collaboration with Department caseworkers
- Assisting caregivers in accessing and coordinating respite services, when needed, from approved, specifically trained providers, including for medially complex members

Where ongoing caregiver stress is identified, we will work with the Department caseworker to develop appropriate action plans to meet the caregiver's additional needs.

Support for Children and Youth During Placement Changes or Removals

When placements or removals occur, UniCare will be poised to respond rapidly to facilitate the transition of services and provide other assistance as needed and requested. We understand the importance of making sure members receive timely screenings and assessments immediately following removal from the home and will work with DHHR and the assigned Department caseworker to arrange all screenings and assessments within required timeframes. Once notified, we will work with DHHR to help ensure medications and services are authorized as applicable to the new placement or setting.

The Concierge Team and Care Coordinator Begin Collaborating Immediately

The Concierge team will conduct initial member outreach within five business days, with the goal of outreaching within two business days of enrollment. This is done to make sure the member has appointments for a comprehensive EPSDT exam including dental, hearing, and developmental screenings, a trauma assessment within 30 calendar days of placement change, as well as a follow-up visit within 90 calendar days and any other necessary appointments.

While a Concierge Representative is working to get the member immediate access to initial screenings and assessments, the Care Coordinator begins working on behalf of the member within one business day of notice of the child's enrollment. The Concierge Representative and Care Coordinator communicate and share information internally, as well as work with the Department caseworker, members, and their caregivers.

A placement change triggers a reassessment of the member's needs to identify and address new or emerging issues. Guided by the member's Care Plan, the Care Coordinator coordinates transition of PH and BH services and SNS, verifying continuity of care, including continuity of providers whenever possible, and confirming the child or youth has medications or DME, and removes any potential barriers to care.

Value-Added Services that Support New Placements



Our New Placement Welcome Portfolio and New Placement Welcome Wardrobe are designed to help support members and help reduce the stress of placement changes. Our Welcome Portfolio helps ease both the member's and the caregiver's transition by providing an activity that lets the member express their feelings and emotions through a creative outlet. Contents include a coloring book, markers, crayons, and colored pencils that allow the member to let their foster care family know more about them through drawing and coloring. In addition, we leveraged current stakeholder feedback and our understanding of the child welfare system to identify a need for additional financial assistance to purchase clothing and shoes when children are placed with new families. Our Welcome Wardrobe benefit will provide a $150 retail store gift card to purchase essential clothing items.

Community Engagement and Increasing Access to Care

Performing Gap Analyses to Determine Services and Resources Not Available in the State (CM025)

We will leverage our current West Virginia Medicaid experience and the input of our members, their families, our providers, and other stakeholders to successfully identify and address service and resource gaps in the state. Some key gaps we look for in our analysis include provider network gaps, individual member or caregiver needs (identifying individuals who need care but are not getting it), and broader population needs (gaps in the delivery system). We then work closely with all of the entities involved in care delivery to develop strategies to address the gaps.

Leveraging Our Experience and Systems to Identify Gaps and Improve Care



We have been serving West Virginia residents for 16 years and will use that experience to identify and address service and resource gaps. For example, we monitor our provider networks to make sure there are enough providers near our members to meet their health care needs. Our Provider Relations team uses tools like our GeoAccess® reports to monitor our provider networks on an ongoing basis. We also perform monthly network change reviews, looking at all network additions, exits, and capacity changes by provider type and location. When we do identify a shortage, we focus our network development activities to address the need, described in greater detail in ND001-ND003.

We look closely at the needs of individual members and their families. Our Concierge Line will be a dedicated point of contact for members and will compile information in our clinical support platform, Health Insight. The platform combines member information from multiple sources into a single record to provide a holistic picture of the member's utilization, care coordination services, gaps in care, and authorizations. This information goes to Care Coordinators, our Social Services Director, and our Provider Relations team for follow-up as needed.

Our Care Coordinators will receive monthly gaps in care reports with information about all the services members need to get or have missed, including pharmacy and dental. If a member has a medical or BH diagnosis requiring frequent access to certain services and they have not engaged with providers or used recommended services in at least six months, the Care Coordinator will conduct follow up. We will also leverage EPSDT reporting to track and monitor upcoming EPSDT visits and services received, including non-covered services. Our Care Coordinators and Concierge Line will also serve as standing resources for members and their caregivers to contact with concerns and gaps in care and will work with the families to address their unique needs.

Care Coordinators will work directly with our members and their caregivers to identify and address unique needs. They will review existing Care Plans for appropriateness of care, assure medically and socially necessary services and supports are in place, continually screen for potential concerns, identify any gaps in care, and engage any additional services needed. During this review, Care Coordinators may contact any specialty care providers, including BH providers, to assess the member's current prescribed treatment and services and identify gaps. They track existing authorizations to make sure members receive services without interruption as part of our continuity of care process.

Individual member needs can also signal broader service and resource gaps. Our Care Coordination team assesses gaps in the service array. When our team analyzes monthly gaps in care reports and identifies services that are not covered in West Virginia, we will work closely with DHHR to identify if policy changes are possible to enhance coverage. We will also work to develop innovative solutions to meet broader member needs. For instance, we recognize that services like Functional Family Therapy and Multisystemic Therapy (MST) are evidence-based practices not currently available in West Virginia. We describe MST in greater detail in CM026. While we work with DHHR, we will also leverage community supports to give members and their caregivers skills to create a healthier home environment for everyone. Additional information about our efforts to reduce gaps through community partnerships appears in CM026 and ND003.

Our Social Services Director and Provider Relations team will use information about member needs to address identified gaps. The Social Services Director will use the information in Health Insight to identify community services meeting member and caregiver needs. The Social Services Director will work closely with the Community Engagement and Training team, which can identify resource gaps through its interactions with the community, to explore ways to fill resource gaps with community partners. The Provider Relations team can use information in Health Insight to identify provider-related gaps and can outreach to providers for training and other supports that will foster collaboration and expand access to services. We also provide members tools to address gaps they identify for themselves through our Community Resource Link — an online resource that locates and displays all available local community-based programs, benefits, and services (described in detail in MS1010).

Working with Members and Caregivers



Members and their caregivers will be key to identifying service and resource gaps. They will work with our Care Coordinators and Concierge Representatives to complete a Fostering Healthy Lives HRS and other assessments. The information gathered during the screenings and assessments will be combined with information from caregivers, Department caseworkers, and providers to provide insight into the member's health needs. We will work with members and their caregivers for feedback on access to care through an annual member satisfaction survey. Based on survey results, we will deploy targeted provider recruitment and contracting strategies to mitigate gaps and will offer additional provider training through our Network Relations Consultants to improve service excellence.

We will gather information about broader population needs and trends through member and caregiver focus groups. We will have 12 focus groups targeting SNS and another 12 related to residential services, addressed in greater detail in QU026-QU030. Focus groups will ask about access barriers and will result in action plans regarding both enhancing access and identifying unavailable services. We will annually report to DHHR about our activities to enhance access.

We will also act on feedback from members and their families to help address gaps. For example, when members and their caregivers identify providers they think should be added to our network, we will follow up on the recommendation.

Partnering with Our Providers

One of the best ways to assure access and avoid gaps for our members is to engage our providers as partners. We take time to meet with providers in a face-to-face setting to discuss any challenges or concerns they face. Throughout 2018, we proactively met with several health care provider groups, including Children's Home Society, Pressley Ridge, Stepping Stones, Youth Academy, and Youth Services System, and have maintained communication with these groups, inviting them to our Stakeholder Advisory Council meeting and other stakeholder-focused outreach activities. In our meetings, we captured key concerns and questions and use the conversations to develop strategies around provider and member challenges and engagement.

We are also prepared to work with providers to identify and address new challenges. For example, medication assisted treatment (MAT) may be the recommended course of treatment for an individual in the child welfare population, and a provider may be authorized to provide that treatment, but the provider may be reluctant to provide the treatment to adolescents. Our Provider Relations team and Medical Directors will work with providers to understand their concerns around treating younger members and provide training support where possible to encourage access to evidence-based services and resources via our Project ECHO® initiative.

We have also collaborated with providers to launch several initiatives to address recognized gaps and expand access to services, including telehealth services through programs like LiveHealth Online, Bright Heart Health, and Project ECHO, discussed in greater detail in CM019. We will pursue similar strategies to expand access for the child welfare population.

We will also gather feedback from providers through regular provider satisfaction surveys. These surveys will be used to identify improvement opportunities, including provider retention and satisfaction initiatives.

Collaborating with Our Other Key Partners

We will also engage community advocates, members, and key providers in our Fostering Healthy Lives Stakeholder Advisory Group (discussed in greater detail in QU032-QU035), with a targeted Parent and Caregiver Advisory Group (discussed in greater detail in CS010) within the broader Stakeholder Advisory Group. These groups will help identify additional member and caregiver needs and challenges, review data, and consult about gap resolution.

We also leverage our knowledge and input from our stakeholders to develop VAS that will address some of the greatest member needs that cannot be met with the Program benefit package. We developed 22 VAS (discussed in greater detail in Attachment E.8.) based on our experience with West Virginia's vulnerable youth populations and that of our affiliates. The considerations behind the VAS we selected are listed in Figure E.2-13.

Access to Care Standards and Methodology (CM031)

We want to be sure members have continuous access to care. We adhere to State and federal provider network requirements and recommendations, described in ND001-ND006. We encourage members to seek health care information and assistance by offering a 24-hour nurse line they can call with medical questions or concerns and speak with an RN, and a 24-hour BH crisis line that members can call with crisis needs and speak with a licensed clinician. We also adhere to State requirements to cover services like urgent and emergency services, family planning, most EPSDT, and BH services without prior authorizations.

We also aim to ease different types of member transitions.

- **Members Joining the Program.** We encourage members — especially those with complex health needs — to continue their existing Care Plans when transitioning their care to us. We work with members to transition to our in-network providers and covered services, minimizing disruption to their course of care.
- **Members Changing Placement Settings.** Through the placement process, we will leverage our Care Coordinators as a single point of contact for the member and caregiver. Using assessment tools, the Care Coordinator will work with the member and caregiver to develop or update the Care Plan and relevant contact information to ensure communications and outreach go to the correct point of contact.

Figure E.2-13. Considerations to Select Value-Added Services

Considerations behind our Value-Added Services:

- **Promote or support education**, as children and youth in child welfare often lag behind their peers academically
- **Foster a sense of normalcy** to overcome the stigma of poverty that is common among children and youth in child welfare, such as covering the costs of youth club memberships and afterschool activities to encourage social engagement
- **Tailor to the age-appropriate interests and needs** of youth populations so Transition Age Youth Value-Added Services vary from those for young children
- **Encourage family togetherness and parent-child bonding** to strengthen families and promote stability, for example a Summer Reading Benefit and Family Activity Coupon Book
- **Verify that our Value-Added Services complement, but do not duplicate**, locally available community resources
- **Identify key gaps** in covered services that offer the greatest opportunity to expand offerings and enhance program results

- **Members Leaving the Program.** We work with members we know are leaving the program to make sure they have a smooth transition to their next form of coverage, giving them tools to better manage their care even after they have left the program. We will also coordinate with the member's new health plan to the extent possible to facilitate the transition.
- **Members Receiving Emergency or Inpatient Services.** We will coordinate care and timely follow-up by requiring the emergency provider to reach out to the member's PCP for additional authorizations and information-sharing.

When members do not access care, we confirm it is not due to lack of access. For that reason, we ask providers to keep records of missed appointments to try to understand why the member missed the appointment. We also require providers meet certain after-hours service standards, like informative answering machine messages and commitment to respond to patient calls.

When members access services, we want to proactively address other possible barriers to care. We encourage providers to help us address common member barriers like:

- **Linguistic and Cultural Differences.** We will promote cultural and linguistic access by offering providers our own cultural competency toolkit and training and offer other ongoing education opportunities through webinars, town hall meetings, and provider orientations.
- **Traumatic Experiences.** We will encourage providers to offer trauma-informed care by providing a small financial incentive and recognizing them with a Gold Star status when they complete training (discussed in QU001). The Gold Star status puts them on a reference list that other providers, stakeholders, and families can access.
- **Adverse Childhood Events.** We will encourage providers to be leaders among their peers by offering funding to support innovative strategies to increase community resilience and address ACEs. Programs are more likely to be successful if they are initiated and sustained

by members of the local community, so we will encourage community-based approaches to improve access to care.

We also promote continuity of care by requiring providers to maintain accurate and timely documentation, with responsibility for communicating clinical findings, treatment plans, prognosis, and the member's psychosocial condition as a part of the coordination process. Care Coordinators will also help identify potential barriers and resources to improve access to care. UniCare understands the importance of using technology to improve access to care and quality of services. We will offer a comprehensive and multifaceted telemedicine approach that recognizes the complexity and range of geographic and service needs in West Virginia.

Community Engagement and Increasing Access to Care — Leveraging Community Partners

Working with Our Partners to Increase Capacity for Services and Resources (CM026)

UniCare has a long history of collaborative relationships with West Virginia community organizations that support the health, well-being, and community integration of trusted member agencies, including connecting members to services that are not covered by the Medicaid benefit package. Some of the different challenges we have worked to address and the organizations and programs we have partnered with include:

Supporting Transition Age Youth

- **Stepping Stones.** In 2018, we provided $39,000 bridge funding for It's My Move — Youth Transitional Coaching Services for health promotion and wellness, including support for those with complex needs for individuals, families, and communities impacted by mental health disorders, SUD, I/DD and associated problems by obtaining physically and emotionally healthy lifestyles. ***We are working to expand access to telemedicine services for youth in residential treatment in Wayne County with funding for telemedicine equipment and connectivity.***

> *It is a humbling experience to find myself again thanking you for UniCare's extremely generous donation of $80,000 for the purchase and development of the hydroponic tower garden and greenhouse at Stepping Stones. UniCare's continued support of our programs and kids is truly remarkable and it was difficult to find the words to describe how your simple acts of generosity such as UniCare's have contributed to our kids well-being. This project has also already sparked such remarkable outreach. We are so excited by this project and I cannot wait for the greenhouse to take shape and the first vegetables to make their way to our kids' table.*
> — **Susan R. Fry**, Executive Director, Stepping Stones
> WV_FC2019_Fry_TST_05

- **Stepping Stones Tiny House Village.** UniCare will support transitional age youth skill development and nutrition with funding for a greenhouse for 20 tower gardens. The project has "broken ground" and is expected to be completed by end of summer 2019. We are also supporting expanding access to telemedicine services at the Tiny House Village location by adding an on-site telemedicine kiosk.

Addressing Barriers to Care for Foster, Adoptive, and Kinship Caregivers with Parent-child Interaction Therapy

University of West Virginia and FMRS Health Systems, Inc. Dr. Cheryl McNeil, a PCIT-certified Master Trainer and Professor of Clinical Child Psychology with the West Virginia University, developed an intensive PCIT model (described in greater detail in ND003). The model offers a combination of in-person and phone consultations with group sessions to help families learn and develop positive parent-child

relationships and interactions. We will support training sessions by offering childcare, snacks, and meals for participants, as appropriate. We are also collaborating with Dr. McNeil to develop training materials and methods to expand the model by "training the trainer."

Promoting Stable and Strong Families

- **Safe at Home.** We are currently working with several organizations to serve children that have been placed or are at risk of being placed in a psychiatric residential treatment facility out of state. The program provides wraparound services to help them return and stay home (described in greater detail in CM011, CM012, and CS012).
- **Multisystemic Therapy (MST).** MST is a family and community-based evidence-based program for youth age 11 to 18 who are at risk of placement or removal from their homes; it is not currently a covered Medicaid service in West Virginia. This therapy provides services to members and their caregivers to reduce residential placement, address SUD, and improve success in managing disruptive behaviors, with service intensity based on the needs of the youth and their supports. ***We are exploring opportunities to bring MST to the state and welcome working with DHHR and local providers on the effort.***
- **Functional Family Therapy.** Functional Family Therapy uses community-based family therapists to address needs for youth with behavioral or emotional problems involved with the West Virginia Supreme Court Division of Children/Juvenile Services, mental health, or child welfare systems. A program developed in Ohio has seen low rates of recidivism for youth enrolled in the program (less than 1% of enrollees were sent to a Department of Youth Services facility after enrolling). UniCare would like to develop a similar model in West Virginia for members in child welfare. ***We would work to identify providers who may be interested in becoming authorized Functional Family Therapy providers, provide training about Functional Family Therapy to promote interest, and link interested providers to authorized trainers through our Provider Relations Liaison.***
- **Family Intervention Treatment Team (FITT).** FITT has been implemented by our affiliates and includes wraparound services to promote home crisis services and interventions, as well as alternatives to the ER. In West Virginia, we would use the model to identify current health outcomes and their upstream determinants and use the measures to partner with providers to offer community and in-home services to prevent out-of-home placements, an alternative to hospitalization, a virtual residential (60-100 days) program, and a virtual Crisis Stabilization Unit (7-10 days) program. The assessment protocol uses the Child and Adolescent Level of Care Utilization System (CALOCUS) psychiatric evaluation, which assesses the member on risk of harm, functional status, comorbidities, recovery environmental stress, resiliency and treatment history, and acceptance and engagement.

UniCare will continue to identify new needs and gaps in our ongoing gap analyses (discussed in greater detail in CM025), and we will work to identify community organizations that address those needs. For example, we recognize that internet and technology access can provide informational resources to members and their caregivers and connect them to virtual communities experiencing similar challenges and identifying solutions. However, access to these electronic and durable resources remains a challenge in many parts of the state. We will work with multiple resources to help address these challenges, including local libraries with their technology services and meeting spaces to provide some on-site training and support. We are also interested in working with DHHR and the West Virginia Primary Care Association to explore opportunities to expand telehealth services in schools through the FQHCs located there (described in greater detail in CM019).

Our Holistic Education and Outreach Materials (CM040)

UniCare aims to reach our members and their caregivers where they are, providing robust outreach and education with meaningful, age-appropriate, linguistically, and culturally appropriate messages and materials. We also ensure our outreach and education strategies and materials adhere to State and federal requirements, which will serve as baseline indicators to assure our education and outreach materials are appropriate for adults and children. For example, we currently adhere to requirements like:

- Marketing materials are written at a reading level no higher than the sixth grade
- Members receive enough information to make informed enrollment decisions
- Materials are written in a readable typeface, with 12- or 14-point font, headings, and short, simple explanations of key concepts
- Avoiding technical and legal language when possible

We will work closely with DHHR to ensure materials have been reviewed and approved, as appropriate. Some of those materials could include marketing materials to potential members, member materials, and website content. UniCare may also work with DHHR to align other health and wellness initiatives and materials.

We will also work with our Stakeholder Advisory Group to test new materials. As the advisory group will be made up of members and their caregivers, stakeholders and other community partners, we will gather feedback around the appropriateness of the topic, content, and presentation of information. Additional descriptions on member and caregiver materials are noted in MS008 and MS011-MS012.

Special Focus on Communications for Our Members and Their Caregivers

UniCare will combine written materials, education, and training with personalized touchpoints to support and educate members and their families. We leverage multiple communication methods to reach out and educate youth, young adults, and their caregivers about available coverage, services, the benefits of continuing to access necessary health care services, and available community-based resources.

- **Written Materials.** We write many of our brochures and informational pieces so they will be useful to both members and their caregivers. For example, depression can be a common challenge in the child welfare population, so we have developed a brochure that gives caregivers information about depression, how to recognize signs of depression in children, and what to do and who to call in a crisis. The brochure also includes a tool to facilitate a conversation between a caregiver and a child so the child also knows that help is available. The document creates a mini action plan to empower the child to know where to go to ask for help and take steps to try and improve their own health. Our materials cover a range of topics relevant to children in child welfare and their caregivers, as well as topics relevant to former foster youth and TAY. We will continue to develop new materials as we identify new needs to address.
- **Education and Training.** Our Care Coordinators and our dedicated Community Engagement and Training team ensure accurate and timely provision of relevant information, such as access and availability of key benefits such as EPSDT services or leveraging community events as an opportunity to provide relevant information, as we do with the Community Baby Showers we offer with our WV Birth to Three partners.

Care Coordinator Outreach and Education Efforts

Care Coordinators will be matched to members with the goal of matching member need and Care Coordinator expertise, which can serve as the foundation for effective communication between the member, his or her caregiver, and the Care Coordinator. Once the member has

been matched with a Care Coordinator, that Care Coordinator will outreach to the member and his or her caregiver to:

- Identify the member's service needs, addressing the needs immediately when possible. Our Care Coordinators understand the unique systems involved in child welfare and bring a combination of clinical and child welfare knowledge, with backgrounds in nursing, social work, and BH. They understand the systems of care model and social environments, and this multidisciplinary perspective informs their communications with members and their caregivers. If we identify any unmet needs, the Care Coordinator reviews the member's history and responses to the screening questions and schedules an in-person assessment to determine treatment, training, or educational services the member may need.
- Assess appropriate ongoing education and training needs for the member and caregivers, stratifying members by their level of need. The level of need will help drive the content and frequency of outreach and education efforts.
- Set expectations around care coordination services, member and caregiver rights and responsibilities, and communication basics, like frequency of contact and contact preferences. Care Coordinators also stress that members and their caregivers can make changes to the arrangement at any time to meet their needs and preferences. This early level-setting and family-centered approach is intended to establish trust and allow families to view the Care Coordinator as a trusted resource and partner. For example, some families who may be new foster or adoptive parents may prefer higher contact frequency so they can feel connected and have the assistance of a Care Coordinator navigating the health care process for the child in their care. Alternately, some families are well-versed in obtaining services, referrals, and prefer little contact from Care Coordinators. Similarly, the needs and dynamic within the household may vary, with some members (like many TAY) able and wanting to play a central role in their own care coordination and others (like young children and those with significant PH or BH challenges) relying heavily on their caregivers to perform this role. We will respect and adhere to those wishes — whatever they are.

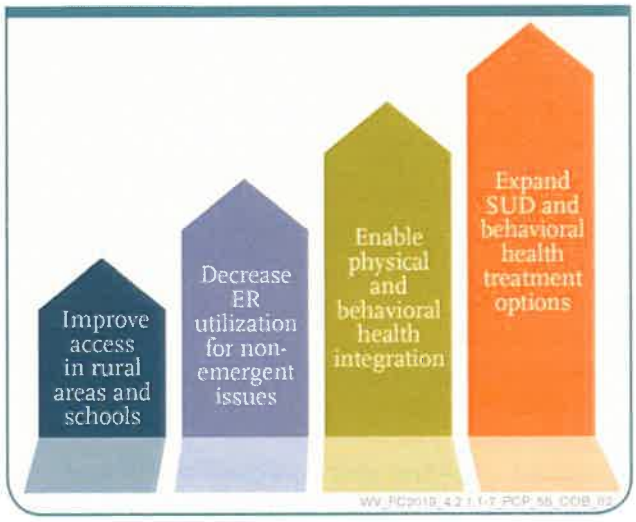
WV Birth to Three partners with UniCare on many family and/or community events. Community Baby Showers are a great example. Programs gather together to provide important information on resources, education, and other topics such as breastfeeding and the dangers of second hand smoke. Also, UniCare explains to families the importance of taking their children to Well-Baby and Child Screenings and staying on track with getting your child immunized.
— Melissa Saddler, Program Director, WV Birth to Three
WV_FC2019_Saddler_TST_0

After a completed or attempted contact, the Care Coordinator will send a welcome letter so the family has the name and number of their assigned Care Coordinator. Families will also gain access to many other education and training tools and documents including, but not limited to:

- **Fostering Healthy Lives Concierge Line.** This is a dedicated line for members, their caregivers, and providers to call with questions and program-related needs. If the person answering the call is unable to address the issue directly, they will provide a warm transfer to another person or specialty area that can help.
- **Member and Caregiver Trainings.** We will work with DHHR to identify local needs and training content, including possible topics like access to care, transition into programs, care coordination, member benefits, information sharing, and medication management. Our training Academy will provide specific materials directed to the member, and caregiver supports as described in CS013.

Using Telemedicine, Telehealth, and Telemonitoring to Improve Quality, Expand Access to Care (CM019)

Figure E.2-14. Strategic Goals of UniCare's Approach to Telemedicine



UniCare's telemedicine, telehealth, and telemonitoring approach (collectively, "telemedicine approach") focuses on internet, video-conferencing, and other web-based services to expand access, support providers, improve quality of services, and accelerate technology adoption.

Strategic goals of our telemedicine approach are in Figure E.2-14.

Our telemedicine approach supports access to care by meeting children in the child welfare system and their families where they are; whether in their home, school, primary care clinic, BH or SUD provider office, or other location.

Using telemedicine solutions that have had positive impacts on access to care and quality in our affiliate health plans' markets, and collaborating with our network providers in West Virginia, UniCare will offer an array of telemedicine solutions for our Program members, such as LiveHealth Online (LHO), Bright Heart Health, and Project ECHO.

Our telemedicine solutions will offer options that increase access to PH, BH, and SUD treatment services. For example, we know that Program enrollees and their caregivers may find it especially difficult to access care due to frequent moves. They may also experience scheduling problems and have difficulty keeping appointments due to caregiver constraints (for example, providing care for multiple children). The greater likelihood of BH problems among Program members, and the fact that they experience more intensive health care needs, compounds these difficulties. Therefore, our approach will include:

- Enabling PCPs to use distance learning technology (through Project ECHO) to expand the scope of their capability to manage more complex cases
- Increased access to virtual visits that enable greater member access to PH and BH services
- Improved person-centered care in areas where access is limited or unavailable by offering low acuity urgent care and BH care
- Expansion of telemedicine access points through deployment of hardware and a HIPAA-compliant platform that brings telemedicine technology to residential service locations, such as Stepping Stones and school-based health clinics

Tackling Internet Disparity

We are exploring the opportunity to impact internet disparity by sponsoring mobile routers in rural communities that do not have reliable internet connections. These mobile routers can be attached to cars and located overnight in these communities so members, their families, and their neighbors can gain access to the internet. Improved internet access for our members results in telemedicine opportunities, access to member materials including our member handbook and Care Plans, and numerous other advantages that internet access can offer such as the ability to complete schoolwork, schedule doctor appointments, perform online job searches, and complete online job applications.

Figure E.2-15 details our proposed telemedicine solutions for the Program, subject to appropriate consent of the legal guardian for members under age 16.

Figure E.2-15. UniCare's Comprehensive Telemedicine Solutions

MEMBER RESOURCES

VENDOR/PARTNER	SPECIALTY/SERVICE	DEMOGRAPHIC	ACCESS POINT
PHYSICAL HEALTH			
LiveHealth Online	General Physical Health/ Preventable ER Visit(s)	Pediatrics* Young Adult	Consumer on Demand
TytoCare	General Physical Health/ Preventable ER Visit(s)	Pediatrics* Young Adult	Schools
BEHAVIORAL HEALTH			
Bright Heart Health	Medication Assisted Treatment/ Addiction Services	Young Adult	Provider Offices
LiveHealth Online – Psychology & Psychiatry	Low Acuity Behavioral Health	Pediatrics* Young Adult	Consumer on Demand
FasPsych	High Acuity Behavioral Health	Pediatrics* Young Adult	Consumer on Demand
Stepping Stones/ Tiny Houses Village Pilot	Physical Health visits/ Behavioral Health Consults	Pediatrics* Young Adult	Stepping Stones Locations/Kiosk Site

PROVIDER RESOURCES

VENDOR/PARTNER	SPECIALTY/SERVICE	DEMOGRAPHIC	ACCESS POINT
FasPsych	Psychiatric Consultation	Pediatrics* Young Adult	Emergency Room
Project ECHO	Provider Enablement	Young Adult	Provider Offices
Practice Edition	Provider owned/managed telehealth solutions	Pediatrics* Young Adult	Provider Offices

**Subject to parental consent/supervised visits*

Member-facing Telemedicine Solutions that Improve Quality, Expand Access to Care

Access to Urgent Care and BH: LiveHealth Online

Our LHO solution provides members with real-time, online access to West Virginia-licensed, board-certified physicians through two-way audio/video technology. LHO offers urgent care consultations on clinically appropriate conditions such as cold, flu, allergies, and other non-emergent conditions. LHO providers are able to diagnose, make medical recommendations, and prescribe medications when medically necessary, in accordance with DHHR requirements. Members are able to access services through a safe and secure internet connection or an application on any video-enabled computer, laptop, tablet, or smartphone. In addition, through LHO, members can access scheduled consultations with West Virginia-licensed psychiatrists and licensed mental health counselors for consistent in-home access, allowing members to pursue their own plan for management and recovery.

LHO is especially beneficial to members and their caregivers in rural areas in which ready access to a provider may be unavailable due to distance or transportation constraints. LHO also supports foster parents and kinship caregivers (such as grandparents) responsible for caring for more than one child, or who may have constraints related to transportation availability.

Examples of Successful Uses of LiveHealth Online

UniCare's affiliates in California, Iowa, Louisiana, Nevada, Texas, and Washington have implemented LHO for their Medicaid programs. As with all new technologies, member awareness and use is initially small but continues to grow. In our California affiliate, over 760 members have utilized LHO since inception in September 2018, for a total of 810 LHO visits. Based on LHO patient responses to post-visit surveys, ***19% of LHO patients said they would have gone to the emergency department if LHO had not been available to them***, and 42% said they would have sought care at an urgent care center. Our Medicaid members are highly satisfied with LHO. Patient feedback survey information indicates ***ratings 4.9 out of 5 points (with 5 points meaning extremely satisfied) for both LHO and the LHO provider.***

Expanding Access for Youth in School-based Settings: TytoCare

According to the National Education Association and the National Association of School Nurses, the ratio of full-time school nurses to students in West Virginia is approximately 1 to 1,159. Recognizing that for some students, the school nurse is the only health care professional they ever see, in 2017, the West Virginia Legislature introduced Senate Bill 319 to adopt the Centers for Disease Control (CDC's) recommended ratio of 1 to 750.

Schools and school-based clinics can serve as key access points to PH screenings and treatment visits for school-aged children in the child welfare system.

Figure E.2-16. TytoPro™ Exam Kit



Through our relationship with TytoCare, we are able to offer an opportunity to significantly expand telemedicine access in schools. TytoCare's new, recently FDA-approved telemedicine technology drastically reduces the cost of implementing a telemedicine presentation site, from approximately $20,000 per site to approximately $2,500 per site. TytoCare's Virtual Exam Platform and suite of medical-grade, FDA-cleared hand-held devices connect patients to their own clinician networks for a complete virtual office visit. Each TytoPro™ exam kit includes a hand-held modular examination tool for examining the heart, lungs, skin, throat, ears and body temperature; a complete telehealth platform for sharing exam data, conducting live video exams and scheduling visits; a cloud-based data repository with analytics; and built-in guidance technology and machine learning algorithms to assure accuracy and ease of use (Figure E.2-16). The TytoCare platform allows for simple integration with electronic health record systems and other telehealth platforms.

UniCare has engaged in discussions with the West Virginia Primary Care Association (WVPCA) and Lincoln Primary Care to explore opportunities for establishment of telemedicine presentation sites in Lincoln County and other school districts throughout West Virginia.

Examples of Successful Uses of TytoCare

TytoCare is already being used in the North Carolina school system. TytoPro was implemented in Burke County in the fall of 2017. The most common reasons for using telehealth included acute conditions (85%), well care (6%), follow-up (4%), and chronic conditions (2%). Since piloting the program, there has been a significant improvement in the level of care that can be provided to students, as they can now cover all 26 schools with their telehealth program. Approximately 89% of students that completed a telehealth visit using TytoCare were able to return to class, thus reducing absenteeism.

Through our affiliate's alliance in North Carolina with a local health plan, we are collaborating with the Center for Rural Health Innovation (CRHI), a non-profit corporation whose mission is to use innovative technologies like TytoCare to improve access to health care in rural communities. This collaboration will increase timely access to services at 54 North Carolina schools participating in the Health-e-Schools School-Based Telehealth Program, facilitating improved management of conditions such as asthma and diabetes. Students can access a health care provider every school day from the nurse's office. Family Nurse Practitioners connect with members via a live, two-way videoconference, with the school nurse operating the equipment at the originating site. CRHI provides the telehealth equipment, needed medical supplies and tools, as well as care coordination between the Health-e-Schools provider and the member's PCP with parents involved in several steps throughout the process. Through our affiliate's alliance, we have signed letters of intent (LOIs) to expand the Health-e-Schools Program to additional areas across the state so more students can benefit from receiving timely care, keeping them out of the ER for non-emergent concerns.

Expanding Access for Members with Substance Use Disorder: Bright Heart Health

UniCare will collaborate with Bright Heart Health to offer members with SUD MAT and mental health treatment via telemedicine. Bright Heart Health is the first nationwide telemedicine opioid use disorder treatment program. Bright Heart Health's Opioid Use Disorder program is available through a smart phone, tablet, or computer. Bright Heart Health counselors meet with individuals online, and help identify and develop strategies to deal with issues and disorders that may have contributed to or been impacted by opioid abuse. At designated primary care locations across the state, members will be able to access MAT provided by Bright Heart Health providers who will oversee telemedicine treatment and delivery of care by primary care clinicians. Bright Heart Health also offers an OB program focused on pregnancy-related MAT and pain management. Bright Heart Health provides chronic pain management using medication and non-medication therapies to address chronic pain issues and opioid dependency. Bright Heart Health is a comprehensive, multi-modal program. Each client is assigned a multidisciplinary care team. Bright Heart Health clinicians can prescribe and monitor medications that allow individuals to stop abusing opioids without experiencing powerful drug cravings or severe withdrawal symptoms. All patients are evaluated for the safe use of medications to address pain issues.

Bright Heart Health also uses non-medication therapies including operant therapy, mindfulness, CBT, and acceptance and commitment therapy. Our multidisciplinary care team evaluates the whole patient to determine a comprehensive treatment plan focused on functional restoration.

Examples of Successful Uses of Bright Health

Our affiliate in Washington recently contracted with Bright Heart Health for statewide access to their nationwide opioid use disorder treatment program. Results of this program are pending.

Expanding Access for Transition Age Youth: Collaboration with Stepping Stones

UniCare collaborated with Stepping Stones to support and expand their TAY programs. We provided bridge funding for a Transition Coach and for building a greenhouse as part of Stepping Stones' Tiny House Village. Further, we are collaborating with their efforts to expand internet connectivity and telemedicine access to PH and BH services for youth in residential treatment by supporting establishment of telemedicine presentation sites at a Stepping Stones location in rural Wayne County. At this location, we are helping fund ***video-enabled telemedicine equipment***, and a ***telemedicine kiosk*** at their Tiny House Village, which will be available to serve the entire community, in addition to children in the welfare system.

Telemedicine Resources to Improve Quality, Expand Access to Care

FasPsych

We will use direct-to-consumer telehealth solutions and FasPsych to provide telemental and telepsych services (including crisis assessments) across West Virginia. This approach best serves communities that struggle with a lack of providers and workforce shortages, that have transportation challenges, or that cannot easily access care centers.

FasPsych expands care and treatment through remote psychiatric services. They are a pioneer in telepsychiatry, with approximately 12,000 virtual visits per month, and currently operate in 15 states. Direct-to-consumer telehealth providers offer a convenient way to facilitate live video visits through a mobile device or computer with a board-certified physician, psychologist, or psychiatrist for non-emergency health conditions.

FasPsych provides access to telehealth services from more than 4,000 qualified psychiatrists and psychiatric Advanced Practice Registered Nurses (APRNs). Services will be accessible in Community Mental Health Centers, FQHCs, psychiatric hospitals, medical/surgical hospitals, counseling practices, primary care clinics, correctional/detention facilities, universities and schools, substance use treatment providers, critical access hospitals, Rural Health Centers, and residential treatment centers.

FasPsych providers are available to provide the following:

- **Phone Consult.** The provider and psychiatrist discuss the member's presenting symptoms and possible treatment options telephonically. A summary of the consultation is provided in writing to the requesting physician within 15 minutes of consult completion.
- **Patient Consult.** Both routine and emergent patient consults are available. The provider requests a video consult between the psychiatrist and a patient requiring further evaluation. Routine consults are provided within 24 hours of request and typically involve patients who have been admitted to the hospital. A written evaluation is provided to the requesting physician within 120 minutes of consult completion. Emergent consults are provided within three hours of the request and typically involve patients who present in the ER. The psychiatrist's findings and recommendations are conveyed in writing to the requesting physician within 30 minutes of consult completion.

Caregivers with their child or youth, and Fostering Healthy Lives members age 18 and older, can access FasPysch when a psychiatrist is not readily available while in their provider's office, clinic, or facility.

Examples of Successful Uses of FasPsych

Our affiliate's health plan alliance in North Carolina collaborates with FastMed Urgent Care and Bright Heart Health to offer members MAT for addiction, as well as providing mental health treatment for substance addiction via telemedicine in one of North Carolina's regions most impacted by the epidemic. At designated FastMed Urgent Care locations, members will be able to access MAT provided by Bright Heart Health providers who will oversee treatment and delivery of care by FastMed clinicians via telemedicine in multiple locations.

Project ECHO

We promote the use of Project ECHO as a collaborative model of medical education and care coordination that supports clinicians with evidence-based guidelines and tools to provide better care to more people where they live. The ECHO model increases access to specialty treatment in rural and underserved areas. UniCare, in conjunction with our parent company, implemented an initiative to train primary care and rural clinicians to treat members with opioid use disorders through collaborations with three academic medical centers, including West Virginia University

School of Medicine. UniCare is providing no-cost training for identification and treatment of opioid addiction to providers and their primary care teams. Training covers management of naloxone, buprenorphine (i.e., Suboxone), and injectable naltrexone (i.e., Vivitrol), as well as access to a virtual learning community for treatment guidelines, tools, and member resources

Examples of Successful Uses of Project ECHO

We discuss this program and its results in greater detail in CM020.

LHO My Practice Edition

We are identifying current opportunities to enhance the telemedicine capacity of our existing network by identifying West Virginia PCPs and Comprehensive Behavioral Health Centers (COMPS) that are interested in expanding access for their patients by adopting telemedicine in their practices. LHO's My Practice Edition allows physicians to see and treat their own patients through private and secure two-way video. Patients enjoy the convenience video visits provide since they can visit with a health care professional they are familiar with from the comfort of their home using a smartphone, tablet, or computer. My Practice Edition offers providers the technology to establish telemedicine capabilities for their patients for after-hours access and follow-up care during non-office hours.

Using Internet or Web-based Services to Improve Quality, Expand Access to Care (CM020)

As discussed previously, UniCare's telemedicine approach focuses directly on using internet and other web-based services to expand member access, support providers, improve quality of services, and accelerate technology adoption. In addition to Project ECHO MAT, we are offering the following VAS that use the internet and other web-based services:

Online Well-being Program. Our Online Well-being program, offered as a VAS, supplements regular BH and SUD treatment and therapy. Accessed through the member's personal device, or via our online member portal, the program is an ideal solution for providing support to members in rural areas. It allows members to reach out in the privacy of their home without concern about the stigma related to BH, which can often be an issue. Members who sign up for the ***Lifeline Smart Phone Benefit***, also offered as a VAS, can use their free smart phone to access the program. It offers HIPAA-compliant web and mobile tools to help members with BH issues such as depression, anxiety, stress, and misuse of drugs and alcohol. It allows eligible members to take an active part in improving their health and well-being.



Community Resource Link. UniCare will continue to provide our members with an online resource that locates and displays available local community-based programs, benefits, and services, such as housing, food, transportation, employment, and more. Community Resource Link is available to members and Care Coordinators to locate appropriate community resources and supports by ZIP code. The Community Resource Link continually updates, allowing us to expand our care management program to include assisting members with accessing resources that increase independence and stability and improve health outcomes. Offered as a VAS, Community Resource Link provides a reliable source of up-to-date information about the wide range of programs and services available to Medicaid members, promoting increased personal responsibility, empowerment, and self-management. The tool includes an internal component

linking directly to our care management system, enabling our teams to track the resources members search for and use most. UniCare staff can also access the tool to help match members to appropriate public services programs.

The USDA-funded project will bring life-changing support to children and teens in foster care in rural, underserved regions. For a child who has experienced abuse or neglect, an iPad can be a direct link to a highly-trained, caring therapist who stands ready to listen and help. The technology will also provide foster parents with new training on how to handle family challenges.
— **B. Wayne Sims,** President and CEO of KVC Health Systems, Inc.

Partnering with Stakeholders

We will also partner with community stakeholders to increase the use of the internet and other web-based services throughout West Virginia. For example, understanding that many children and youth in the child welfare system in rural West Virginia may lack access to electronics that would allow them to access programs like LHO, we will partner with stakeholders like KVC West Virginia, who was just awarded a grant from the United States Department of Agriculture (USDA) to purchase 400 iPads® for foster homes in West Virginia and Kentucky in order to give them a direct link to online behavioral healthcare.

Examples of Using Internet or Web-based Services to Improve Quality, Expand Access to Care

Project ECHO Medication Assisted Treatment

We launched Project ECHO on June 9, 2017, as part of UniCare's solutions to address the ongoing opioid epidemic in West Virginia. Project ECHO MAT facilitates the expansion of scope of PCPs through distance learning. This innovative hub-and-spoke knowledge-sharing network allows rural physicians to connect with substance abuse specialists at West Virginia University in order to present patient cases and participate in didactic presentations covering a variety of MAT topics. During sessions, providers from across West Virginia are instructed on the benefits of MAT and learn how to implement a group-based recovery model in various practice settings. Our West Virginia Project ECHO MAT is supported by our ultimate parent company, Anthem, Inc., West Virginia's Clinical and Translational Science Institute, and the West Virginia University School of Medicine. Since inception through June 2019:

- 46 one-hour sessions have been held
- Total of 656 attendees, including 124 individual attendees with an average 14.3 providers per session
- 38 de-identified case presentations have been presented
- Hub members have presented 32 didactic presentations
- 40 organizations have participated, including Charleston Area Medical Center, Marshall University and other providers in and outside of West Virginia

Since Project ECHO MAT started in West Virginia, it has significantly contributed to increasing the percentage of our members experiencing opioid use disorder who received MAT (including MAT with recommended counseling) from 57.4% in January 2018 to 62.4% in June 2019, and a corresponding decrease in opioid overdose claims of more than 55% over the same time period.

Using Video-conferencing to Improve Quality, Expand Access to Care (CM021)

Our proposed telemedicine solutions described previously — specifically LHO, TytoCare, Bright Heart Health, and FasPsych — incorporate video-conferencing capabilities. We will also use Virtual Care Coordination (VCC) technology to further expand video-conferencing capabilities. VCC will allow members to video connect to their Care Coordinator using their computer, tablet, or smartphone camera. Video conferences will require a meeting password to assure secure connections; other members of the care team are able to participate at the member's request.

Examples of Using Video-conferencing to Improve Quality, Expand Access to Care

Our Georgia affiliate provides Georgia Families 360°SM members and their caregivers with access to VCC technology to enable them to work with their Care Coordination team virtually to ask health-related questions, or discuss concerns and benefits. They receive health-related advice from anywhere with an internet connection, and tablet or smartphone that is camera-enabled. VCC has been very well received by our Georgia Families 360° members and has resulted in significant savings since its implementation.

We will continue to invest in and expand our telemedicine, telehealth, and teleconferencing capabilities as new technologies become available.

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Name: **Subscriber ID#:**

CM Special Needs Assessment *(v.2)*
** Required*

Activities/Abilities:

Are member's activity/abilities limited? *(check one):*	☐ Yes	☐ No
If yes, will they last>12 months? *(check one):*	☐ Yes	☐ No

Medication, MH, PT/OT/ST, Equipment Need:

Does member need Prescription meds? *(check one):*	☐ Yes	☐ No
Does the member need Mental Health counseling treatment? *(check one):*	☐ Yes	☐ No
Does the member need PT/OT/ST? *(check one):*	☐ Yes	☐ No
Does member need special equipment or DME? *(check one).*	☐ Yes	☐ No
If yes, will need >12 months? *(check one):*	☐ Yes	☐ No
Does member have a life-threatening allergy? *(check one):*	☐ Yes	☐ No
Does the member need prescription diet? *(check one):*	☐ Yes	☐ No
Does the member receive learning/behavioral treatment? *(check one):*	☐ Yes	☐ No
Does the member receive ECI/Special Education/Rehab? *(check one):*	☐ Yes	☐ No
If yes, will member need any of these >12 months? *(check one):*	☐ Yes	☐ No
Does member need medication/mental health education > average? *(check one):*	☐ Yes	☐ No
If yes, will member need either of these > 12 months? *(check one):*	☐ Yes	☐ No
Is member confirmed for Special Needs Program? *(check one):*	☐ Yes	☐ No

Internal use only

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Name: **Subscriber ID#:**

Adult CM Initial Assessment (v.7)
* Required

Demographics/General Information

First Name: _____

Last Name: _____

Member ID number: _____

Birthday: _____

Plan: _____

Product info: _____

Street Address: _____

City: _____

State: _____

County: _____

Zip Code: _____

Home phone: _____

Cultural and Linguistic Needs, Preferences or Limitations

* Who is providing the information to complete this assessment (include name and relationship if it is a member representative)? _____

* What language are you most comfortable speaking and receiving information? _____

* Do you have a communication preference? (check one): ○ Yes, written communications ○ Yes, verbal communication ○ No preference identified

List alternate/preferred contact information, such as phone, address, or designated representative information, if applicable. _____

* Do you have any cultural and/or religious beliefs that you feel may impact your ability to make healthcare decisions or follow your doctor's instructions? (check all that apply):

- ○ Taking Medications as prescribed
- ○ Seeing a physician as recommended
- ○ Female provider preference
- ○ Following Prescribed diet
- ○ Communicating with a practitioner
- ○ Other
- ○ Undergoing a recommended test
- ○ Male provider preference
- ○ None Identified

If other, please explain: _____

Life Planning Activities

* Do you have a life planning document or advanced directive in place? (check one): ○ Yes ○ No

Name: **Subscriber ID#:**

* Do you have a person designated to make health care decisions for you if you are unable to make your wishes known (health care proxy)? *(check one)*:	Yes		No
* Have you discussed your wishes about the type of care you want or do not want with your health care provider? *(check one)*:	Yes		No
If member answers no to any of the life planning questions, was education/resources provided? *(check one)*:	Yes		No

For female members between ages 15 and 44, ask the following question:

Would you like to become pregnant in the next year? *(check one)*:	Yes Refuses to answer	No	I am not sure (doesn't know)

CM Note:

- If yes, direct member to primary or women's health provider for preconception health care.
- If no, direct member to primary or women's health provider for contraception/family planning purposes.
- If response is "I am not sure/doesn't know" direct member to primary or women's health provider for interconception health care including contraception advice.
- If member refuses to answer - remind her that she has family planning coverage if this becomes important to her at a later date.

Clinical History-Physicians/Conditions/Pregnant

* What physicians, including specialists are involved in your care? (include name and number if available)	_____ _____ _____		
Have you seen a dentist in the last 6 months? *(check one)*:	Yes	No-Education regarding benefits provided	
* What are your current medical and behavioral health conditions/diagnoses with dates of onset (if onset dates unknown, indicate 'member unaware of onset date')?	_____ _____ _____		
Are you pregnant? *(check one)*:	Yes		No

If member is pregnant, refer to OB CM.

Clinical History-Inpatient/ER/Falls

* How many times have you been inpatient in the last 6 months? *(check one)*:	None	One time	Two or more
* How many times have you visited the Emergency Room in the last 6 months? *(check one)*:	None	One time	Two or more times
Have you fallen in the last month? *(check one)*:	Yes		No

Name: **Subscriber ID#:**

If yes, please describe. _____

Clinical History-Barriers to Care/Cognitive Status

* Do you have any of the following barriers to care? *(check all that apply):*

- Do not understand my diagnosis (knowledge deficit)
- Lack of transportation
- Unable to get an appointment
- Unable to obtain an appointment
- Lack of adequate family/community support
- Unable to get consent to speak other than to the member (member is mentally/physically challenged)
- No barriers to care identified
- Motivation
- Fear of doctors/dentist
- Language barrier/communication
- Unable to fill prescription as ordered
- Poor historian (cognitive challenge)
- Inadequate housing
- Financial
- Ability to read or write
- Distance to the physician's office/clinic
- Unable to take medications as prescribed
- Frailty/medical condition
- Other

If other, please explain. _____

* In the case managers, caregiver, or guardian's opinion, what is the member's cognitive status? *(check one):*

- Alert/oriented
- Requires considerable assistance
- Required prompting
- Totally dependent/constant disorientation
- Requires assistance and some direction
- Other

If other, please explain: _____

Clinical History-Medications

* Do you take any medications (including over the counter, vitamins, and herbal medications)? (If yes, list medications with schedule and dosages on Initial Assessment template). *(check one).*

- Yes
- No
- Unknown

Clinical History-Height/Weight !

* Do you know your height and weight? *(check all that apply):*

- Height
- Weight
- Member unable to provide any of the above

Clinical History-Nutrition

Have you experienced any recent unintentional weight loss/weight gain within the last 6 months? *(check one):*

- Yes, weight gain
- Yes, weight loss
- Member denies weight gain/weight loss

If yes, how much weight gain/loss? _____

Has your doctor recommended any specific nutritional (eating) plan? *(check one):*

- Yes
- No

If yes, please describe. _____

* Do you have any problems eating, such as (check all that apply): *(check all that apply):*

- Issue with Teeth/Dentures
- Food allergy
- Requires Nutritional Supplements
- Receives GT feeds
- Lack of appetite
- Difficulty swallowing
- GI disturbances (constipation, distension, diarrhea)
- Vomiting
- Inability to obtain food
- Other
- Fluid restriction
- Lactose intolerance
- Reflux/GERD
- Choking (aspiration)
- None

Name: **Subscriber ID#:**

If other, please describe. _____

Clinical History-Vision/Hearing/Immunizations

* Do you have vision problems not corrected with lenses? *(check one):* ○ Yes ○ No

If yes, please explain. _____

* Do you have hearing problems not corrected with assistive devices? *(check one):* ○ Yes ○ No

If yes, please explain. _____

List any immunizations you have received in the past 12 months. Including date if known? (such as flu, pneumonia, shingles) _____

Activities of Daily Living/ Community and Caregiver Resources

* Do you require assistance with any of these ADLs or IADLs ? *(check all that apply):*

- ○ Eating
- ○ Grooming
- ○ Walking
- ○ Light Housekeeping/Laundry
- ○ Meal preparation
- ○ Dressing
- ○ Paying bills/Managing finances
- ○ Continence/Incontinence Care
- ○ Bathing
- ○ Toileting
- ○ Grocery shopping
- ○ No issues

* Do you have a family member or other caregiver assisting you? *(check one):*

- ○ Member is independent and does not need caregiver assistance
- ○ Caregiver is not likely to provide assistance- - CM provided resources
- ○ Name of the caregiver and level of involvement of care. Please specify below.
- ○ Caregiver currently provides assistance/meets member needs
- ○ Unclear if caregiver will provide assistance- CM provided resources
- ○ Caregiver needs training/supportive services- CM provided resources
- ○ Assistance needed but no caregiver available- CM provided resources

If Name of caregiver and level of involvement of care are selected above, please specify: _____

* What home or community support services do you currently have in place? (check all that apply) *(check all that apply):*

- ○ Home Delivered Meals
- ○ DME Supply
- ○ Home Health - Skilled Nursing (short term)
- ○ Housing Assistance
- ○ Personal Care Services
- ○ SSI
- ○ Access to transportation/Transportation services
- ○ Behavioral Health Professional
- ○ Emergent Situation Assistance
- ○ Home Health - Skilled Nursing (long term-private duty nursing)
- ○ Infusion Therapy
- ○ PT/OT/ST
- ○ Substance Use Facility/Provider
- ○ Other
- ○ Dialysis
- ○ Assistance/Resources
- ○ Hospice/Palliative care
- ○ Medical Day Care
- ○ Social Services
- ○ Tobacco Cessation
- ○ None needed

If other, please explain _____

Do you feel you need additional assistance, services and/or equipment to adequately care for yourself? *(check one):* ○ Yes ○ No

If yes, please explain _____

* Do you have any of the following social concerns? *(check all that apply):*

- ○ Clothing
- ○ Finances/Difficulty making ends meet at the end of the month
- ○ Legal Issues
- ○ Sexual Abuse
- ○ Other
- ○ Employment
- ○ Food
- ○ Pharmacy
- ○ Transportation
- ○ None identified
- ○ Family/Marital
- ○ Housing
- ○ Safety
- ○ Violence/Abuse

Name: **Subscriber ID#:**

If other, please explain. _____

CM reviewed available plan benefits with the member/member representative (check all that apply). *(check all that apply)*

- Transportation
- Dental
- Vision
- Hearing
- Network Medical providers
- Network BH providers
- Network SUD providers
- Nurse Helpline
- Services
- Pharmacy assistance
- Member handbook reviewed/requested to be sent
- Other

If Other, Please specify: _____

CM reviewed available community programs/services with the member/member representative (check all that apply). *(check all that apply)*

- Home Delivered Meals
- Behavioral Health Professional
- Dialysis
- DME Supply
- Emergent Situation Assistance
- Financial Assistance/Resources
- Home Health - Skilled Nursing (short term)
- Home Health - Skilled Nursing (long term-private duty nursing)
- Hospice/Palliative Care
- Housing Assistance
- Infusion Therapy
- Medical Day Care
- Personal Care Services
- PT/OT/ST
- Social Services
- SSI
- Substance Use Facility/Provider
- Tobacco Cessation
- Access to transportation/Transportation services
- Other
- None needed

If other, list plan benefits or community resources provided. _____

How confident are you, on a scale of 0-10 (with 10 being the most confident) that you understand and can manage your health care needs *(check one)*:

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Do you need help with referrals from other health care or social services such as shelter, food, clothing or other? *(check one)*:

- Yes
- No

If Yes, please describe the needs in the space below: _____

Substance Use

Do you smoke, use tobacco products or are exposed to tobacco smoke? *(check one)*:

- Yes
- No

If yes, are you interested in learning more about avoiding tobacco or exposure? _____

Do you use recreational drugs or medications not prescribed to you? *(check one)*:

- Yes
- No

If yes, have you ever felt the need to discontinue recreational drugs or medications not prescribed to you? *(check one)*:

- Yes
- No

Do you drink alcohol? *(check one)*:

- Yes
- No

Name: **Subscriber ID#:**

If yes, on a typical day, how many drinks do you have? _____

If yes, do you or your family have any concerns about your use of alcohol? *(check one)*. Yes No

If yes to above question, please explain: _____

Behavioral Health

Over the past two weeks, how often have you been bothered by the following problems? (2 questions below)

* Little interest or pleasure in doing things? *(check one)*. Not at all | Several days | More than half the days | Nearly every day

* Feeling down, depressed or hopeless? *(check one)*. Not at all | Several days | More than half the days | Nearly every day

If the total score for the two questions above is greater than or equal to 3 then a BH assessment should be completed. You will be prompted at the end of this assessment to complete the PHQ-9 assessment.

PHQ-2 Score

PHQ-2 Score _____

Assessments

Select potential assessments for the future at this time: *(check all that apply)*:

- None identified at this time
- BH General Adult Initial
- CM COPD
- CM GERD Assessment
- CM Migraine Headache
- CM Obesity/Bariatric
- CM Wound & Cellulitis
- 2016 Anthem OB High Risk Screener
- CM Low Back Pain
- CM Asthma Initial
- CM CAD
- CM CVA Assessment
- CM HIV Assessment
- CM MS
- CM Private Duty Nursing
- CM Adult Oncology Assessment
- CM Hep C Assessment
- Transplant Assessment
- BAS (Cognitive) Screening Test
- CM CHF Initial
- CM Diabetes
- CM HTN Initial Assessment
- CM Neurology
- CM Traumatic Brain Injury
- CM ER HRA
- CM Homeless Assessment
- Other

If Other, please specify: _____

Do you want to branch to the PHQ-9 Assessment now? *(check one)*. Yes No

Name: **Subscriber ID#:**

Clinical History-Height/Weight II

What is your height in inches ? _____

What is your height in inches ? _____

Clinical History-Height/Weight III

What is your weight in pounds? _____

What is your weight in pounds? _____

BMI Calculation

BMI Calculation: _____

AGP BH PHQ-9 *(v.68)*

* Required

Member Information

First Name: _____

Last Name: _____

Member ID# : _____

Date of Birth: _____

Date PHQ-9 was done: _____

PHQ-9 1

Over the last 2 weeks, how often have you been bothered by any of the following problems?

*	Little interest or pleasure in doing things *(check one)*:	Not at all Nearly every day	Several days	More than half the days
*	Feeling down, depressed, or hopeless? *(check one)*:	Not at all Nearly every day	Several days	More than half the days
*	Trouble falling or staying asleep, or sleeping too much? *(check one)*:	Not at all Nearly every day	Several days	More than half the days

DRAFT

Name: **Subscriber ID#:**

PHQ-9 2

* Feeling tired or having little energy *(check one)*:	Not at all Nearly every day	Several days	More than half the days
* Poor appetite or overeating *(check one)*:	Not at all Nearly every day	Several days	More than half the days
* Feeling bad about yourself, or that you are a failure or have let yourself or your family down *(check one)*:	Not at all Nearly every day	Several days	More than half the days

PHQ-9 3

* Trouble concentrating on things, such as reading the newspaper or watching television *(check one)*:	Not at all Nearly every day	Several days	More than half the days
* Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual *(check one)*:	Not at all Nearly every day	Several days	More than half the days
* Thoughts that you would be better off dead, or of hurting yourself in some way *(check one)*:	Not at all Nearly every day	Several days	More than half the days

Score

Score _____

1- If total score is 1-4 minimal depression
2- If total score is 5-9 mild depression
3- If total score is 10-14 moderate depression
4- If total score is 15-19 moderate severe depression
5- If total score is 20 or greater, severe depression

If score is 5-14, discuss with member a referral for further evaluation:

If score is 15 or above, refer to BH provider on an urgent basis.

Internal use only:

Name: **Subscriber ID#:**

Pediatric CM Initial Assessment (v. 6)
* Required

Demographics/General Information

First Name: _____

Last Name: _____

Member ID Number: _____

Birthday: _____

Plan: _____

Product info: _____

Street Address: _____

City: _____

State: _____

County: _____

Zip Code: _____

Home Phone: _____

Cultural and Linguistic Needs, Preferences or Limitations

* Who is providing the information to complete this assessment (include name and relationship to child/member)? _____

* What language are you most comfortable speaking and receiving information? _____

* Do you have a communication preference? (check one):
- Yes, written communication
- Yes, verbal communication
- No preference identified

List alternate/preferred contact information, such as phone, address, or designated representative information, if applicable. _____

* Do you have any cultural and/or religious beliefs that you feel may impact you or the child's ability to make healthcare decisions or follow your doctor's instructions? (check all that apply):
- Taking Medications as prescribed
- Following Prescribed diet
- Undergoing a recommended test
- Seeing a physician as recommended
- Communicating with a practitioner
- Other
- None Identified

If Other, please explain: _____

Life Planning Activities

* Who makes the primary healthcare decisions for the member? (check one):
- Mother
- Father
- Both Parents
- Grandparent(s)
- Guardian
- Other

Name: **Subscriber ID#:**

If Other, please explain: _____

Does the member have a life planning * document or advanced directive in place? *(check one):*

- Pediatric member with no life-threatening issues
- Pediatric member: Life Planning not addressed at this time or inappropriate
- Yes, member has Advance Directives in place
- No, member does not have Advance Directives in place (referred caregiver to Member Handbook)
- No, Member's Representative instructed on Advance Directives/Life Planning
- No issues or concerns with life planning identified
- Member's Representative verbalizes understanding of Advance Directives but does not wish to pursue at this time
- Unknown

Do you have a person designated to make health care * decisions for the member if you are unable to make your wishes known (health care proxy)? *(check one):*

- Yes
- No, education provided

Have you discussed your wishes about the type of care you * want or do not want for the child with their health care provider? *(check one):*

- Yes
- No, education provided

For female members between ages 15 and 44, ask the following question:

Would you like to become pregnant in the next year? *(check one):*

- Yes
- No
- I am not sure (doesn't know)
- Refuses to answer

CM Note:

- If yes, direct member to primary or women's health provider for preconception health care.
- If no, direct member to primary or women's health provider for contraception/family planning purposes.
- If response is "I am not sure/doesn't know" direct member to primary or women's health provider for interconception health care including contraception advice.
- If member refuses to answer - remind her that she has family planning coverage if this becomes important to her at a later date.

Clinical History-Physicians/Dentist/Conditions

What physicians, including specialists * are involved in the child's care? (include name and number if available) _____ _____ _____

Has the child seen a dentist in the last 6 months? *(check one):*

- Yes
- No, education provided

What are the child's current medical and behavioral health conditions/diagnoses * with dates of onset (if onset dates unknown, indicate 'member unaware of onset date')? _____ _____ _____

Clinical History-Inpatient/ER/Barriers to Care

How many times has * the child been inpatient in the last 6 months? *(check one):*

- None
- One time
- Two or more times

How many times has the child visited the * Emergency Room in the last 6 months? *(check one):*

- None
- One time
- Two or more

Name: **Subscriber ID#:**

Does the child have * any of the following barriers to care? *(check all that apply):*

- Does not understand diagnosis (knowledge deficit)
- Motivation
- Financial
- Lack of transportation
- Mobility issues
- Fear of doctors/dentist
- Ability to read or write (as age appropriate)
- Language barrier/communication (age appropriate)
- Distance to the physician's office/clinic
- Unable to obtain an appointment
- Unable to fill prescription as ordered
- Unable to take medications as prescribed
- Lack of adequate family/community support
- Frailty/medical condition
- Challenging Behavior (such as aggression, agitation, inability to redirect, uncooperative, unable to participate in care)
- Inadequate housing
- Other
- No barriers to care identified

If Other, please explain: _____

Cognitive

In your opinion, what is the child's cognitive status? *(check one):*

- Alert/oriented
- Required prompting
- Requires assistance and some direction
- Requires considerable assistance
- Serious difficulty concentrating, remembering or making decisions (members 5 years or greater only)
- Totally dependent/constant disorientation
- Other

If Other, please explain: _____

Clinical History-Medications

Does the child take any medications (including over the counter, vitamins, and herbal * medications)? If yes, list medications with schedule and dosages on Initial Assessment template. *(check one):*

- Yes
- No
- Unknown

Clinical History-Height/Weight

Is height and weight * information available? *(check one):*

- Yes
- No

Clinical History-Nutrition

Has the child experienced any recent unintentional weight loss/weight gain within the last 6 months? *(check one):*

- Yes, Wt gain
- Yes, Wt loss
- Denies wt gain/wt loss

If Yes, how much weight gain/loss? _____

Has the doctor recommended any specific nutritional (eating) plan for the child? *(check one):*

- Yes
- No

If Yes, please describe: _____

Does the child have any problems eating, * such as (check all that apply) *(check all that*

- Issue with Teeth/chewing
- Difficulty swallowing
- Fluid restriction
- Food allergy
- GI disturbances (constipation, distension, diarrhea)
- Lactose/Formula intolerance
- Requires Nutritional Supplements
- Vomiting
- Reflux/GERD
- Receives NG/GT feeds
- Inability to obtain food
- Inability to obtain specialty formula

Name: **Subscriber ID#:**

apply):
- Choking (aspiration)
- Lack of appetite
- Other
- None

If Other, please describe: _____

Clinical History-Vision/Hearing/Immunizations/Lead

* Does the child have vision problems not corrected with lenses? (check one)
- Yes
- No

If Yes, please explain: _____

* Does the child have hearing problems not corrected with assistive devices? (check one):
- Yes
- No

If Yes, please explain: _____

Is the child up to date with his/her age appropriate immunizations? (check one):
- Yes
- No - Education provided
- No - Religious exemption
- No - Allergic or contraindicated
- Unsure - Education provided

Please list any other immunizations the child has received within the past 12 months, such as flu, pneumonia, Synagis for RSV. (List date received, if known.) _____

ATTN CM: Only ask if member is between the ages of 6 months and 6 years of age - Has the child had a lead screening test? (check one):
- Yes
- No - Education provided
- Unknown - Education provided
- N/A

Activities of Daily Living/ Community and Caregiver Resources

(Do not ask if TN-see TN question below) Does the child have difficulty/need assistance performing any of the following activities? (check all that apply):
- No issues/Age appropriate
- Bathing
- Bowel and/or Bladder Management (Continence/Incontinence Care, as age appropriate)
- Other
- Grooming
- Ambulation/ Transfers
- Climbing Stairs
- Dressing
- Feeding Self
- Age Appropriate Exercise

If Other, please explain: _____

* What home or community support services does the child currently have in place? (check all that apply) (check all that apply):
- WIC
- Behavioral Health Professional
- Home Health - Skilled Nursing (hourly temporary)
- Housing Assistance
- Personal Care Services/HHA
- School based services
- Substance Use Facility/Provider
- Waiver services
- SSI
- Early intervention Program (EIP)
- DME Supply
- Home Health - Skilled Nursing (private duty long term)
- Infusion Therapy
- Physical therapy
- Speech therapy
- Tobacco Cessation
- Faith based support services
- Other
- School based Individualized Education Plan (IEP)
- Financial Assistance/Resources
- Hospice/Palliative care
- Medical Day Care
- Occupational therapy
- Social Services
- Access to transportation/Transportation services
- Child Protective Services
- None needed

If Other, please explain: (PLEASE SPECIFY

Name: **Subscriber ID#:**

CAREGIVER NAME AND LEVEL OF INVOLMENT OF CARE, IF APPLICABLE) _____

* Do you feel you need additional assistance, services and/or equipment to adequately care for the child and support you as the caregiver (if appropriate)? *(check one)*:

- Yes, additional assistance, services or equipment needed
- No, additional assistance, services or equipment needed

If Yes, please explain and list resources/education provided _____

* Do you have any of the following social concerns? *(check all that apply)*:

- Clothing
- Family
- Finances/Difficulty making ends meet at the end of the month
- Food
- Housing
- Pharmacy
- Safety
- School
- Sexual Abuse
- Transportation
- Violence/Abuse
- Other
- None identified

If Other, please explain: _____

CM reviewed available plan benefits with the member representative (check all that apply). *(check all that apply)*:

- Transporation
- Dental
- Vision
- Hearing
- Network Medical providers
- Network BH providers
- Network SUD providers
- Nurse Helpline
- Member Services
- Pharmacy assistance
- Member handbook reviewed/requested to be sent
- Other

If Other, please describe: _____

CM reviewed available community programs/services with the member/member representative (check all that apply). *(check all that apply)*:

- WIC
- Early intervention Program (EIP)
- School based Individualized Education Plan (IEP)
- Behavioral Health Professional
- DME Supply
- Financial Assistance/Resources
- Home Health - Skilled Nursing (hourly temporary)
- Home Health - Skilled Nursing (private duty long term)
- Hospice/Palliative care
- Housing Assistance
- Infusion Therapy
- Medical Day Care
- Personal Care Services/HHA
- Physical therapy
- Occupational therapy
- School based services
- Speech therapy
- Social Services
- Substance Use Facility/Provider
- Tobacco Cessation
- Access to transportation/Transportation services
- Waiver services
- Faith based support services
- Child Protective Services
- SSI
- Other
- None needed

If Other, please describe: _____

* How confident are you, on a scale of 0-10 (with 10 being the most confident) that you understand and can manage the health care needs of the child *(check one)*:

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Do you need help with referrals from other health care or social services such as shelter, food, clothing or other? *(check one)*:

- Yes
- No

If Yes, please describe the needs in the space below: _____

Substance Use/Behavioral Health (>10 yrs of age)

Name: **Subscriber ID#:**

Does the member participate in any of the following activities? (check all that apply) *(check all that apply)*:
- Uses recreational drugs or medications not prescribed to them
- Drinks alcohol
- Uses tobacco products
- Exposed to tobacco smoke in environment
- None identified
- No
- Unknown

(Ask If the child participates in any of the above activities above) Are you and/or the member interested in learning more about supportive services that can assist them in quitting? *(check one)*:
- Yes, education provided
- No

Over the past two weeks, how often has the member been bothered by the following problems? (2 questions below)

Little interest or pleasure in doing things? *(check one)*:
- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed or hopeless? *(check one)*:
- Not at all
- Several days
- More than half the days
- Nearly every day

PHQ-2 Score

PHQ-2 Score: _____

If the total score for the two questions above is greater than or equal to 3 then a BH assessment should be completed. You will be prompted at the end of this assessment to complete the PHQ-9 assessment.

Assessments

Select potential assessments for the future at this time: *(check all that apply)*:
- None identified at this time
- CM Asthma Initial
- BAS (Cognitive) Screening Test
- BH General Pediatric
- CM Pediatric Cardiology
- CM CVA Assessment
- CM Diabetes
- CM GERD Assessment
- CM HIV Assessment
- CM HTN Initial Assessment
- CM Migraine Headache
- CM MS
- CM Neurology
- CM Obesity/Bariatric
- CM Private Duty Nursing
- CM Traumatic Brain Injury
- CM Wound & Cellulitis
- CM ER HRA
- 2016 Anthem OB High Risk Screener
- CM Homeless Assessment
- Transplant Assessment
- CM Lead Toxicity
- NICU Post Discharge Screening Assessment
- NICU PTSD Initial Screening HRA
- Other

If Other, please specify: _____

Do you want to branch to the PHQ-9 Assessment and BH General Peds Assessment now? *(check one)*:
- Yes
- No

Age

Is the member under the age of 24 months? *(check one)*:
- Yes
- No

Clinical History-Height/Weight under 2

What is the child's height/length in inches? _____

What is the child's weight in pounds/ounces? _____

Name: **Subscriber ID#:**

Clinical History-Height/Weight over 2

What is the child's height/length in inches? _____

What is the child's weight in pounds? _____

Child/Teen BMI calculator/ BMI over 2

Child/Teen BMI Calculator

https://nccd.cdc.gov/dnpabmi/Calculator.aspx

Current BMI: _____

Clinical History-Females > 8 years old only

Has the member begun menstruation? *(check one)*: ☐ Yes ☐ No ☐ Unknown, Education provided/to discuss with PCP

Clinical History-Females > 8 years old only II

At what age did the member begin menstruation? _____

Are you aware if the member is using birth control? *(check one)*: ☐ Yes ☐ No-Education/Resources provided ☐ No- Not sexually active/Not applicable ☐ Unknown/Education resources provided

Are you aware if the member is pregnant? *(check one)*: ☐ Yes ☐ No

If member is pregnant, refer to OB CM.

BH PHQ-9 *(v.68)*
** Required*

Member Information

First Name: _____

Last Name: _____

Member ID# : _____

Date of Birth: _____

Date PHQ-9 was done: _____

PHQ-9 1

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Name: Subscriber ID#:

* Little interest or pleasure in doing things (check one):	Not at all Nearly every day	Several days	More than half the days
* Feeling down, depressed, or hopeless? (check one):	Not at all Nearly every day	Several days	More than half the days
* Trouble falling or staying asleep, or sleeping too much? (check one):	Not at all Nearly every day	Several days	More than half the days

PHQ-9 2

* Feeling tired or having little energy (check one):	Not at all Nearly every day	Several days	More than half the days
* Poor appetite or overeating (check one):	Not at all Nearly every day	Several days	More than half the days
* Feeling bad about yourself, or that you are a failure or have let yourself or your family down (check one):	Not at all Nearly every day	Several days	More than half the days

PHQ-9 3

* Trouble concentrating on things, such as reading the newspaper or watching television (check one):	Not at all Nearly every day	Several days	More than half the days
* Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual (check one):	Not at all Nearly every day	Several days	More than half the days
* Thoughts that you would be better off dead, or of hurting yourself in some way (check one):	Not at all Nearly every day	Several days	More than half the days

Score

Score _____

1- If total score is 1-4 minimal depression
2- If total score is 5-9 mild depression
3- If total score is 10-14 moderate depression
4- If total score is 15-19 moderate severe depression
5- If total score is 20 or greater, severe depression

If score is 5-14, discuss with member a referral for further evaluation:

If score is 15 or above, refer to BH provider on an urgent basis.

BH General Pediatric Assessment (v.96)
* Required

Crisis Question

* Is member in crisis at time of the call? (check one):	Yes	No

Name: **Subscriber ID#:**

Crisis Assessment

* Is your child having thoughts of hurting him or herself or someone else? (If yes, DO NOT put member on hold. Follow Crisis Call procedure.) *(check one):* Yes No

* To the best of your knowledge, is your child feeling physical discomfort related to drug or alcohol abuse? (If yes, DO NOT put member on hold. Follow Crisis Call procedure) *(check one).* Yes No

Crisis Protocol

CM: IF ANSWER IS YES TO EITHER OF THE QUESTIONS ON THE CRISIS ASSESSMENT, FOLLOW CRISIS PROTOCOL

Specific Condition

HAVE YOU EVER BEEN TOLD BY A MENTAL HEALTH PROFESSIONAL THAT YOUR CHILD HAS ANY OF THE FOLLOWING CONDITIONS:

Specific Condition I

* Schizophrenia? *(check one).* Yes No

If Yes, can you tell me what you know about it? _____

For CM only: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one):* Yes No

Specific Condition II

* Schizoaffective Disorder? *(check one):* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one):* Yes No

Specific Condition III

* Bipolar Disorder? *(check one):* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her childs's Yes No

Name: **Subscriber ID#:**

condition(s)? *(check one).*

Specific Condition IV

* Depression (or Major Depression)? *(check one):* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one):* Yes No

How often do you need to have someone help you read instructions, pamphlets, or other written material from your doctor or pharmacy? *(check one):* Never Rarely Sometimes Often Always

Specific Condition V

* Attention-Deficit Hyperactivity Disorder or Attention-Deficit Disorder? *(check one).* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one):* Yes No

Specific Condition VI

* Have you ever been told by a mental health professional that your child has Autism Spectrum Disorder or Intellectual Developmental Disability? *(check one):* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one):* Yes No

"In the past week, has your child had any symptoms that got in the way of his/her doing important things like going to school, going to Yes No

Name: **Subscriber ID#:**

appointments, or that interfered with any of his/her usual activities?" *(check one)*

If Yes, request information about the nature and acuity of symptoms. _____

Self-Management

* Do you have a plan for the management of your child's condition (e.g. recognition of relapse triggers, stressors, signs of decompensation, etc.)? *(check one)*: Yes No

* For CM Only: In the CM's judgement, is the stated management plan adequate to reduce the risk of relapse/recurrence? *(check one)*: Yes No

Provider Type

* Is your child currently seeing a psychiatrist? (CM Note: If yes to any of the questions on this page you will be linked to the Address Book to enter/review the provider information) *(check one)*: Yes No

* Is your child currently seeing any other mental health provider or professional (that is, a psychologist, a social worker, family therapist, case manager, etc)? *(check one)*: Yes No

* Is your child currently going to any other type of treatment program such as AA or NA? *(check one)*: Yes No

Referral to BH Provider

CM: Evaluate the need for referral to BH Provider

Scheduled Appointment

* Does your child have an appointment scheduled to see his/her psychiatrist or other mental health provider, or PCP? *(check one)*: Yes No

Medications

Have you noticed any side-effects from the medications, that is,

Name: Subscriber ID#:

any problems that you think are caused by your child taking the medicine? (check one):	Yes	No
If Yes, Please tell me about side effects you have noticed.	_____	
Do these side effects get in the way of your child taking his/her medications as directed? (check one):	Yes	No

Referral to Prescriber

CM: Evalute the need to refer to prescribing provider for medication evaluation

Hospital History

* Has your child ever been in the hospital overnight related to a mental health or substance abuse problem? (check one):	Yes	No	
When was the last time your child was hospitalized for a mental health or substance abuse problem? (check one):	Less than three months ago More than one year ago	Three months to six months ago	Six months to one year ago
How many times has your child been admitted to the hospital for a mental health or substance abuse problem in the last year? (check one):	none three times	once more than three times	twice

Substance Abuse History

* Has your child ever been treated for problems with alcohol, drugs, or substance abuse? (check one):	Yes	No

Referral to SA Provider

CM: Evaluate the need to refer to SA Provider for SA evaluation

BH Relapse Risk 1

* Does the member have a history of treatment non-adherence? (check one):	Yes	No	N/A
* Is the member currently adherent with outpatient treatments and medications? (check one):	Yes	No	N/A
* Does the member understand that he/she has a mental illness for which she/he needs treatment? (check one):	Yes	No	N/A

BH Relapse Risk 2

Name: **Subscriber ID#:**

* Does the member have a good relationship with a Behavioral Health Provider? *(check one):*	Yes	No	N/A

Provider Type II

Does your child get help for a mental health issue or problem from his/her regular doctor, that is, his/her Primary Care doctor or PCP? *(check one):*	Yes	No

Internal use only:

DRAFT

This page is intentionally left blank

Name: **Subscriber ID#:**

2016 OB High Risk Screener *(v.22)*
*Required

Member Identification

ATTN SCREENER: Please select Yes. (Do not select No option- it will affect queuing). FOR DUALS ONLY: Please select No. *(check one)* * Yes No

Today's Date: _____

Member's Age: (at time of screener) _____

CI3 Risk Score: _____

Attn Screener: Please select the "Member Identification Source". *(check one)*

- NCC-PDS
- Fast Track Report
- Unable to Reach Report
- Provider Referral
- Member Self Referral
- Web Survey
- NCC-Callback
- TX Call Center
- Hospital Census
- Bad Contact Info Report
- HRA on Enrollment
- Transfer- Other CM Specialty
- Other
- My Advocate
- Lab Report
- Prior Authorization Report
- UM Nurse Referral
- Nurse Help Line
- Returned Paper Survey
- Warm Health

Intro Script 1

FOR ARKANSAS
: Hello, this is [Name of Call Rep]. I'm calling on behalf of Summit Community Care, your health plan.

FOR DELL CHILDREN'S CHIP Perinate:
(Note Call Reps- Follow HIPAA requirements for the call). Hello, this is [Name of Call Rep]. I am calling on behalf of Dell Children's Health Plan.

FOR DISTRICT OF COLUMBIA:
Hello, this is [Name of Call Rep]. I am calling on behalf of Amerigroup District of Columbia, Inc., your health plan.

FOR FLORIDA AGP:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Amerigroup, your health plan.

FOR FLORIDA CLEAR HEALTH ALLIANCE:
Hello, this is [Name of Call Rep]. I am calling on behalf of Clear Health Alliance.

FOR FLORIDA SIMPLY:
Hello, this is [Name of Call Rep]. I am calling on behalf of Simply Healthcare Plans, Inc.

FOR INDIANA, KENTUCKY & WISCONSIN:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Anthem Blue Cross and Blue Shield, your health plan.

FOR IOWA:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Amerigroup Iowa, Inc., your health plan.

FOR KANSAS:

Hello, this [Name of Call Rep]. I'm calling on behalf of Amerigroup Kansas, Inc., your health plan.

FOR LOUISIANA:

Hello, this is [Name of Call Rep]. I'm calling on behalf of Healthy Blue, your health plan.

FOR GEORGIA, MARYLAND, NEW JERSEY:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Amerigroup Community Care, your health plan.

FOR MINNESOTA:

Hello, this is [Name of Call Rep]. I'm calling on behalf of Blue Plus, your health plan.

FOR NEVADA:
Hello, this is [Name of Call Rep]. I am calling on behalf of Anthem Blue Cross Blue Shield Healthcare Solution, your health plan.

FOR NEW YORK EMPIRE:
Hello, this is [Name of Call Rep]. I am calling on behalf of Empire BlueCross BlueShield HealthPlus, your health plan.

FOR NORTH and SOUTH CAROLINA:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Healthy Blue, your health plan.

Name: **Subscriber ID#:**

FOR TENNESSEE:
Hello, this is [Name of Call Rep]. I am calling on behalf of Amerigroup Community Care, your health plan.

FOR TEXAS:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Amerigroup Texas, your health care plan.

FOR TEXAS CHIP Perinate: (Note Call Reps- Follow HIPPA requirements for the call).
Hello, this is (Name of Call Rep). I am calling on behalf of Amerigroup.

FOR TEXAS STAR Kids:
Hello, this is [Name of Call Rep]. I am calling on behalf of Amerigroup, your health care plan.

FOR TEXAS MMP:
Hello, this is [Name of Call Rep]. I'm calling on behalf of Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) Texas, your health care plan.

FOR VIRGINIA (Medicaid, FAMIS, CCC+):

Hello, this is [Name of Call Rep]. I'm calling on behalf of Anthem HealthKeepers, Inc., your health plan.

FOR VIRGINIA MMP
:
Hello, this is [Name of Call Rep.]. I am calling on behalf of Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, your health plan.

FOR WASHINGTON:
Hello, this is [Name of Call Rep.]. I'm calling on behalf of Amerigroup Washington, Inc. your health plan.

FOR WESTERN NEW YORK:
Hello, this is [Name of Call Rep]. I am calling on behalf of BlueCross BlueShield of Western New York, your health plan.

FOR WEST VIRGINIA:

Hello, this is [Name of Call Rep]. I'm calling on behalf of UniCare Health Plan of West Virginia, Inc., your health plan.

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FOR ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate:
Before we start, I want to let you know this call may be recorded for quality assurance.

FOR ALL OTHER Markets:
Before we start, I want to let you know this call may be recorded for quality assurance.

We would like to discuss your health care benefits, ask you some questions about your health and answer any questions you might have. This message is for (member's name). Am I speaking to the right person?

FOR NEW JERSEY:
For privacy purposes, can you verify your address, ID and date of birth? Thank you.
If
No
verification: We are not able to discuss this person's information with you due to privacy laws. When would be a good time to reach [Member's name]?

****

Member response: *(check one)*:
- ☐ Yes
- ☐ Wrong Number- New number NOT obtained
- ☐ No- Member not available
- ☐ Member refused survey
- ☐ Wrong Number- New number obtained
- ☐ Hung up

If No, please document alternate phone number: _____

ALL MARKETS EXCEPT ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate, MINNESOTA, NEVADA, NORTH CAROLINA & TEXAS CHIP Perinate: If Yes, because we value your safety, are you driving? *(check one)*
- ☐ Yes
- ☐ No

If Yes, member is driving:
Thank you, I will call you back at a more convenient time.

Name: **Subscriber ID#:**

Will you need an interpreter for this call and future calls? (NOTE for FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate- If an interpreter is required, follow health plan guidelines to obtain an interpreter in order to proceed with the call.) *(check one):*

Yes No

Intro Script 2

FOR TEXAS MMP:
If you are unable to verify, case manager may terminate the call.

OK. Thanks! I have one more step to protect your privacy, please tell me your birthdate. Great, now I know I have the right person. FOR FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate- If no verification: We are not able to discuss this person's information with you due to privacy laws. When would be a good time to reach [Member Name]? Make a note when to call back.

My Advocate Only - Year of Birth? _____

We want you to get the most from your health benefits during this important time by gathering some health information about you. But first, I want to verify our records.

FOR FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate: We would like to discuss your health care benefits, ask you some questions about your health and answer any questions you may have. We want you to get the most from your health benefits during this important time by gathering some health information about you. But first, I want to verify our records.

Pregnancy Verification

Our records show that you are pregnant. Is this true?

FOR FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate: Our records show that you may be pregnant. Is this true?

* Member response: *(check one):* Yes Yes- Terminating No Unsure Hung up

Intro Script 3

If Yes, member is pregnant:
Congratulations! We are here to help you get the best care for you and your baby. To do this, we would like to get some information that will help us help you during your pregnancy.
We will ask you a series of questions related to your pregnancy. This will take only about five minutes. Your answers are private and will not change your current coverage. They'll help us to serve you better.

FOR NEW JERSEY:

Name: **Subscriber ID#:**

Congratulations! We are here to help you get the best care possible for you and your baby. To do this, we would like to get some information that will help us help you during your pregnancy.
We will ask you a series of questions related to your pregnancy. This will take only about five minutes. Your answers are private and will not change your current coverage. They'll help us to serve you better.

FOR TEXAS, TEXAS STAR Kids and TEXAS MMP:
Congratulations! We are here to help you and offer you quality care for you and your baby. To do this, I would like to get some information that will help us help you during your pregnancy.
We will ask you a series of questions related to your pregnancy. This will take only about five minutes. Your answers are private and will not change your current coverage. They'll help us to serve you better.

FOR DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate
: Congratulations! We are here to help you and offer quality care for you and your baby. To do this, I would like to get some information that will help us help you during your pregnancy.

I will ask you a series of questions related to your pregnancy. This will take only about 5 minutes. Your answers are private and will not change your current coverage. They'll help us to serve you better.

Intro Script 4

FOR WESTERN NEW YORK:
Is there another number you would prefer us to use to reach you for future calls?

Is there another phone number that you prefer us to use to reach you for future calls? *(check one)*: ☐ Yes ☐ Hung up ☐ No ☐ Skip

If Yes, please document alternate phone number: _____

If member provides different phone number:

To confirm, you consent to have: [Insert Health Plan Content Below] *(check one)*: ☐ Yes Hung up ☐ No ☐ Skip

FOR ARKANSAS:
Summit Community Care call you on this number?

FOR DELL CHILDREN'S HEALTH PLAN & DELL CHILDREN'S CHIP Perinate:
Dell Children Health Plan call you on this number?

FOR DISTRICT OF COLUMBIA, FLORIDA AGP, GEORGIA, IOWA, KANSAS, MARYLAND, NEW JERSEY, TENNESSEE, TEXAS , TEXAS CHIP PERINATE, TEXAS STAR Kids & WASHINGTON:
Amerigroup call you on this number?

FOR FLORIDA CLEAR HEALTH ALLIANCE:
CHA (Clear Health Alliance) call you on this number?

FOR FLORIDA SIMPLY:
Simply call you on this number?

FOR LOUISIANA:
Healthy Blue call you on this number?

FOR MINNESOTA :
Blue Plus call you on this number?

FOR NEW YORK EMPIRE :
Empire call you on this number?

FOR TEXAS MMP:

STAR+PLUS for TX MMP call you on this number?

FOR INDIANA, KENTUCKY, NEVADA & WISCONSIN:

Anthem call you on this number?

FOR NORTH and SOUTH CAROLINA:
Healthy Blue call you on this number?

FOR VIRGINIA (Medicaid, FAMIS, CCC+):
Anthem HealthKeepers Plus offered by HealthKeepers, Inc. call you on this number?

Name: **Subscriber ID#:**

FOR VIRGINIA MMP:
Anthem HealthKeepers MMP call you on this number?

FOR WESTERN NEW YORK:
BlueCross BlueShields call you on this number?

FOR WEST VIRGINIA:

UniCare call you on this number?

****

FOR ARKANSAS, DELL CHILDREN'S HEALTH PLAN, DISTRICT OF COLUMBIA, FLORIDA AGP, FLORIDA CLEAR HEALTH ALLIANCE, GEORGIA, INDIANA, IOWA, KANSAS, KENTUCKY, LOUISIANA, MARYLAND, NEVADA, NEW YORK EMPIRE, NORTH CAROLINA, TENNESSEE, TEXAS, TEXAS STAR Kids, VIRGINIA (Medicaid, FAMIS, CCC+), WASHINGTON, WEST VIRGINIA & WISCONSIN:

Inform the member they will need to call their state Medicaid agency to change the number.

FLORIDA SIMPLY:

Inform the member they will need to call your Florida Medicaid agency or Florida Healthy Kids to change the number.

FOR NEW JERSEY:

Inform the member they will need to call NJ FamilyCare at 1-800-701-0710 (TTY 1-800-701-0720) to change their number.

FOR SOUTH CAROLINA:

Inform the member she will need to call South Carolina Healthy Connections at 1-888-549-0820 to change the number.

FOR TEXAS CHIP Perinate & DELL CHILDREN'S CHIP Perinate:
Inform members they will need to call the Texas Health and Human Services Commission at 2-1-1 to change the number.

FOR TEXAS MMP:

Inform the member they will need to call their state Medicare agency to change the number.

FOR VIRGINIA MMP:
Inform the member she will need to call her local Department of Social Services to change the number.

FOR WESTERN NEW YORK:
Inform the member they will need to call their state agency to change the number.

If member opts out, add phone number to "Do Not Call" list.

Intro Script 5

Have you picked a doctor to provide you with prenatal care? *(check one)*
- Yes
- No
- Skip
- Hung up

ATTN Screener: Attempt to get general location of office. If yes, what is the provider's name? (If member does not know, type "Doesn't know" in the text field) _____

If Yes, what is provider's street address? (If member does not know, type "Doesn't know" in the text field) _____

If Yes, what is provider's City? (If member does not know, type "Doesn't know" in the text field) _____

If Yes, what is provider's State? (If member does not know, type "Doesn't know" in the text _____

Name: **Subscriber ID#:**

field)

If Yes, what is provider's Zip Code? (If member does not know, type "Doesn't know" in the text field) _____

If Yes, what is provider's phone number? (If member does not know, type "Doesn't know" in the text field) _____

FOR NEW JERSEY, NEW YORK EMPIRE, TENNESSEE & WESTERN NEW YORK:
When *WAS* the date of your first prenatal care appointment for this pregnancy?

FOR ALL OTHERS: When is the date of your first prenatal care appointment for this pregnancy?

When is the date of your first prenatal care appointment for this pregnancy? _____

*If member does not recall the exact date, the approximate date is acceptable

If No, do you need assistance finding an OB provider? (check one): Yes, No, N/A, Skip, Hung up

If Yes, refer to Member Services after the call

FOR SOUTH CAROLINA & WEST VIRGINIA:
Refer to Customer Care Center after the call

Do you have any special needs that we can assist you with? (If yes, note the response.) (check all that apply): Blindness, Deafness, Unable to read, Unable to speak, Speak another language, Other, None, Skip, Hung up

Speak another language? _____

Other special needs? _____

If the member answers yes to any of the special needs listed above, record the special need(s) and enter a phone log to Enrollment for data capture and health plan follow-up.

Pregnancy Intro

Now I'd like to ask a few questions about your current pregnancy and any prior pregnancies.

When is your baby due? _____

Pregnancy Intro 2

Attn Screener: Please select continue.

General OB

Weeks of gestation (1- 45): _____

Have you been told by your provider that you are going to have twins or more than one baby? (check one): Yes, No, Unknown, Skip, Hung up

Is this the first time you have ever been pregnant? (check one): Yes, No, Skip, Hung up

Name: **Subscriber ID#:**

Preterm labor is labor that happens before your 37th week of pregnancy. This is about three weeks earlier than your due date.

FOR NEW YORK EMPIRE & WESTERN NEW YORK:
If member is between 20 weeks and 37 weeks gestation, ask the following question.

Have you had preterm labor during this pregnancy? *(check one):*	Yes Hung up	No	Skip

Previous Pregnancy

In any previous pregnancies, were you told by your provider that you had preterm labor? *(check one):*	Yes Hung up	No	Skip
Have you ever given birth to a baby more than 3 weeks before your due date? *(check one):*	Yes Hung up	No	Skip
Have you ever given birth to a baby that weighed less than 5 pounds? *(check one):*	Yes Hung up	No	Skip
Have you ever had a C-section? *(check one):*	Yes Hung up	No	Skip

Current Pregnancy

Have you had to go to the emergency room during this pregnancy for a pregnancy-related problem? *(check one):*	Yes Hung up	No	Skip
Have you been admitted to the hospital during this pregnancy for a pregnancy- related problem? *(check one):*	Yes Hung up	No	Skip

General Health

Next, I'm going to ask you some questions about your general health.

Have you ever been told that you had any type of diabetes? *(check one):*	Yes Hung up	No	Skip

I'm going to name some health conditions. Tell me if you have any of these now (pause between each):

Asthma or other chronic lung disease? *(check one):*	Yes Hung up	No	Skip
High blood pressure? *(check one):*	Yes Hung up	No	Skip

Can you please tell me how tall you are?

Feet? _____

Inches? _____

How much did you weigh at the start of your pregnancy? _____

Name: **Subscriber ID#:**

Race and Ethnicity

The next question is about your race and ethnicity. Some ethnicities are at greater risk for complications during pregnancy.

Would you tell me the race that you classify yourself as? Is it: *(check one)*
- White
- Black or African American
- Hispanic or Latino
- Asian
- American Indian or Alaska Native
- Some other race
- Chose not to answer
- WH All Other
- Hung Up

Do you travel with a parent or family member who is a traveling farm worker? *(check one)*
- Yes
- No
- Skip
- Hung up

General Health 2

Thanks, we're almost done.

During the past month, have you often been bothered by feeling down, depressed or hopeless? *(check one)*
- Yes
- No
- Skip
- Hung up

During the past month, have you often been bothered by little interest or pleasure in doing things? *(check one)*
- Yes
- No
- Skip
- Hung up

Have you enrolled in Woman, Infants and Children or WIC? *(check one)*
- Yes
- No
- Skip
- Hung up

Have you seen a dentist in the last 6 months? *(check one)*
- Yes
- No
- Skip
- Hung up

Social Concerns 1

These next few questions are very personal but your answers can help us better serve you:

Have you had a sexually transmitted disease in the past year? *(check one)*
- Yes
- No
- Skip
- Hung up

Have you been told that you are HIV positive? *(check one)*
- Yes
- No
- Skip

If Yes: Have you received HIV counseling on the latest recommended antiretroviral regimen? *(check one)*
- Yes
- No
- Skip

Have you been told that you have Hepatitis B? *(check one)*
- Yes
- No
- Skip

Social Concerns 2

Have you ever been emotionally, sexually or physically abused by your partner or someone important to you? *(check one)*
- Yes
- No
- Skip
- Hung up

FOR NEW JERSEY:

If Yes: If you need to speak with a domestic abuse crisis counselor, call 1-800-799-7233 (TTY 1-800-787-3224).

Name: **Subscriber ID#:**

Health Habits

In the month before you were pregnant, how often did you use cigarettes, other tobacco products, E-cigarettes or a vape pen? *(check one):*	Never/No Hung up	Sometimes/Yes	Skip
For ARKANSAS, DC, DELL CHILDREN'S CHIP Perinate, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, MINNESOTA, NEVADA, NORTH CAROLINA, & TEXAS CHIP PERINATE: In the month before you were pregnant, did you use cigarettes, other tobacco products, E-cigarettes or a vape pen? *(check one):*	Yes Hung up	No	Skip

If Yes or Sometimes:

FOR ARKANSAS:
If you are interested, I can provide you with a free resource called the Arkansas Tobacco Quitline.

FOR DISTRICT OF COLUMBIA:
If you are interested, I can provide you with a free resource called the District of Columbia Tobacco Quitline.

FOR FLORIDA AGP; FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY:
If you are interested, I can provide you with a free resource called the Florida Tobacco Quitline.

FOR GEORGIA:
If you are interested, I can provide you with a free resource called the Georgia Tobacco Quitline.

FOR DELL CHILDREN'S HEALTH PLAN, DELL CHILDREN'S CHIP Perinate, TEXAS, TEXAS CHIP Perinate, TEXAS STAR Kids & TEXAS MMP
:
If you are interested, I can provide you with a free resource called TX Tobacco Quitline.

FOR INDIANA:

If you are interested, I can provide you with a free resource called the Indiana Tobacco Quitline.

FOR IOWA:

If you are interested, I can provide you with a free resource called Quitline Iowa.

FOR KANSAS:

If you are interested, I can provide you with a free resource called Kansas Tobacco Quitline.

FOR KENTUCKY:

If you are interested, I can provide you with a free resource called the Kentucky Tobacco Quitline.

FOR LOUISIANA
:
If you are interested, I can provide you with a free resource called the Louisiana Tobacco Quitline.

FOR MARYLAND
:
If you are interested, I can provide you with a free resource called the Maryland Tobacco Quitline.

FOR MINNESOTA
:
If you are interested, I can provide you with a free resource called the Minnesota Tobacco Quitline.

FOR NEW JERSEY:

If you are interested, I can provide you with a free resource called New Jersey Tobacco Quitline.

FOR NEW YORK EMPIRE & WESTERN NEW YORK:
If you are interested, I can provide you with a free resource called the New York Tobacco Quitline.

FOR NEVADA:

If you are interested, I can provide you with a free resource called the Nevada Tobacco Quitline.

FOR NORTH CAROLINA
: If you are interested, I can provide you wtih a free resource called QuitlineNC.

FOR SOUTH CAROLINA:

If you are interested, I can provide you with a free resource called the South Carolina Tobacco Quitline.

FOR TENNESSEE:
If you are interested, I can provide you with a free resource called the TN Tobacco Quitline.

FOR VIRGINIA (Medicaid, FAMIS, CCC+) & VIRGINIA MMP:
If you are interested, I can provide a free resource called the Virginia Tobacco Quitline.

FOR WASHINGTON:
If you are interested, I can provide you with a free resource called the Washington Tobacco Quitline.

FOR WEST VIRGINIA:

If you are interested, I can provide you with a free resource called the West Virginia Tobacco Quitline.

FOR WISCONSIN:

If you are interested, I can provide you with a free resource called the Wisconsin Tobacco Quitline.

****

The program can help pregnant women deal with tobacco cravings and other challenges, as well as quit smoking for good.

Would you like the phone number? (check one): Yes | No | N/A | Skip | Hung up

If Yes:

The number is 1-800-QUIT-NOW. Let me repeat that for you 1-800-QUIT-NOW (1-800-784-8669).

FOR NEW JERSEY:

The number is 1-866-NJSTOPS (TTY 711). Let me repeat that for you. 1-866-NJSTOPS, 1-866-657-8677 (TTY 711).

In the month before you were pregnant, how often did you use Marijuana? (check one): Never/No | Sometimes/Yes | Skip | Hung up

FOR ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DC, DELL CHILDREN'S CHIP PERINATE, MINNESOTA, NEVADA, NORTH CAROLINA & TEXAS CHIP PERINATE: In the month before you were pregnant, did you use marijuana? (check one): Yes | No | Skip | Hung Up

FOR ALL MARKETS, INCLUDING TEXAS MMP
: Have you ever experimented with street drugs?

FOR ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate, DISTRICT OF COLUMBIA, MINNESOTA, NEVADA, NORTH CAROLINA & TEXAS:
During the past year, have you used any street drugs?

Street drugs? (check one): Yes | No | Skip | Hung up

In the month before you were pregnant, how often did you drink any beer, wine or liquor? (check one): Never/No | Sometimes/Yes | Skip | Hung up

Name: **Subscriber ID#:**

FOR ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DC, DELL CHILDREN'S CHIP Perinate, MINNESOTA, NEVADA, NORTH CAROLINA & TEXAS CHIP PERINATE: In the month before you were pregnant, did you drink any beer, wine or liquor? *(check one)*:	Yes Hung up	No	Skip
In the month before you were pregnant, how often did you take a prescription drug that was NOT prescribed for you? *(check one)*:	Never/No Hung up	Sometimes/Yes	Skip
FOR ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DELL CHILDREN'S CHIP Perinate, DC, MINNESOTA, NEVADA, NORTH CAROLINA & TEXAS CHIP Perinate: In the month before you were pregnant, did you take a prescription drug that was NOT prescribed for you? *(check one)*:	Yes Hung up	No	Skip

FOR ARKANSAS, FLORIDA CLEAR HEALTH ALLIANCE/SIMPLY, DISTRICT OF COLUMBIA, MINNESOTA, NEVADA & NORTH CAROLINA: Being homeless means that you do not have a regular, safe place to live at this time.

Are you homeless? *(check one)*:	Yes Hung up	No	Skip

FOR ARKANSAS- do not ask transportation question.

ALL MARKETS EXCEPT ARKANSAS, DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate: Do you need assistance with transportation to your OB provider? FOR FLORIDA SIMPLY-SMMC MMA and LTC members only; does not apply to FHK members *(check one)*:	Yes Hung up	No	Skip
Do you have a pediatrician in mind to take care of your baby? *(check one)*:	Yes Hung up	No	Skip
If Yes, what is the provider's name? (If member does not know, type "Doesn't know" in the text field)	_____		
If No, do you need assistance finding a pediatrician? *(check one)*:	Yes Skip	No Hung up	N/A

If member needs assistance with finding an OB provider, transportation to their OB provider or finding a pediatrician:

FOR ARKANSAS:
Refer to Member Services at 1-844-405-4295 (TTY 711) for assistance

FOR DELL CHILDREN'S HEALTH PLAN: & DELL CHILDREN'S CHIP Perinate
Refer to Member Services at 1-888-596-0268 for assistance.

FOR: DISTRICT OF COLUMBIA, FLORIDA AGP, GEORGIA, IOWA, KANSAS, MARYLAND, NEW JERSEY, TENNESSEE, TEXAS, TEXAS CHIP Perinate & WASHINGTON
: Refer to Member Services at 1-800-600-4441**(DISTRICT OF COLUMBIA, FLORIDA, IOWA & NEW JERSEY: TTY 711)**for assistance.

FOR FLORIDA CLEAR HEALTH ALLIANCE:
Refer to Member Services at 1-844-406-2398 (TTY 711) for assistance.

FOR FLORIDA SIMPLY:
Refer member to call the Member Services number on their ID card for assistance.

FOR LOUISIANA:
Refer to Member Services at 1-844-521-6941 for assistance.

FOR INDIANA:
Refer to Member Services for
Hoosier Healthwise and Healthy Indiana Plan:
1-866-408-6131 and for
Hoosier Care Connect:
1-844-284-1797 for assistance.

FOR KENTUCKY:
Refer to Member Services at 1-855-690-7784 for assistance.

FOR MINNESOTA:
Refer to Member Services at 1-800-711-9862 (TTY 711) for assistance.

FOR NEVADA:
Refer to Member Services at 1-844-396-2329 (TTY 711) for assistance.

FOR NEW YORK EMPIRE:
Refer to Member Services at 1-800-300-8181 for assistance.

FOR NORTH CAROLINA
: Refer to Member Services at 1-844-594-5070 (TTY 711) for assistance.

FOR SOUTH CAROLINA:

Refer to the Customer Care Center at 1-866-781-5094 for assistance.

FOR TEXAS MMP:

Refer to Member Services at 1-855-878-1784 for assistance.

FOR TEXAS STAR Kids:
Refer to STAR Kids Member Services at 1-844-756-4600 for assistance.

FOR VIRGINIA (Medicaid, FAMIS, CCC+):
If Medicaid member:
Refer to Member Services at 1-800-901-0020 for assistance.
If FAMIS member:
Notify member transportation is not a covered benefit; however, an OB case manager may reach out to the member.
If CCC+ member:
Refer to Member Services at 1-855-323-4687.

FOR VIRGINIA MMP:
Refer to Member Services at 1-855-817-5787 (TTY 711) for assistance.

FOR WESTERN NEW YORK:

Refer to Member Services at 1-866-231-0847 for assistance.

FOR WEST VIRGINIA:
Refer to Customer Care at 1-800-782-0095 for assistance.

FOR WISCONSIN:
Refer to Member Services at 1-800-690-7800 for assistance.

Closing Statement 1

Thank you for taking the time to answer these questions. Your answers will help us provide (DELL CHILDREN'S CHIP Perinate & TEXAS CHIP Perinate - offer) to you with the best service possible. You will receive educational materials in the mail, and a nurse might call you to follow up.

FOR ARKANSAS:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time —24 hours a day. That number is 1-844-405-4295 (TTY 711).

Name: **Subscriber ID#:**

FOR DELL CHILDREN'S HEALTH PLAN & DELL CHILDREN'S CHIP Perinate:
In the meantime, if you have any questions, please call the 24-hour Nurse HelpLine at any time, 24 hours a day. The number is 1-888-596-0268.

FOR INDIANA:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time —24 hours a day. That number is for Hoosier Healthwise and Healthy Indiana Plan: 1-866-408-6131 and for Hoosier Care Connect: 1-844-284-1797.

FOR DISTRICT OF COLUMBIA, GEORGIA, IOWA, NEW JERSEY, NEVADA , TENNESSEE & TEXAS CHIP Perinate:
In the meantime, if you have any questions, please call the 24-hour Nurse HelpLine at any time, 24 hours a day.
That number is 1-800-600-4441**(DISTRICT OF COLUMBIA, IOWA & NEW JERSEY: TTY 771).**

FOR LOUISIANA:

In the meantime, if you have any questions, please call 1-866-864-2544 at any time - 24 hours a day. That number is 1-866-864-2544.

FOR FLORIDA AGP:
In the meantime, if you have any questions, please call the 24-hour Nurse HelpLine at any time-24 hours a day. That number is 1-866-864-2544 (TYY 711).

FOR FLORIDA CLEAR HEALTH ALLIANCE:
In the meantime, if you have any qusetions please call the 24-hour Nurse HelpLine at any time-24 hours a day. That number is 1-844-406-2398 (TTY 711).

FOR FLORIDA SIMPLY:
In the meantime, if you have any questions, please call the 24-hour Nurse Helpline at any time-24 hours a day at the number on your member ID card.

FOR KANSAS & MARYLAND:
In the meantime, if you have any questions, please call the Amerigroup On Call/24-hour Nurse Helpline at any time - 24 hours a day. That number is 1-866-864-2544.

FOR KENTUCKY:
In the meantime, if you have any questions, please call Care On Call at anytime-24 hours a day. That number is 1-866-864-2544.

FOR MINNESOTA:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time-24 hours a day. That number is 1-800-771-9862 (TTY 711).

FOR NEVADA:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time-24 hours a day. That number is 1-844-396-2329 (TTY 711).

FOR NEW YORK EMPIRE:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time-24 hours a day. That number is 1-800-300-8181.

FOR NORTH CAOLINA:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time - 24 hours a day. That number is 1-844-545-1427 (TTY 711).

FOR SOUTH CAROLINA:

In the meantime, if you have any questions, please call the 24-Hour Nurseline at any time - 24 hours a day. That number is 1-866-577-9710.

FOR TEXAS:
In the meantime, if you have any questions, please call the 24-hour Nurse HelpLine at any time - 24 hours a day. That number is 1-866-864-2544.

FOR TEXAS STAR Kids:
In the meantime, if you have any questions, please call the STAR Kids 24-hour Nurse HelpLine, 24 hours a day. The number is 1-844-756-4600.

FOR TEXAS MMP:
In the meantime, if you have any questions, please call the 24-hour Nurse HelpLine at any time - 24 hours a day. That number is 1-855-878-1784.

FOR VIRGINIA (Medicaid, FAMIS, CCC+):
In the meantime, if you have questions, please call the 24/7 NurseLine at any time 24 hours a day.
If Medicaid/FAMIS member:
That number is 1-800-901-0200.
If CCC+ member:
That number is 1-855-323-4687.

FOR VIRGINA MMP:
In the meantime, if you have any questions, please call the 24 hour NurseLine at any time-24 hours a day. That number is 1-855-817-5787 (TTY 711).

FOR WASHINGTON:
In the meantime, if you have any questions, please call the Amerigroup On Call/24 hour Nurse Helpline at any time-24 hours a day. That number is 1-866-864-2544.

FOR WESTERN NEW YORK:
In the meantime, if you have any questions, please call the 24/7 NurseLine at any time-24 hours a day. That number is 1-866-231-0847.

FOR WEST VIRGINIA:

In the meantime, if you have any questions, please call the 24-hour NurseLine at any time - 24 hours a day. That number is 1-888-850-1108.

FOR WISCONSIN:

In the meantime,if you have any questions, please call the 24/7 NurseLine at any time - 24 hours a day. That number is 1-855-690-7800.

Closing Statement 2

Is there anything else that I may help you with today? *(check one)*:	Yes	No	Skip
	Hung up		

Name: **Subscriber ID#:**

If yes, explain _____

Closing Statement 2 - continued

Attn Screener: Please select continue.

Closing Statement 3

FOR ARKANSAS:
Thank you for choosing Summit Community Care.

FOR DELL CHILDREN'S HEALTH PLAN
& DELL CHILDREN'S CHIP Perinate:

Thank you for being a Dell Children's Health Plan member.

FOR INDIANA:

Thank you for choosing Anthem Blue Cross and Blue Shield.

FOR DISTRICT OF COLUMBIA, FLORIDA AGP, GEORGIA, IOWA, KANSAS, MARYLAND & WASHINGTON:

Thank you for choosing Amerigroup. Goodbye

FOR FLORIDA CLEAR HEALTH ALLIANCE:
Thank you for choosing CHA (Clear Health Alliance).

FOR FLORIDA SIMPLY:
Thank you for choosing Simply.

FOR LOUISIANA:
Thank you for choosing Healthy Blue.

FOR KENTUCKY, NEVADA & WISCONSIN:

Thank you for choosing Anthem.

FOR MINNESOTA:
Thank you for choosing Blue Plus.

FOR NEW JERSEY & TENNESSEE:

Thank you for choosing Amerigroup Community Care.

FOR NEW YORK EMPIRE:

Thank you for choosing Empire.

FOR NORTH and SOUTH CAROLINA:

Thank you for choosing Healthy Blue.

FOR TEXAS & TEXAS STAR KIDS
& TEXAS CHIP Perinate:

Thank you for being an Amerigroup member. Goodbye

FOR TEXAS MMP:

Thank you for choosing Amerigroup STAR+PLUS MMP. Goodbye

FOR VIRGINIA (Medicaid, FAMIS, CCC+):

Thank you for choosing Anthem HealthKeepers Plus offered by HealthKeepers, Inc.

FOR VIRGINIA MMP:

Thank you for choosing Anthem HealthKeepers MMP.

FOR WESTERN NEW YORK:

Thank you for choosing BlueCross Blue Shield.

FOR WEST VIRGINIA:

Thank you for choosing UniCare Health Plan of West Virginia, Inc.

STORK Score

STORK Score _____

Name: **Subscriber ID#:**

Group Level Score

Group Level Score _____

NY EMPIRE ONLY Services in Community

These last few questions will help us assist you to connect with services in your community.

Have you applied for or received a Medicaid ID card for baby? (check one):	Yes Hung up	No	Skip
Have you reported your pregnancy to HRA (Medicaid)? (check one):	Yes Hung up	No	Skip
When is your next prenatal appointment?	_____		
Are you taking prenatal vitamins? (check one):	Yes Hung up	No	Skip
Are you taking any other medicines? (check one):	Yes Hung Up	No	Skip
Do you plan to breastfeed? (check one):	Yes Hung up	No	Skip
Are you interested in FREE prenatal and newborn classes? (check one):	Yes Hung up	No	Skip
Are you interested in the Nurse Family Partnership? Look for information on this program in your packet. (check one):	Yes Hung Up	No	Skip

Please call the Health Promotion Outreach Service Line at 1-888-743-3508 for help with reporting your pregnancy to the Human Resource Administration or to register for classes or Text4baby.

Intro Script 3 - Not Pregnant

If No, member is not pregnant:

FOR ARKANSAS:
OK, thanks. We will update our records. In case you have any questions, call our Member Services. The toll-free number is 1-844-405-4295 (TTY 711). That number again is 1-844-405-4295 (TTY 711). You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Summit Community Care. Goodbye.

FOR DELL CHILDREN'S HEALTH PLAN: & DELL CHILDREN'S CHIP Perinate:
OK. Thanks. We will update our records. In case you have any questions, our Member Services toll free number is 1-888-596-0268 (DELL CHILDREN'S CHIP Perinate TTY 711). That number again is 1-888-596-0268 (DELL CHILDREN'S CHIP Perinate TTY 711). You may get a call from Member Services to review your information (DELL CHILDREN'S CHIP Perinate- and health care benefits). Thank you for being a Dell Children's Health Plan member. Goodbye.

FOR DISTRICT OF COLUMBIA, FLORIDA AGP, GEORGIA, IOWA, KANSAS, MARYLAND, NEW JERSEY, NEVADA, TENNESSEE, TEXAS, TEXAS CHIP Perinate & WASHINGTON:
OK, Thanks. We will update our records. In case you have any questions, our Member Services toll free number is 1-800-600-4441 (District of Columbia, Iowa & New Jersey, & TEXAS CHIP Perinate: TTY 711). That number again is 1-800-600-4441 (District of Columbia, Iowa & New Jersey, & TEXAS CHIP Perinate: TTY 711). You may get a call from Member Services to review your information and health care benefits.

FOR DISTRICT OF COLUMBIA, FLORIDA AGP, GEORGIA, IOWA, KANSAS, MARYLAND, NEW JERSEY & WASHINGTON:
Thank you for choosing Amerigroup. Goodbye.

FOR FLORIDA CLEAR HEALTH ALLIANCE:
OK. Thanks. We will update our records. In case you have any questions, our Member Services toll free number is 1-844-406-2398 (TTY 711). That number again is 1-844-406-2398 (TTY 711). You may get a call from Member Services to review your informatin and health care benefits. Thank you for being a CHA (CLear Health Alliance) member. Goodbye.

FOR FLORIDA SIMPLY:
OK. Thanks. We will update our records. In case you have any questions, call our Member Services toll free number on your member ID card. You may get a call from Member Services to review your information and health care benefits. Thank you for being a Simply member. Goodbye.

FOR TENNESSEE:

Thank you for choosing Amerigroup Community Care. Goodbye.

FOR TEXAS & TEXAS CHIP Perinate:
Thank you for being an Amerigroup member. Goodbye.

FOR LOUISIANA:
Ok, thanks. We will update our records. In case you have any questions, call our Member Services. The toll-free number is 1-844-521-6941. That number again is 1-844-521-6941. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Healthy Blue. Goodbye.

FOR INDIANA:
Ok, thanks. We will update our records. In case you have any questions, call Member Services. Toll-free number is: for
Hoosier Healthwise and Healthy Indiana Plan:
1-866-408-6131 and for
Hoosier Care Connect:
1-844-284-1797. That number again is for
Hoosier Healthwise and Healthy Indiana Plan:
1-866-408-6131 and for
Hoosier Care Connect:
1-844-284-1797. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Anthem. Goodbye.

FOR KENTUCKY:
Ok, thanks. We will update our records. In case you have any questions, our Member Services toll-free number is 1-855-690-7784. That number again is 1-855-690-7784. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Anthem. Goodbye.

FOR MINNESOTA:
Ok, thanks. We will update our records. In case you have any questions, call our Member Services. The toll-free number is 1-800-711-9862 (TTY 711). That number again is 1-800-711-9862 (TTY 711). You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Blue Plus. Goodbye.

FOR NEVADA:
Ok, thanks. We will update our records. In case you have any questions, call our Member Services. The toll-free number is 1-844-396-2329 (TTY 711). That number again is 1-844-396-2329 (TTY 711). You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Anthem. Goodbye.

FOR NEW YORK EMPIRE:
Ok, thanks. We will update our records. In case you have any questions, our Member Services toll-free number is 1-800-300-8181. That number again is 1-800-300-8181. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Empire. Goodbye.

FOR NORTH CAROLINA
: OK, thanks. We will update our records. In case you have any questions, call our Member Services. The toll-free numbers is 1-844-594-5070 (TTY 711). That number again is 1-844-594-5070 (TTY 711). You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Healthy Blue. Goodbye.

FOR INDIANA:
Ok, thanks. We will update our records. In case you have any questions, call Member Services. Toll-free number is: for Hoosier Healthwise and Healthy Indiana Plan 1-866-408-6131 and for Hoosier Care Connect: 1-844-284-1797. That number again is for Hoosier Healthwise and Healthy Indiana Plan: 1-866-408-6131 and for Hoosier Care Connect: 1-844-284-1797. You may get a call from Member Services to review your information and health care benefits.
Thank you for choosing Anthem. Goodbye.

FOR SOUTH CAROLINA:
OK. Thanks. We will update our records. In case you have any questions, our Customer Care Center toll-free number is 1-866-781-5094. That number again is 1-866-781-5094. You may get a call from the Customer Care Center to review your information and health care benefits.
Thank you for choosing Healthy Blue. Goodbye.

FOR TEXAS MMP:

OK, Thanks. We will update our records. In case you have any questions, our Member Services toll free number is 1-855-878-1784. That number again is 1-855-878-1784. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Amerigroup STAR+PLUS MMP. Goodbye.

FOR TEXAS STAR Kids:

OK, Thanks. We will update our records. In case you have any questions, our STAR Kids Member Services toll free number is 1-844-756-4600 (TTY 711). That number again is 1-844-756-4600 (TTY 711). You may get a call from STAR Kids Member Services to review your information and health care benefits. Thank you for being an Amerigroup member. Goodbye.

FOR VIRGINIA (Medicaid, FAMIS, CCC+):
OK. Thanks. We will update our records. In case you have any questions, our Member Services toll-free number is 1-800-901-0020. That number again is 1-800-901-0020.
If CCC+ member
our Member Services toll-free number is 1-855-323-4687.
That number again is 1-855-323-4687. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Anthem HealthKeepers Plus offered by HealthKeepers, Inc. Goodbye.

FOR VIRGINIA MMP:
OK. Thanks. We will update our records. In case you have any questions, our Member Services toll-free number is 1-855-817-5787 (TTY 711). That number again is 1-855-817-5787 (TTY 711). You may get a call from Member Services to review your information and health care benefits. Thanks for choosing Anthem HealthKeepers MMP. Goodbye.

FOR WESTERN NEW YORK:
Ok, thanks. We will update our records. In case you have any questions, our Member Services toll-free number is 1-866-231-0847. That number again is 1-866-231-0847. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing BlueCross BlueShield. Goodbye.

FOR WEST VIRGINIA:

Name: **Subscriber ID#:**

OK, thanks. We will update our records. In case you have any questions, our Customer Care Center. The toll-free number is 1-800-782-0095. That number again is 1-800-782-0095. You may get a call from Customer Care to review your information and health care benefits. Thank you for choosing UniCare. Goodbye.

FOR WISCONSIN:

OK, thanks. We will update our records. In case you have any questions, our Member Services. The toll-free number is 1-855-690-7800. That number again is 1-800-690-7800. You may get a call from Member Services to review your information and health care benefits. Thank you for choosing Anthem. Goodbye.

Intro Script - Return Call

If the member is out:

Would you please tell me when it would be a good time to call back? Thank you for the information.
Good morning/afternoon/evening.
(Make a note when to call back.)

Member response: _____

Internal use only

This page is intentionally left blank

Name: **Subscriber ID#:**

CM OB Assessment (v.3)
* Required

Type of Assessment

Date of Assessment: _____

Usage instructions: If the answer to this question is 2, then skip to the 'General 1' Section

* Type of Assessment: (check one): ○ Initial ○ Follow up

Source

CM Note:
Ensure OB High Risk Screener Completed

General 1

CM Note:
Please note text fields from the OB High Risk Screener and/or PH Adult HRA will not auto populate on this assessment. Refer to the appropriate assessment as required.

First Name: _____

Last Name: _____

Member ID Number: _____

Date of Birth: _____

Plan: _____

Product: _____

Street Address: _____

City: _____

State: _____

County: _____

Zip Code: _____

Home Phone: _____

* Is there another phone number that you would prefer us to use to reach you for future calls? (check one): ○ Yes ○ No ○ Skip ○ Hung up

If yes, please document alternate phone number: _____

To confirm, you consent to have [insert Health Plan name] call you on this number? (check one): ○ Yes ○ No ○ Skip ○ Hung up

CM Note:
If member opts out, add phone number to the "Do Not Call" list

Do you have a preferred date/time for follow up phone calls? (check one): ○ Yes ○ No

If yes, please document preferred date/time: _____

* Do you have any other Health Insurance coverage? (check one): ○ Yes ○ No

Name: **Subscriber ID#:**

If yes, provide information: policy #, subscriber, contact #: _____

CM Note:
Follow your specific health plan process for reporting OHI

Do you have a communication preference? *(check one)*:
- Yes, written communications
- Yes, verbal communication
- No preference identified

What language are you most comfortable speaking and receiving information? *(check one)*:
- English (default)
- Arabic
- French
- Korean
- Russian
- Other
- Spanish
- Braille
- Hindi
- Mandarin
- Urdu
- Refused to Answer
- Amharic
- Creole
- Japanese
- Polish
- Vietnamese

How often do you need to have someone help you read instructions, pamphlets, or other written material from your doctor or pharmacy? *(check one)*:
- Never
- Often
- Rarely
- Always
- Sometimes

As a [CM to note name of plan] member you can expect that your medical records and communications will be treated confidentially. This includes our conversation today and all future conversations. Do you have any questions or concerns about that? *(check one)*:
- Yes
- No

If yes, please list any questions or concerns from above: _____

Do you have a living will or advanced directive? *(check one)*:
- Yes
- No

CM Note:
If no, CM to educate the member as appropriate. In some states during pregnancy an advanced directive may not be valid, refer to your specific state guidelines.

Do you have a person designated to make health care decisions for you if you are unable to make your wishes known (health care proxy)? *(check one)*:
- Yes
- No

If yes, can you please tell me the name and relationship of the person? _____

Have you discussed your wishes about the type of care you want or do not want with your health care provider? *(check one)*:
- Yes
- No

If member answers no to any of the life

Name: **Subscriber ID#:**

planning questions, was education/resources provided? *(check one):*
- Yes
- No

Do you have any cultural and/or religious beliefs that you feel may impact your ability to make healthcare decisions or follow your doctor's instructions? *(check all that apply):*
- Taking Medications as prescribed
- Following Prescribed diet
- Undergoing a recommended test
- Seeing a physician as recommended
- Communicating with a practitioner
- Male provider preference
- Female provider preference
- Other
- None Identified

If other, please explain: _____

How confident are you, on a scale of 0-10 (with 10 being the most confident) that you understand and can manage your health care needs? *(check one):*
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Comments: _____

During pregnancy women undergo many emotional and physical changes and face new responsibilities and challenges. Many women find it is important and helpful to have someone she can rely on. Is there someone in your life that can provide you with support during your pregnancy? *(check all that apply):*
- Father of the baby
- Parent
- Siblings
- Neighbor
- Church
- Other
- No Support

For any answer except no support, please describe and explain the level of involvement: _____

Are there other children living in your home? *(check one):*
- Yes
- No

General 2

Please continue with the assessment.

Does the Member have any service preferences? *(check one):*
- Yes
- No

If member answered Yes to service preferences, please describe preferences: _____

Texas Only Page

General 3

Do you have any difficulty making ends meet at the end of the month? *(check one):*
- Yes
- No

If yes, please explain: _____

Name: **Subscriber ID#:**

Do you receive or require assistance on any of the following services/resources? Check all that apply. *(check all that apply):*

- Case Management by another agency
- Community/Agency/Pregnancy Resources Receives
- Community/Agency/Pregnancy Resources Requires Assistance
- Dental Care Receives
- Dental Care Requires Assistance
- Financial (Rent/Electricity/Gas/etc.) Receives
- Financial (Rent/Electricity/Gas/etc.) Requires Assistance
- Food (WIC, Food Stamps, Food Banks) Receives
- Food (WIC, Food Stamps, Food Banks) Requires Assistance
- Housing Receives
- Housing Requires Assistance
- Pharmacy Receives
- Pharmacy Requires Assistance
- SSI Receives
- SSI Requires Assistance
- Transportation Receives
- Transportation Requires Assistance
- Other

If other or additional comments required, please explain: _____

CM Note:
Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

CM Note:
CM to review available benefits with member.

Are benefits adequate to meet the member's needs? *(check one):* Yes No

If Additional comments required, please explain: _____

CM Note:
Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

CM Note:
CM to provide appropriate Nurse Help Line Name and Number

Do you have the 24-Hour nurse helpline? *(check one):* Yes No

Maternity

Is this the first time you have ever been pregnant? *(check one):* Yes No

Any new changes with your pregnancy since we last spoke? *(check one):* Yes No

If yes, comment: _____

When is your baby due? _____

What providers do you currently see? *(check all that apply):* OB GYN, High Risk OB Specialist, Other, None

If Other, Please specify: _____

If none, do you need assistance finding a provider? *(check one):* Yes No

When is/was the date of your first prenatal care appointment for this pregnancy? _____

CM Note:
Attempt to narrow down an approximate date of the visit if the member is not sure of the exact date. If able to determine the month and date is not known choose the 15th of the month. Do not leave blank.

Have you been told

Name: **Subscriber ID#:**

* by your provider that you are going to have twins or more than one baby? (check one):	Yes	No		Unknown
	Skip	Hung up		
If yes, how many babies? (check one):	One	Two		Three
	Four	Five		Six
	Seven	Eight		
* Have you been told you will have a c/sect? (check one):	Yes		No	
Have you seen your OB MD or PCP since we last spoke? (check one):	Yes		No	
If yes, when?	_____			
Has your OB Provider changed? (CM Note: If yes, please update the address book after completing this HRA) (check one):	Yes		No	

Gestational Age

Weeks of Gestation Calculation: _____

Pregnancy History

Number of previous pregnancies? _____

Number of deliveries? _____

Date of last delivery: _____

Have you ever had a C-Section? (check one):	Yes	No	Skip
	Hung up		

If yes- date and reason: _____

Number of live births? _____

Number of full term births? _____

Number of births prior to 37 weeks? _____

Number of births less than 3 lbs 5oz (1500 gms)? _____

Have you had any miscarriages? (check one):	Yes	No

If any, list gestational age of miscarriage: _____

Have you had any elective terminations? (check one):	Yes	No

If any, list gestational age of elective terminations: _____

Name: Subscriber ID#:

Pregnancy Complications 1-Prima Gravida

Have you had to go to the emergency room during this pregnancy for a pregnancy-related problem? *(check one)*: ☐ Yes ☐ No

Have you been admitted to the hospital during this pregnancy for a pregnancy-related problem? *(check one)*: ☐ Yes ☐ No

Since we last spoke, have you had to go to the emergency room during this pregnancy for a pregnancy-related problem? *(check one)*: ☐ Yes ☐ No

Since we last spoke, have you been admitted to the hospital during this pregnancy for a pregnancy-related problem? *(check one)*: ☐ Yes ☐ No

If yes for either emergency room or hospital visit ask: What was the date of the encounter, reason for the admission and type of treatment(s)? _____

Have you experienced any of the following with this pregnancy: *(check all that apply)*:

- ☐ Back pain
- ☐ Tocolytic Therapy
- ☐ Hyperemesis
- ☐ Abruptio Placenta
- ☐ Pregnancy Induced Hypertension (PIH)
- ☐ Polyhydramnios
- ☐ Exposure to drugs, chemicals, hazardous products, gases or materials or any products that could be harmful to your unborn baby
- ☐ Other
- ☐ Cervical Incompetence
- ☐ Fever
- ☐ Vaginal bleeding
- ☐ Gestational Diabetes
- ☐ Preeclampsia
- ☐ Oligohydraminos
- ☐ Infertility treatments
- ☐ Preterm Labor
- ☐ Bladder/kidney infections
- ☐ Placenta Previa
- ☐ Watery discharge
- ☐ Group B Strep Infection (GBS)
- ☐ Exposure to Teratogens
- ☐ None

If other, please explain: _____

For any answer other than none, provide details including date of onset and treatment? _____

Pregnancy Complications 2

* Are you feeling your baby move daily? *(check one)*: ☐ Yes ☐ No ☐ N/A Less than 24 weeks gestation

If no, have you notified your OB provider? *(check one)*: ☐ Yes ☐ No

CM Note:
Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

Name: **Subscriber ID#:**

Medical History

* Have you ever been diagnosed or treated for any of the following: *(check all that apply)*:

- Bacterial Vaginosis
- HPV
- Trichomoniasis
- Diabetes
- Uterine surgeries
- Abnormal Pap Smear
- Other
- Chlamydia
- Gonorrhea
- Clotting disorders
- HTN
- Cervical abnormalities
- Rubella-Non-Immune
- None
- Herpes
- Syphilis
- Cardiac abnormalities
- Uterine abnormalities
- Surgery on cervix
- Sickle Cell

If any answer except None selected, provide details (date of onset, treatment): _____

CM Note
: Prior to asking the question more than one sex partner potentially start with this introduction: Having multiple sex partners can put you at risk for contracting STD's. I understand that this topic is personal but it is very important for your overall health.

* If you have more than one sex partner, do you protect yourself from STD's? *(check one)*:

- Yes
- Declines to answer
- No
- N/A as has only one sex partner

CM Note
: Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

Special Needs/Functional Limitations

* In the case managers, caregiver, or guardian's opinion, what is the member's cognitive status? *(check one)*:

- Alert/oriented
- Requires considerable assistance
- Required prompting
- Totally dependent/constant disorientation
- Requires assistance and some direction
- Other

If Other, please explain: _____

* Do you have vision problems not corrected with lenses? *(check one)*:

- Yes
- No

If Yes, please explain: _____

* Do you have hearing problems not corrected with assistive devices? *(check one)*:

- Yes
- No

If yes, please explain: _____

Assistance

* Are you currently on any modified activity restrictions? *(check one)*:

- Yes
- No

If yes, please explain: _____

* Do you have rest periods throughout the day? *(check one)*:

- Yes
- No
- Sometimes

* Do you require assistance with any of the these ADLs or IADLs? *(check all that apply)*:

- Eating
- Grooming
- Walking
- Light Housekeeping/Laundry
- Meal preparation
- Dressing
- Paying bills/Managing finances
- Continence/Incontinence Care
- Bathing
- Toileting
- Grocery shopping
- No issues

Comments: _____

DO NOT ASK FOR TN: Does the member have

Name: **Subscriber ID#:**

difficulty doing errands alone such as visiting a doctor's office or shopping due to a physical, mental, or emotional condition? *(check one)*: Yes No Refused to answer

* Do you have family/caregiver to assist you if needed? *(check one)*: Yes No

If yes, describe the your support system and the level of involvement. _____

Diet, Exercise & Other 1

What was your pre-pregnancy weight? _____

* What is your current weight? _____

* How tall are you? _____ Date _____

BMI Calculation

BMI: _____

Diet, Exercise & Other 2

CM Note
Discuss the member's diet and eating habits.

* Based on 24 hour recall, is member eating a well balanced diet including all food groups? *(check one)*: Yes No

* How many meals do you eat a day? _____

* Do you drink 8 -eight oz glasses of water a day? *(check one)*: Yes No

* Do you plan to breast feed? *(check one)*: Yes No Undecided

Did you take folic acid prior to becoming pregnant? *(check one)*: Yes No

* Are you taking any of the following: *(check all that apply)*: Prenatal vitamins Iron supplements Herbal supplements Any other medications No Medications

* List any immunizations you have received in the past 12 months. Including date if known? (such as flu, DTaP, pneumonia, shingles) _____

Mental Health 1

* Have you ever been diagnosed with depression? *(check one)*: Yes No

_____

Name: **Subscriber ID#:**

If yes, please explain. _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

* Little interest or pleasure in doing things? (check one):	Not at all Nearly every day	Several days	More than half the days
* Feeling down, depressed, or hopeless? (check one):	Not at all Nearly every day	Several days	More than half the days
* Trouble falling asleep or staying asleep, or sleeping too much: (check one):	Not at all Nearly everyday	Several days	More than half the days
* Feeling tired or having little energy: (check one):	Not at all Nearly everyday	Several days	More than half the days
* Poor appetite or overeating: (check one):	Not at all Nearly everyday	Several days	More than half the days
* Feeling bad about yourself, or that you are a failure or have let yourself or your family down: (check one):	Not at all Nearly everyday	Several days	More than half the days
* Trouble concentrating on things, such as reading the newspaper or watching television: (check one):	Not at all Nearly everyday	Several days	More than half the days
* Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual: (check one):	Not at all Nearly everyday	Several days	More than half the days
* Thoughts that you would be better off dead, or of hurting yourself in some way: (check one):	Not at all Nearly everyday	Several days	More than half the days

PHQ-9 Score

PHQ-9 Score: _____

NOTE
: If any of the PHQ-9 questions are blank, the PHQ-9 cannot be scored and this score box will be blank. This is not a valid score.

-If total score is 1-4 minimal depression
-If total score is 5-9 mild depression
-If total score is 10-14 moderate depression
-If total score is 15-19 moderate severe depression
-If total score is 20 or greater, severe depression

-If score is 5-14, discuss with member a referral for further evaluation:

-If score is 15 or above, refer to BH provider on an urgent basis.

Mental Health 2

* Are you under additional stress not related to your pregnancy? (check one):	Yes	No

Name: **Subscriber ID#:**

If yes, please explain: _____

CM Note
: Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

Substance Use

In the month before you were pregnant, how often did you use cigarettes, other tobacco products, E-cigarettes or a vape pen? *(check one)*: ☐ Never ☐ Sometimes ☐ Skip ☐ Hung up

CM Note
: If member answered never, skip the next 3 questions related to smoking.

Are you currently smoking cigarettes, using other tobacco products, E-cigarettes or a vape pen? *(check one)*: ☐ Yes ☐ No

How often do you use the product named above? (CM note: Mention the product the member noted they are using) _____

Are you interested in quitting? *(check one)*: ☐ Yes ☐ No ☐ N/A

CM Note: CM will refer to appropriate Tobacco Cessation resources. Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

* In your opinion, did your parents ever have a problem with drug or alcohol use? *(check one)*: ☐ Yes ☐ No

If yes, provide information: _____

* Does your partner have problems with alcohol or drug use? *(check one)*: ☐ Yes ☐ No

If yes, provide information: _____

* Before you were pregnant did you have problems with alcohol or drug use? *(check one)*: ☐ Yes ☐ No

* In the past month, did you drink beer, wine or liquor, or use other drugs? *(check one)*: ☐ Yes ☐ No

If yes, which ones? *(check all that apply)*: ☐ Alcohol ☐ Cocaine ☐ Crack ☐ Heroin ☐ Marijuana ☐ Methamphetamine ☐ Other

If Other, please specify: _____

Provide frequency and last used date for any substances identified (i.e. Alcohol, cocaine. _____

Name: **Subscriber ID#:**

crack, etc):

Intimate Partner

* Do you have a safe place to live? *(check one)*. Yes No

If no, explain: _____

Because violence is so common in many pregnant women's lives, I've begun to ask everyone about it.

* Have you ever been emotionally or physically abused by your partner or someone important to you? *(check one)*: Yes No

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? *(check one)*: Yes No

If yes, by whom and total number of times: _____

Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? *(check one)*: Yes No

If yes, by whom and how many times: _____

* Within the past year, has anyone forced you to have sexual activities? *(check one)*: Yes No

If yes, by whom and how many times: _____

* Are you afraid of your partner or anyone else you have mentioned? *(check one)*: Yes No

If yes, would you like for me to share this information with your OB or other provider? *(check one)*: Yes No

Family Planning

* Do you have a plan for family planning after this delivery? *(check all that apply)*.
Birth Control Pills
Diaphragm
Implant
Intrauterine Device (IUD)
Long Acting Reversible Contraception (LARC)
Tubal ligation
Other
None

If other, please explain: _____

CM Program

* Case Manager: Did you schedule a follow-up task? *(check one)*: Yes No

Name: **Subscriber ID#:**

If yes, explain: _____

CM: Did you make a * referral to any other CM Programs (i.e. BH)? *(check one):* ☐ Yes ☐ No

If yes, explain: _____

Are there any gaps in * care identified? *(check one)* ☐ Yes ☐ No

CM Note: Provide appropriate documentation in the Initial/Follow Up Progress Note, Care Plan or OB NICU Intervention Checklist.

Is there anything else I can assist you with today? _____

Assessments

Select additional Assessments at this time: *(check one):*

- ☐ OB CM Diabetes
- ☐ BH Depression
- ☐ CAD
- ☐ GERD
- ☐ HTN
- ☐ Migraine
- ☐ Obesity
- ☐ TBI
- ☐ None
- ☐ OB Post-Partum
- ☐ BH General Adult
- ☐ CHF
- ☐ Hep C
- ☐ LBP
- ☐ MS
- ☐ Private Duty Nursing (PDN)
- ☐ Wound
- ☐ Asthma
- ☐ BH General Peds
- ☐ COPD
- ☐ HIV
- ☐ Lead Tox
- ☐ Neuro
- ☐ Stroke
- ☐ Peds Cardiac

Name: **Subscriber ID#:**

Pregnancy Complications 1-Multi Gravida

Have you had to go to the emergency room during this pregnancy for a pregnancy-related problem? *(check one):*	Yes	No
Have you been admitted to the hospital during this pregnancy for a pregnancy-related problem? *(check one).*	Yes	No
Since we last spoke, have you had to go to the emergency room during this pregnancy for a pregnancy-related problem? *(check one):*	Yes	No
Since we last spoke, have you been admitted to the hospital during this pregnancy for a pregnancy-related problem? *(check one):*	Yes	No
If yes for either emergency room or hospital visit ask: What was the date of the encounter, reason for the admission and type of treatment(s)?	_____	

Have you experienced any of the following with this pregnancy or any of your previous pregnancies: *(check all that apply):*

Back pain Current	Back pain Previous	Cervical Incompetence Current
Cervical Incompetence Previous	Preterm Labor Current	Preterm Labor Previous
Tocolytic Therapy Current	Tocolytic Therapy Previous	Uterine Rupture Previous
Fever Current	Fever Previous	Bladder/Kidney Infections Current
Bladder/Kidney Infections Previous	Hyperemesis Current	Hyperemesis Previous
Vaginal Bleeding Current	Vaginal Bleeding Previous	Placenta Previa Current
Placenta Previa Previous	Abruptio Placenta Current	Abruptio Placenta Previous
Gestational Diabetes Current	Gestational Diabetes Previous	Watery Discharge Current
Watery Discharge Previous	Pregnancy Induced Hypertension (PIH) Current	Pregnancy Induced Hypertension(PIH) Previous
Preeclampsia Current	Preeclampsia Previous	Eclampsia Previous
Group B Strep Infection (GBS) Current	Group B Strep Infection (GBS) Previous	Polyhydramnios Current
Polyhydramnios Previous	Oligohydramnios Current	Oligohydramnios Previous

Name: **Subscriber ID#:**

- Exposure to Teratogens Current
- Exposure to drugs, chemicals, hazardous products, gases or materials or any products that could be harmful to your unborn baby Previous
- None
- Exposure to Teratogens Previous
- Infertility treatments Current
- Other
- Exposure to drugs, chemicals, hazardous products, gases or materials or any products that could be harmful to your unborn baby Current
- Infertility treatments Previous

If Other, please specify: _____

For any answer other than none, provide details including date of onset and treatment? _____

Internal use only:

Supplemental Document E.2-3: Health Risk Assessment to Identify Behavioral Health Needs

Supplemental Document E.2-3 includes the following:

- Supplemental Document E.2-3a: BH General Adult Assessment
- Supplemental Document E.2-3b: BH General Pediatric Assessment

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Name: **Subscriber ID#:**

BH General Adult Assessment *(v.10)*
* Required

Assessment Type

* Type of assessment? *(check one)*: ☐ BH General - Part I ☐ BH General - Part II ☐ BH General - Part III ☐ Follow - up

Introduction 1

We conduct a follow-up assessment to see what progress our members have made. Some of the questions are the same from when we first talked but asking them again will help me identify any additional needs you might have.

Environment/Housing/Community

Let's continue our discussion in more detail. This will help us develop solutions that will work best for you.

* Where do you live? *(check one)*:
☐ ALF/PCH ☐ Group Home /supported housing ☐ 3/4 or halfway house
☐ Boarding house ☐ Live in home rented or owned by family ☐ Live in home rented or owned by me
☐ Shelter ☐ On street/outside ☐ Other

If other, please explain: _____

Strengths/Weaknesses 1

* What things are going well for you right now? *(check all that apply)*:
☐ Physical health ☐ Mental health ☐ Substance use
☐ Housing ☐ Children/dependents ☐ Spouse/partner
☐ Family ☐ Finances ☐ Job
☐ School ☐ Friends ☐ Social well-being
☐ Legal issues ☐ Spiritual well-being ☐ Ability to care for self
☐ Access to services ☐ Other

If other than the options listed above, please explain: _____

* What things are not going well for you right now? *(check all that apply)*:
☐ Physical health ☐ Mental health ☐ Substance use
☐ Housing ☐ Children/dependents ☐ Spouse/partner
☐ Family ☐ Finances ☐ Job
☐ School ☐ Friends ☐ Social well-being
☐ Legal issues ☐ Spiritual well being ☐ Violence or abuse
☐ Ability to care for self ☐ Access to services ☐ Other

If other than the options listed above, please explain: _____

* What areas of your life are most concerning to you? *(check all that apply)*:
☐ Physical health ☐ Mental health ☐ Substance use
☐ Housing ☐ Children/dependents ☐ Spouse/partner
☐ Family ☐ Finances ☐ Job
☐ School ☐ Friends ☐ Social well-being
☐ Legal issues ☐ Spiritual well-being ☐ Violence or abuse
☐ Ability to care for self ☐ Access to services ☐ Other

If other than the options listed above please explain: _____

* In general, what has worked for you in the past in dealing with these concerns? *(check all that apply)*:
☐ Family support ☐ Church or religious org support ☐ Medical professional
☐ Case manager ☐ Other community organization ☐ Stuff I do for myself
☐ The internet ☐ Governmental organization (welfare office, police, etc.) ☐ Friends
☐ Therapy ☐ Self-help ☐ Other

If other than the options listed above, please explain: _____

* How are those approaches working for you now? *(check one)*:
☐ Very well ☐ Well ☐ Just okay
☐ Not well ☐ Not well at all ☐ I have not tried any of these approaches this time
☐ I have not tried all these approaches this time

Name: **Subscriber ID#:**

If the answer to the above question is "Just okay", "Not well" or "Not well at all", ask the following question, otherwise do not ask the following question.

What has made it difficult for these approaches to work as well as they have in the past?

If the answer to the above question is "I have not tried any of these approaches this time" or "I have not tried all these approaches this time", ask the following question, otherwise do not ask the following question.

What has made it difficult for you to try these approaches?

* How ready are you to address your concerns? *(check one)*: Very ready; Ready; Somewhat ready; Not so ready; Not at all ready

* How can I assist you to address your concerns?

Smoking

* Tell me about any past or present tobacco use: *(check one)*: Former tobacco user; Current tobacco user; Not/Never a tobacco user

If response is"Former tobacco user" or "Current tobacco user", ask the following question: When was the last time you used tobacco?

If response is "Current Tobacco user" ask the following question: How much tobacco do you use on average?

If response is "Current Tobacco user", ask the following question: May I share information with you about smoking cessation programs in your area? *(check one)*: Yes; No

Associate to document smoking cessation discussion:

Substance Use 1 - Historical/Current Use 1

MUST COMPLETE EVEN IF NO ISSUES IDENTIFIED

* How often did you have a drink containing alcohol in the past year? *(check one)*: Never; Monthly or less; Two to four times a month; Two to three times per week; Four or more times a week

* How many drinks did you have on a typical day when you were drinking in the past year? *(check one)*: None; 1 or 2; 3 or 4; 5 or 6; 7 or 9; 10 or more

How often did you

Name: **Subscriber ID#:**

* have six or more drinks on one occasion in the past year? (check one):	Never Weekly	Less than monthly Daily or almost daily	Monthly

Substance Use 1 - Historical/Current Use 1 AUDIT Score

AUDIT Score 1 _____

Substance Use 1 - Historical/Current Use 2

* How often during the last year have you found that you were not able to stop drinking once you had started? (check one):	Never Weekly	Less than monthly Daily or almost daily	Monthly
* How often during the last year have you failed to do what was normally expected from you because of drinking? (check one):	Never Weekly	Less than monthly Daily or almost daily	Monthly
* How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (check one):	Never Weekly	Less than monthly Daily or almost daily	Monthly
* How often during the last year have you had a feeling of guilt or remorse after drinking? (check one):	Never Weekly	Less than monthly Daily or almost daily	Monthly
* How often during the last year have you been unable to remember what happened the night before because you had been drinking? (check one):	Never Weekly	Less than monthly Daily or almost daily	Monthly

* Have you, or has someone else, been injured as a result of your drinking? (check one):	No	Yes, but not in the last year	Yes, during the last year
* Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down? (check one):	No	Yes, but not in the last year	Yes, during the last year

Substance Use 1 - Historical/Current Use 2 AUDIT Score

AUDIT Score 2 _____

Substance Use 1 - Historical/Current Use 3

* How many times in the past year have you used an illegal drug? (check one):	Never	1 or more

Name: **Subscriber ID#:**

* How many times in the past year have you used a prescription medication for nonmedical reasons? (check one).	Never	1 or more

Substance Use 1 - Historical/Current Use 3 Drug Screen Score

Drug Screen Score 3 _____

Substance Use 1 - Historical/Current Use 4

* In the past 12 months do you abuse more than one drug at a time? (check one):	Yes	No
* In the past 12 months are you unable to stop using drugs when you want to? (check one):	Yes	No
* In the past 12 months have you ever had blackouts or flashbacks as a result of drug use? (check one).	Yes	No
* In the past 12 months do you ever feel bad or guilty about your drug use? (check one):	Yes	No
* In the past 12 months does your spouse (or parents) ever complain about your involvement with drugs? (check one):	Yes	No
* In the past 12 months have you neglected your family because of your use of drugs? (check one):	Yes	No
* In the past 12 months have you engaged in illegal activities in order to obtain drugs? (check one):	Yes	No
* In the past 12 months have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? (check one):	Yes	No
* In the past 12 months have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions bleeding)? (check one):	Yes	No

Name: **Subscriber ID#:**

Substance Use 1 - Historical/Current Use 4 Drug Screen Score

DAST Score _____

Substance Use 2 - Stages of Change Assessment

How would you like to * change your use of substances? *(check one)*: I'd like to stop completely. | I'd like to cut down. | I'd like to use more. | I do not wish to change today.

* In your opinion, what are the advantages of your substance use [can insert alcohol/drug here] to you personally? What are the disadvantages? _____

* What's getting in the way of you meeting your goals? _____

* List member's stage of change: *(check one)*: Precontemplation | Contemplation | Preparation | Action | Maintenance | Relapse

Hospitalizations & Emergency Room Visits

Associate Note: For any answer other than "None" you will be directed to the Condition List to enter the related diagnosis after completing this page

* I see in our claims history that you were in the ER [x] times in the last 3 months. How many times do you recall being in the ER in the last 3 months? *(check one)*: None | One time | Two or more times

* I see in our claims history that you were hospitalized [x] times in the last 3 months. How many times do you recall being hospitalized in the last 3 months? *(check one)*: None | One time | Two or more times

Date of Last IP Admission: _____

Condition List Selector- Behavioral Health

Associate Note: Review claims history prior to asking condition questions

BH Conditions
Associate prompt: If claims in system: Based on our claims history, I see that you have been treated for [name of condition(s)]. What * other conditions have you been treated for that I didn't mention? If no claims in system: What mental health conditions have you been treated for in the past? *(check all that apply)*:

None	Major Depressive Disorder	Bipolar Disorder
Schizophrenia	Schizoaffective Disorder	Psychosis
Generalized Anxiety Disorder (GAD)	Obsessive Compulsive Disorder (OCD)	Post-Traumatic Stress Disorder (PTSD)
Social phobia	Anorexia	Bulimia
Binge-eating	ADD/ADHD	Autism
Asperger's	Borderline	Narcissistic
Histrionic	Antisocial	Alcohol
Drug Abuse/Dependence	Other	

When were you first diagnosed with this condition? (CM must

Name: **Subscriber ID#:**

document onset date for each condition checked above or document "member does not know onset date") *

If other, please explain and include onset date:

If response is other than "None", how is/are that/these condition(s) going for you?

Behavioral Health-Treatment Current/History

Tell me about any current or past treatment and/or self-help services you may have had for behavioral health.

Treatment types received: (check all that apply). *

- Inpatient (clarify if locked unit; if not locked unit, member probably means residential)
- Residential
- IOP/PHP
- Other outpatient treatment
- From PCP
- Other
- N/A

If Other, please explain and include onset date:

If Inpatient, date:

If Residential, date:

If IOP/PHP, date:

If Other Treatment, date:

If From PCP, date:

If Other, date:

What self-help groups do you attend? (check one). *

- 12-step/self-help recovery groups
- Other self-help groups
- None

If other, please explain:

Do you have a sponsor? (check one):

- Yes
- No
- None
- N/A

If not, what has gotten in the way of you getting a sponsor?

CM should review community resources with member - eg 911, United Way, ADA, etc.

Were the available benefits offered by the health plan reviewed with and determined adequate for the member? (check one): *

- Yes
- No

For person administering HRA-Record any additional information obtained during the engagement process that should be considered in developing the initial care plan or requires immediate action. *

Name: **Subscriber ID#:**

Mental Health 2 - Suicide/Homicide Assessment

FOLLOW CRISIS PROTOCOL warm transfer to a care manager, or follow health plan specific crisis policy, if any answer is "Several Days", "More than half the days","Nearly every day" or "Yes". If all answers are "Not at all" or "No" select "Continue".

How often in the past 30 days have you had thoughts of hurting yourself or * others? EG: 1) Have you wished you were dead or wished you could go to sleep and not wake up? *(check one):*

- Not at all
- Several Days
- More than half the days
- Nearly every day

Have you been thinking about how you might kill yourself? *(check one):*

- Yes
- No

Have you had these thoughts and had some intention of acting on them? *(check one):*

- Yes
- No

If yes, what is the plan? _____

Have you ever done anything, started to do anything, or prepared to do anything to end your life? *(check one):*

- Yes
- No

If yes, how long ago did you do any of these? *(check one):*

- Over a year ago
- Between 3 months and a year ago
- Within the last 3 months

FOLLOW CRISIS PROTOCOL if answer is "Yes" to any of the above questions. Document crisis protocol and outcome. _____

Did the associate document the outcome of the crisis call? *(check one):*

- Yes
- No
- N/A

Mental Health 3

On a scale of 1 - 5, with 1 being not well * at all and 5 being great, How are you coping with life and relationships? *(check one):*

- Poor
- Fair
- Average
- Good
- Excellent

If response is "Poor" or "Fair" please explain why and provide details. _____

On scale of 1- 5 with 1 = not satisfied and * 5 = satisfied, how satisfied are you with where you live today? *(check one):*

- Not satisfied at all
- Not so satisfied
- Just as satisfied as not
- Satisfied
- Very satisfied

If response is "Not satisfied at all" or Not so satisfied" , please explain why and provide details. _____

On a scale of 1 - 5, with 1

Name: **Subscriber ID#:**

being not good at all and 5 being great, how well would you rate your safety in your community/environment? (check one):

Poor Fair Average
Good Excellent

If response is "Poor" or " Fair", please explain why and provide details.

Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? (check one): Yes No

Do you feel safe in your current relationship? (check one): Yes No N/A

If the member states not feeling safe in current relationship, ask the following question:

May I share information with you about domestic/intimate partner violence resources in your area? (check one): Yes No

Associate to document domestic/intimate partner violence resources discussion, if applicable:

Legal Issues

Have you ever been involved with the police or courts or any legal issues? (check one): Yes No

If yes, ask the remaining questions

Have you been in jail or prison? (check one): Yes No

Do have a parole or probation officer? (check one): Yes No

If yes, may we contact him/her if it will be helpful? (check one): Yes No

Mental Health - PC PTSD Screen (Part III)

THE RESULTS OF THE PC-PTSD SHOULD BE CONSIDERED "POSITIVE" IF A MEMBER ANSWERS "YES" TO ANY THREE ITEMS.

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

Have had nightmares about it or thought about it when you did not want to? (check one): Yes No

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? (check one): Yes No

Were constantly on guard, watchful, or easily startled? (check one): Yes No

Name: **Subscriber ID#:**

* Felt numb or detached from others, activities, or your surroundings? *(check one)*:	Yes	No
If response is "Yes", ask the following question: May I share information with you about treatment options, programs, or support groups in your area? *(check one)*:	Yes	No
Associate to document PTSD discussion:	_____	

Family/Children/Friends

* On a scale of 1 - 5, with 1 being not well at all and 5 being great, how well would you rate your social life? *(check one)*:	Poor Good	Fair Excellent	Average
* Tell me about your family: *(check all that apply)*:	Married/significant other Never married Children live elsewhere No friends Siblings	Divorced Children live with Fewer than 3 friends One or more parent alive In contact with siblings	Widowed No children More than 3 friends In contact with parents
* Tell me who in your life is most supportive of your recovery?	_____		

Strengths/Weaknesses 2

In order to develop a plan that gets you where you want to go, one way is to identify your strengths.

* What are you like when you are at your best?	_____
* What are you proud of?	_____
* What are you good at?	_____
* What things do you regularly do to keep yourself well?	_____
* What are you looking forward to doing in your life?	_____

Internal use only:

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Name: **Subscriber ID#:**

BH General Pediatric Assessment (v.98)
* Required

Crisis Question

* Is member in crisis at time of the call? (check one) ○ Yes ○ No

Crisis Assessment

* Is your child having thoughts of hurting him or herself or someone else? (If yes, DO NOT put member on hold. Follow Crisis Call procedure.) (check one) ○ Yes ○ No

* To the best of your knowledge, is your child feeling physical discomfort related to drug or alcohol abuse? (If yes, DO NOT put member on hold. Follow Crisis Call procedure) (check one) ○ Yes ○ No

Crisis Protocol

CM: IF ANSWER IS YES TO EITHER OF THE QUESTIONS ON THE CRISIS ASSESSMENT, FOLLOW CRISIS PROTOCOL

Specific Condition

HAVE YOU EVER BEEN TOLD BY A MENTAL HEALTH PROFESSIONAL THAT YOUR CHILD HAS ANY OF THE FOLLOWING CONDITIONS:

Specific Condition I

* Schizophrenia? (check one) ○ Yes ○ No

If Yes, can you tell me what you know about it? _____

For CM only: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? (check one) ○ Yes ○ No

Specific Condition II

* Schizoaffective Disorder? (check one) ○ Yes ○ No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge ○ Yes ○ No

Name: **Subscriber ID#:**

of his/her child's condition(s)? *(check one)*

Specific Condition III

* Bipolar Disorder? *(check one)* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her childs's condition(s)? *(check one)* Yes No

Specific Condition IV

* Depression (or Major Depression)? *(check one)* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one)* Yes No

How often do you need to have someone help you read instructions, pamphlets, or other written material from your doctor or pharmacy? *(check one)* Never Rarely Sometimes Often Always

Specific Condition V

Attention-Deficit Hyperactivity * Disorder or Attention-Deficit Disorder? *(check one)* Yes No

If Yes, can you tell me what you know about it? _____

FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one)* Yes No

Specific Condition VI

Have you ever been told by a mental

Name: **Subscriber ID#:**

health professional that your child has * Autism Spectrum Disorder or Intellectual Developmental Disability? *(check one)*	Yes	No
If Yes, can you tell me what you know about it?	_____	
FOR CM ONLY: In the CM's judgement, does member demonstrate adequate knowledge of his/her child's condition(s)? *(check one)*	Yes	No
"In the past week, has your child had any symptoms that got in the way of his/her doing important things like going to school, going to appointments, or that interfered with any of his/her usual activities?" *(check one)*	Yes	No
If Yes, request information about the nature and acuity of symptoms.	_____	

Self-Management

Do you have a plan for the management of your child's condition (e.g. * recognition of relapse triggers, stressors, signs of decompensation, etc.)? *(check one)*	Yes	No
For CM Only: In the CM's judgement, is the stated management * plan adequate to reduce the risk of relapse/recurrence? *(check one)*	Yes	No

Provider Type

Is your child currently seeing a psychiatrist? (CM Note: If yes to any of * the questions on this page you will be linked to the Address Book to enter/review the provider information) *(check one)*	Yes	No
Is your child currently seeing any other		

Name: **Subscriber ID#:**

* mental health provider or professional (that is, a psychologist, a social worker, family therapist, case manager, etc)? *(check one)*	Yes	No
* Is your child currently going to any other type of treatment program such as AA or NA? *(check one)*	Yes	No

Referral to BH Provider

CM: Evaluate the need for referral to BH Provider

Scheduled Appointment

* Does your child have an appointment scheduled to see his/her psychiatrist or other mental health provider, or PCP? *(check one)*	Yes	No

Medications

Have you noticed any side-effects from the medications, that is, any problems that you think are caused by your child taking the medicine? *(check one)*	Yes	No
If Yes, Please tell me about side effects you have noticed.	_____	
Do these side effects get in the way of your child taking his/her medications as directed? *(check one)*	Yes	No

Referral to Prescriber

CM: Evalute the need to refer to prescribing provider for medication evaluation

Hospital History

* Has your child ever been in the hospital overnight related to a mental health or substance abuse problem? *(check one)*	Yes		No
When was the last time your child was hospitalized for a mental health or substance abuse problem? *(check one)*	Less than three months ago	Three months to six months ago	Six months to one year ago
	More than one year ago		
How many times has			

Name: Subscriber ID#:

your child been admitted to the hospital for a mental health or substance abuse problem in the last year? (check one)	none	once	twice
	three times	more than three times	

Substance Abuse History

* Has your child ever been treated for problems with alcohol, drugs, or substance abuse? (check one)	Yes	No

Referral to SA Provider

CM: Evaluate the need to refer to SA Provider for SA evaluation

BH Relapse Risk 1

* Does the member have a history of treatment non-adherence? (check one)	Yes	No	N/A
* Is the member currently adherent with outpatient treatments and medications? (check one)	Yes	No	N/A
* Does the member understand that he/she has a mental illness for which she/he needs treatment? (check one)	Yes	No	N/A

BH Relapse Risk 2

* Does the member have a good relationship with a Behavioral Health Provider? (check one)	Yes	No	N/A

Provider Type II

Does your child get help for a mental health issue or problem from his/her regular doctor, that is, his/her Primary Care doctor or PCP? (check one)	Yes	No

Internal use only

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3. COMMUNITY/STAKEHOLDER ENGAGEMENT

The Vendor should refer to the relevant specifications located in **Appendix 1: Detailed Specifications** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in **Section 4: Project Specifications** in this RFP, and then describe its approach to Community/Stakeholder Engagement below. The Vendor's narrative response should not exceed 25 pages.

CS001	The Vendor should coordinate care across child-serving systems, including, but not limited to, the educational system, community services, and after-school programs.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of child-serving systems in the State.
CS002	The Vendor should establish relationships with Child Protective Services (CPS) workers and coordinate the needs of the child to reduce duplication of services and Improve access to service needs.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the Child Protective Services (CPS) system in the State. With regard to improving coordination, the Vendor should describe how it will structure interactions between CPS workers, providers, and the Vendor to be efficient and effective.
CS003	The Vendor should establish relationships with child welfare workers in addition to Child Protective Services (CPS), Including, but not limited to, workers who provide case management, case planning, and permanency planning while the child is in care.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the child welfare system in the State.
CS004	The Vendor should establish communications with the judicial system to help drive that the services being ordered for the child are in the child's best interest and most medically and/or socially appropriate.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of the interactions between the judicial system and child welfare system in the State.
CS005	The Vendor should inform the court of alternative services that best meet the child's needs, as deemed appropriate by the Department.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of court orders, how the Vendor's expertise and care coordination can help inform services provided, and circumstances under which the Vendor would provide these alternatives.
CS006	The Vendor should establish relationships with applicable Department agencies and State advocacy groups, including, but not limited to, the following:	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect and understanding of the Department organization and State advocacy stakeholders.

CS007	Child advocacy centers (CACs)	See the parent specification.
CS008	Court appointed special advocates (CASAs)	See the parent specification.
CS009	The West Virginia Child Abuse Network, as defined by applicable State Code, as defined by the Department.	See the parent specification.
CS010	The Vendor should establish communications with foster parents based on Department foster care guidelines.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the foster care system in the State.
CS011	The Vendor should collaborate with the Bureau for Public Health (BPH) to increase the number of families enrolled in the West Virginia (WV) Home Visitation Program.	The Vendor should describe how it will meet this specification. *Note: This program has demonstrated that its engagement in the lives of families has helped to reduce the risk of a child being removed. More information can be found at https://wvdhhr.org/wvhomevisitation/*
CS012	The Vendor should engage community-based child welfare organizations to help provide family-centered treatment that goes beyond traditional medical care.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of State community-based child welfare organizations and family-centered treatment.
CS013	The Vendor should provide initial (during implementation) and ongoing training for advocates and other stakeholders.	The Vendor should describe in detail the audience(s), frequency, method(s), and topic(s) for this training
CS014	The Vendor should coordinate with child placement agencies to ensure each agency has access to the most up-to-date records, as appropriate.	The Vendor should describe how it will meet this specification.

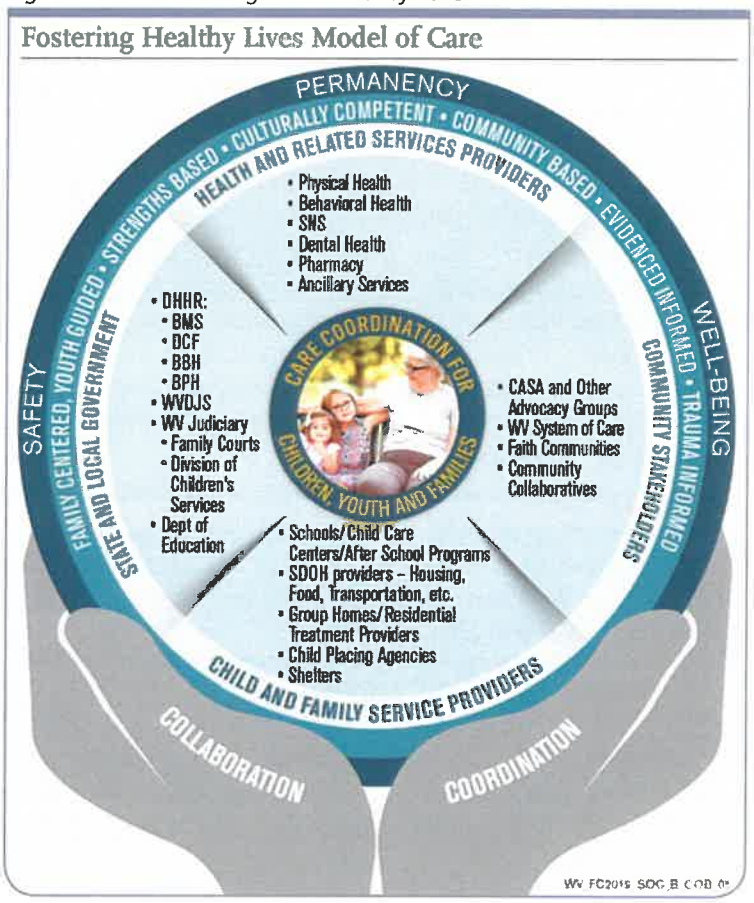
Our ***Fostering Healthy Lives Model of Care*** — developed for West Virginians by West Virginians to improve the health, social outcomes, and overall well-being of children, youth, and young adults in child welfare and their families and caregivers — uses a system-based approach to engage and improve communication between all stakeholders. Children, youth, and young adults in the Specialized Managed Care for Children and Youth Program (the Program) face challenges, such as a high prevalence of behavioral health (BH) conditions, the significant impact of Adverse Childhood Experiences (ACEs), trauma, and sporadic and fragmented health care. We address these challenges by coordinating with caregivers, families, Department caseworkers, and system of care partners who provide services and advocate for members. Our comprehensive model of care provides individualized, strength-based, trauma-informed services tailored to each child and family's needs supported by engagement with stakeholders including those outlined in our model of care in Figure E.3-1.

As an existing Medicaid health plan with 16 years' experience providing services to West Virginians, UniCare Health Plan of West Virginia, Inc. (UniCare) maintains and continues to develop strong relationships with government partners, providers, stakeholders, advocates, and community agencies — encouraging and supporting stability for children, youth, and families.

We will expand on these experiences to focus on supports needed to serve members through our Fostering Healthy Lives model:

- Our dedicated, regionally located ***Fostering Healthy Lives Community Engagement and Training team*** will engage with stakeholders by building relationships, establishing partnerships, and providing training.
- Our ***Social Services Director*** will act as the Child Protective Services (CPS) liaison, including serving as the designated contact for CPS workers in order to facilitate our involvement and scheduling in multidisciplinary treatment teams (MDTs). Internally, the Social Services Director will provide expertise and awareness to MCO staff on the policies and functions of CPS, MDTs, and community-based social service supports. The Social Services Director and the Community Engagement and Training team will collaborate on trainings and engagement activities and identify additional community resources.

Figure E.3-1. Describing Our Model of Care



- Our ***Fostering Healthy Lives Stakeholder Advisory Group*** will be comprised of stakeholders serving children, youth, and young adults receiving child welfare services and will address programmatic or organizational issues.
- Our ***Parent and Caregiver Advisory Group*** will include foster, adoptive, and kinship caregivers who will offer insight to issues they find and can recommend potential solutions.
- We will collaborate with the State ***to co-locate staff*** in beneficial locations to support improved communication, including select regional Bureau for Children and Families (BCF) offices to build local relationships and increase collaboration, and a liaison within the Department of Health and Human Resources (DHHR) for organizational level collaboration.
- Our ***Fostering Healthy Lives Care Coordinators*** (Care Coordinators) will act as a single point of contact and lead our care teams who will support Members to reach their goals, collaborate with Department caseworkers, and streamline communication for stakeholders.
- Our dedicated ***Fostering Healthy Lives Concierge team*** (Concierge team) will go beyond call center functions to augment care coordination and support stakeholders such as caregivers, child placing agencies, and Department caseworkers.

- Our ***Network Relations Consultants*** *engage* providers and offer supports that ease administrative burdens, establish and maintain provider partnerships with community-based stakeholders and agencies, and offer trainings for providers such as trauma-informed care.
- Our ***Youth Records Access Portal (YouthRAP) system*** — a secure member portal — integrates all components of the delivery of care to the member and will support stakeholders with the appropriate permissions to access information.
- Our ***Justice/Court Liaison*** will engage with the judicial system by providing program and resource information. They will have a clinical background to address questions from Family Court Judges and to link to the member's Care Coordinator.
- Our ***Career Development Specialist*** will be responsible for developing specific Transition Age Youth (TAY) career development strategies and supports that will increase successful employment outcomes for youth. They will work with leaders from child welfare agencies, workforce development, and education to remove barriers for agencies and members and will develop strategies and mechanisms to increase available funding for partner agencies.
- Our ***Dental Liaison*** will engage to remove barriers to care, identify appropriate dental providers, communicate with other providers as necessary, and advise members regarding individual dental needs.
- Our ***Pharmacist*** will be responsible for reviewing medication regimens, additions, or adjustments to assess potential drug-to-drug interactions or side effect implications.

These components of our model of care will support a comprehensive, system-based, high-quality approach to providing services for children in the Program to promote the health, safety, and well-being of members.

MY WHY **Sylvia Parker, UniCare Associate**

I was blessed to grow up with two cousins living with special needs in a small, close-knit West Virginia community. I watched how frustrating it was, and still is, for my cousins and others in my area to access needed health care services. I focused my higher education on learning to help others and received my Master's degree in Rehabilitation Counseling. This eventually led to volunteering with an organization called the Hearts of Gold Service Dog (HGSD) program. HGSD raises, trains, and places dogs to assist people with disabilities at no cost to the recipient.

My experience with the HGSD program grew into a much larger project. We are working to develop a support network for youth in foster care as they age out of the system, and provide them with a structure to further their education in nursing, veterinary tech, agriculture, or other programs. These youth transitioning from foster care would be trained to work in an all-inclusive, animal-assisted living community. By integrating youth in foster care, seniors, and individuals with disabilities, we can give youth in foster care a consistent and on-going support community that allows for the development of interdependence and promotes a sense of purpose, belonging, and responsibility.

If we, as individuals, volunteers, and corporations can help support and streamline foster care support networks, we can provide a much needed pathway for these youth toward a more productive and happier life. **MY WHY is doing better for our communities and our kids.**

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Coordinating Care Across Child-Serving Systems (CS001)

Stronger Together As an existing Medicaid plan already providing services to West Virginia members, we built relationships with child-serving community partners, which will serve as a foundation for our Fostering Healthy Lives team to better serve children in child welfare and coordinate care across systems. Through our collaborative efforts, we will develop processes for identifying issues such as school transition, BH or physical health (PH) consultations, access to services, and crisis response. We will expand our relationships to coordinate care across child-serving systems, including the educational system, community services, and after-school programs, to identify ways to provide support through training,

processes to identify children who may need services, care coordination, and the best communication methods. Our members will receive support at each level in the educational, community, and after-school systems including:

- **At the member level.** Our Care Coordinators use a system-based approach that engages community partners to support members' goals, including those that serve as natural supports. For example, if requested by DHHR or the MDT, Care Coordinators will collaborate with the member's school to develop individualized education plans or provide feedback regarding necessary services or supports.
- **At the community level.** Our Community Engagement and Training team is a field-based, local resource for educators, advocates, and parents that builds upon existing relationships and develops new partnerships with local schools, after-school programs, preschool programs, community programs, and day care centers to collaborate and provide training and orientation to the Program.
- **At the system level.** We will facilitate routine, collaborative interactions with the Department of Education, community associations, and after-school alliances to address systemic issues.

We will establish communication across child-serving systems based on the preferences of organizations, stakeholders, and advocates, which will include routine meetings or opportunities to share and learn. Communication will be through multiple methods, including face-to-face, telephonic, and electronic such as YouthRAP.

Coordinating Care Across the Educational System

Through our experiences in West Virginia and our affiliates' experience managing child welfare needs in other states, our organization has established processes to address educational disparities facing this population, including higher rates of absences, multiple school changes, and lower graduation rates. At the member level, our care coordination process — which includes our Health Risk Screener (HRS) — can identify needs that may require educational system involvement in addressing or providing support to achieve the member's goals. We understand children in foster care may have numerous placement changes resulting in the loss of educational progress. For example, a member may be transitioning from a residential treatment setting to the community and entering a new school. A Care Coordinator can work with the member's Department caseworker to provide information to the educational representative about necessary supports to facilitate the child's enrollment and attendance. This may include helping the member access services through a School-Based Health Center (SBHC), connection to behavioral supports, or providing Educational Tutorial Services to support educational goals.

Our Community Engagement and Training team will identify and develop new relationships in local communities with other educational partners, such as preschools and early education providers or faith-based educational programs. Through coordination and training we will identify additional issues experienced by members in child welfare that require a community approach to address — for example, those communities hardest hit by the opioid crisis or those with large numbers of kids in care with no after-school or recreational resources. We will provide training to school staff, including teachers, on topics such as understanding trauma, how behaviors resulting from trauma can have an impact on learning and can be confused with other disorders such as ADHD, the prevalence of psychotropic medication and its impact on learning, how to identify BH issues, and how to refer to treatment. Elementary educators can identify gaps in preparedness for school or supports for younger children that we could address systemically and add to our training. This includes exploring opportunities for collaboration, such as working jointly to develop processes to identify children who may need services and care coordination or providing Program orientation training to caregivers and community partners.

Leveraging Existing Relationships Across the Educational System

We have existing relationships with the West Virginia Department of Education and the West Virginia Primary Care Associations' School Based and Behavioral Health Care Services with whom we collaborated to establish relationships with SBHCs. We will leverage these relationships to enhance coordination across the educational system by inviting them to join our Stakeholder Advisory Committee. Using the information we receive from the SBHCs, we will identify children at risk and close gaps in PH, BH, or social determinants of health (SDOH) needs. We will explore opportunities to provide system-wide information on multiple topics, including how to identify conditions prevalent in the child welfare population. As we explore opportunities to link children to services, we will collaborate with the Department of Education to determine how we can best engage with local schools through trainings, issue forums, or other community events. Understanding the importance of outreaching to TAY and former foster care youth, we will build on current experience through multiple community colleges and universities across the state including West Virginia State University and Marshall University. We will explore opportunities to train university and college staff on the needs of youth in child welfare.

Building on Our Relationships with School-based Health Centers

With nearly 160 SBHCs in 700 West Virginia schools, UniCare recognizes and rewards sponsoring agencies to encourage expansion. The largely rural geography of the state made SBHCs an ideal community partner to increase access to high-quality primary care for children and adolescents. Serving youth at school where they are already spending most of their day reduces transportation needs and minimizes lost instructional time. We listen first to the needs of each individual school to determine how our support and funding opportunities can best serve children in child welfare — bringing our successful program ideas from our experience in West Virginia and across the country. One way in which we accomplish this is through an SBHC Well Child Quality Initiative we created in 2015 to support our HEDIS® performance and the CMS goal for all Medicaid programs to achieve an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) participant ratio greater than 80%. Immunization rates and well child and adolescent well care exams were persistently below the national average due to transportation challenges and other barriers. We collaborated with community stakeholders and state and local agencies to support improving access to well-visits.

Through our Unicare and SBHC collaborative well-child quality initiative, from 2015 to 2019 we completed 8,027 exams for members. HEDIS rates for W34, AWC, and WCC Nutrition each **increased more than 11 percentage points**, exceeding state goals of achieving 5% increases over baseline rates with **90% meeting national criteria.**

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Since 2015, UniCare has distributed almost $250,000 in incentives to SBHCs and $15,000 directly to schools. For each completed check-up, eligible families earned a $25 incentive through our Healthy Rewards Program, offered as a Value-Added Service (VAS). We will continue our current work with SBHCs and will outreach to additional schools to implement our successful collaborations to reach more West Virginia children in child welfare. This includes providing education and prevention trainings, ***such as bringing Overdose Lifeline Inc.'s This is (Not) About Drugs program and Preventure program for middle school students to schools in counties hardest hit by the opioid epidemic***. This is (Not) About Drugs program is specifically designed to address prescription opioid misuse. The Preventure program is a selective evidence-based program that takes a personality-targeted approach to adolescent substance use prevention which we intend to begin in the third quarter of 2019.

We realize many of our members can be reached inside school classrooms across the state as we partner with many schools to provide health education, sponsorships, and other resources to

students, their caregivers, and staff. For example we collaborated with the education system through the programs listed in Table E.3-1.

Table E.3-1. Supporting the West Virginia Educational System Through Our UniCare Programs

Program	Description
Repack the Backpack	UniCare provides Title 1 Schools with school supplies mid-year, such as paper, pens, rulers, pencil pouches, and sports bags.
Teachers Closet	Initiated in 2018, we provided selected schools teacher totes full of classroom teacher supplies to help reduce teachers' out-of-pocket expenses used to support students and to thank them for their commitment to students' academic achievements.
Kids Heart Challenge	UniCare sponsors events within schools to encourage kids to learn about their heart health and participate in physical and emotional well-being activities. We are building partnerships with selected schools for future health promotion initiatives.
Reality Store Program	This interactive program explores how choices in education, careers, income, expenses, and savings impact future outcomes.
Tuesdays for Toddlers	Since 2012 we partnered with local malls to sponsor initiatives for parents and toddlers making over 4,000 family contacts. The events provide activities on health-related subjects including My Plate Healthy Eating, importance of exercise play, germ prevention and hand washing, sun safety, and anti-bullying.

Trauma-informed Six-week Mindfulness Sessions

In 2019, we collaborated with Ruffner Elementary School to provide trauma-informed mindfulness practice and deliver multiple best-practice six-week Mindfulness Sessions in a trauma-informed way to improve academic performance, classroom climate, and overall well-being of students. Trauma-informed delivery is the cornerstone of mindfulness practice, as more than 52% of West Virginia children have experienced trauma. ACE research shows increased trauma exposure leads to increased lifetime of negative outcomes in health, well-being, and SDOH. We collected data through surveying participants (both students and teachers) on the effectiveness of implementing mindfulness practices in everyday life. Student post-self-surveys showed an improvement in 100% of the students' population within all three categories. We plan to implement this training and a train the trainer program to provide trauma-informed care to more schools across West Virginia and will continue it at Ruffner Elementary School.

THINK Program Focused on Members

UniCare provided funds to Mission West Virginia, Inc. (Mission WV) to implement and support its Teaching Health Instead of Nagging Kids (THINK) program from July 1, 2018, through December 31, 2018. This program helps youth make better decisions regarding their education, substance use, sexual activity, and relationships. It includes a needs assessment and referral process to identify SDOH needs and connect members to community resources. Mission WV is a nonprofit organization that collaborates with public, private, and faith-based partners to build stronger communities across the state. The goal of Mission WV's Office of Adolescent Health-funded project is to positively impact the communities they reach by reducing rates of teen pregnancy and sexually transmitted diseases. They aim to increase awareness and access to youth-friendly health care services, provide positive youth development, and mobilize community members to become active in the program and the wider community.

> Our UniCare funding allowed Mission WV to continue the THINK program in Cabell County and to add the THINK program to four schools in Putnam and Boone Counties – reaching over 420 additional children.

Coordinating with Shine Light on Depression

To help address the BH needs of youth, we are investing in a community- and education-based program called Shine Light on Depression. This program is a multidisciplinary, multi-institutional,

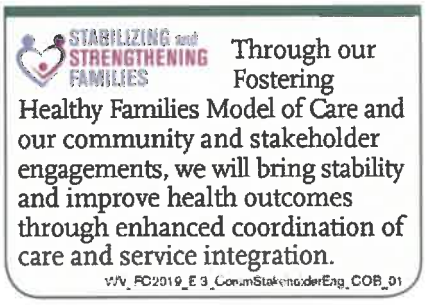
school-based, public health initiative between UniCare, the American School Health Association, and the National Parent Teacher Association. We are collaborating to address teen depression and suicide in youth nationwide through the dissemination of the Shine Light on Depression e-toolkit. The e-toolkit provides schools with free, ready-to-use resources designed to raise awareness of depression and suicide prevention among middle and high school youth and families in a positive, honest, fact-based, and culturally inclusive manner.

Coordinating Care Across Community Services

Through our Fostering Healthy Lives structure and processes, we developed three primary approaches to coordinating care across community services and developing solid community connections — direct involvement by our Care Coordinators, support by our Social Services Director, and engagement by our Community Engagement and Training team. To identify member-specific community resource needs, our Care Coordination teams will gather information from the member's caregiver and Department caseworker through initial and ongoing contacts and our HRS and HRA. The Social Services Director will support care coordination by providing expertise on existing community services to connect the member with necessary community services. Understanding that caregivers — particularly kinship caregivers — may need access to community services and may be hesitant to request support from our staff, they can access our Community Resource Link VAS to identify additional resources.

To determine community resource needs, we will use internal data and operational processes and multiple critical external sources, such as our advisory groups, provider or community engagement referrals, Department caseworkers, Concierge Line contacts, caregiver referrals, and specific community-based outreach. We will work directly with community-based organizations to enhance the programs and services that we will provide to members. Our strategy for coordinating care with community-based organizations includes:

- Identifying resources and population health needs
- Contracting to establish information-sharing and data privacy protocols
- Developing interventions, such as referrals and communication mechanisms and technology to coordinate care and service delivery
- Identifying metrics to capture outcomes and efficient use of resources



Our Community Engagement and Training team will be community-based and regionally located to identify resources and ways to engage members and caregivers. This will enable us to effectively coordinate both services and communications with members and caregivers.

Partnering with Stepping Stones to Develop a Tiny House Village

Since 2018, UniCare has partnered with Stepping Stones and provided $39,000 to help fund It's My Move — Youth Transitional Coaching Services for health promotion and wellness. We provided financial support for the Tiny House Village that will offer TAY a place to live and will teach job and life skills necessary for a successful launch into adulthood. In addition to the Tiny House Village, we provided funding to facilitate the planning process and $80,000 to build a greenhouse at the village. Through our relationship with Stepping Stones, which includes our participation in the Youth Transition Project (YTP) Community Meetings, we will continue to assure all members who receive services through Stepping Stones are linked to care coordination, our Fostering Healthy Lives support, and can access needed services.

Supporting Kinship Caregivers Through Healthy Grandfamilies

Healthy Grandfamilies is a free initiative led by West Virginia State University to provide information and resources to grandparents who are raising one or more grandchildren. The program includes topic sessions on parenting, communication, self-care, stress management, legal issues, social media, public school programs, policies, family response to addiction, and nutrition. UniCare partners with Healthy Grandfamilies to support a statewide expansion, including providing meals for training sessions, offering staff to teach program components, and $25,000 to support printing of program materials in 2019.

Additional Community Service Relationships

We include examples of additional community service relationships we established with West Virginia-based organizations in Table E.3-2.

Table E.3-2. Coordinating Care Through Our UniCare Programs with Community Services

Program	Description
Comfort Cases	UniCare partners with Comfort Cases, an organization that provides cases that include items such as sleepwear, a blanket, hygiene products, books or activities, a stuffed animal, a journal, and a One Simple Wish card. Starting in 2019, we provided $25,000 to receive 600 Comfort Cases distributed to foster care agencies and police departments statewide.
Family Resource Networks	UniCare participates in monthly meetings for each West Virginia county and provides sponsorship to health fairs, community baby showers, and smoking cessation programs. During the meetings, we provide updated information about member benefits and services, resources for community needs, sponsorship of community events, and health relative programs. Since 2014, UniCare supported over 300 Family Resource Networks hosted events and community initiatives.
United Way of Central WV	UniCare provides support for nonprofit social services that address community needs such as safety net, substance abuse recovery, health, education, and financial stability. Since 2011, UniCare has contributed both financial support — more than $11,000 — and time to support local agencies through volunteerism, grant reviews, and community outreach.
Rape, Education, Advocacy, Counseling, and Healing (REACH)	We collaborated with REACH to offer events that support women and provides professional, compassionate care to survivors of sexual violence and works toward a community in which sexual violence is no longer tolerated.

Coordinating Care Across After School Programs

UniCare sponsored the Boys & Girl Club Triple Play program to clubs throughout WV – receiving more than $50,000 in 5 years.

Leveraging our experience working with children in child welfare across the country, we understand the need for additional help when school is not in session. In our summer camp collaborations, we support children with conditions such as asthma or diabetes to better understand how to prevent episodes and daily manage their condition through a combination of entertainment and educational activities. As we outreach to additional schools, we will help our programs and camps reach a larger population throughout the state and will expand on our existing programs through our routine interactions with the SBHCs and schools with which we have existing relationships. Our Care Coordination and Community Engagement and Training Teams will collaborate with after-school programs and summer camps to provide the following:

- Extracurricular Support VAS: Eligible members will receive up to a $100 allowance to help cover the cost of school-based clubs and activities
- Youth Club Memberships VAS: Eligible members will receive up to a $100

Value-Added Services

allowance to help cover the costs of youth club memberships including: Boys and Girls Clubs, Boys and Girls Clubs Summer Camps, The National FFA Organization, and 4-H
- Hands-on health education and wellness activities
- A combination of educational and entertainment activities
- Continuing and developing food insecurity collaborations that address food insecurity for children after school and during school breaks

In Table E.3-3 we describe some of the West Virginia after-school programs, summer camps, and efforts to address food insecurity during school breaks.

Table E.3-3. Supporting West Virginia After-school Programs

Program	Description
Boys and Girls Club	Since 2014, UniCare has funded the Triple Play Program at local Boys and Girls Clubs. To date, more than 650 kids at six clubs across the state have received instruction in healthy living and active learning.
Wade Center	We partner with this school program and summer camp to provide health education outreach and activities. In 2019, we hosted a Safety Palooza event for children.
Bluefield Parks and Recreation After-school Program	UniCare provides interactive health outreach to youth during summer camps and after-school programs. Some of the activities include physical activity and obstacle courses, health trivia, healthy crafts, and games.
YMCA	We sponsor YMCA Healthy Kids Day events and partnered with them to provide health education during the summer.
Camp Catch Your Breath (VAS)	UniCare provides sponsorships for members to participate in a week-long overnight summer camp that provides fun and educational experiences for children with asthma.
Camp Kno-Koma (VAS)	Our sponsorship provides a summer camp experience for children with diabetes. Children learn ways to better manage their diabetes, make lasting friendships, and enjoy a week of fun activities under the supervision of medical personnel.
Backpack Buddy Program	Since 2017, UniCare has co-sponsored and partnered with the Backpack Buddy Program, annually providing **1,500 boxes of supplemental food** for students in need during the summer break in Putnam, Kanawha, and Boone counties.

Coordinating Children's Needs Through Established Relationships with Child Protective Services Workers (CS002)



We will support CPS Workers in carrying out the vital role of ensuring children and their families receive services to meet safety, permanency, and well-being needs. We understand CPS' role is complex, with different workers for each phase of casework including investigation, assessment, intake, planning, placement, case management, and transition. We will build relationships with all levels of DHHR staff throughout the system and work in partnership to support children and families to achieve their goals.

UniCare developed our ***Fostering Healthy Lives model of care*** to align with DHHR's goals to reduce fragmentation, improve training and communication, enhance coordination of care, and improve access to high quality health care services. Our experience in affiliate markets across the country has taught us the importance of developing meaningful relationships with Department caseworkers. We will build these relationships in West Virginia through interactions that create mutual understanding of the MCO's role and how we support DHHR through shared goals for those we serve. This communication builds trust and demonstrates respect for their role and the demands of their work by minimizing administrative burden and duplication.

Facilitating Communication and Coordination with CPS Workers

UniCare will ease the administrative burden and facilitate communication to coordinate care through the foundational principle of ***No Wrong Door*** to access the MCO for our members, families, providers, and stakeholders, including Department caseworkers. We will have a regionalized approach to services with staff located throughout the state to promote a common understanding of local issues, services, and the child welfare system. Our local staff is a cornerstone of our model and will promote close collaboration with the regional system of care.

As the regionalized, ***single point of contact*** for each member and their family, the Care Coordinator will be familiar with local services and establish trust with the member and caregiver in order to refer the member to the most appropriate services. To engage fully with all stakeholders, we will establish key teams to provide outreach, connect members with services, and partner with community supports to improve access to service needs:

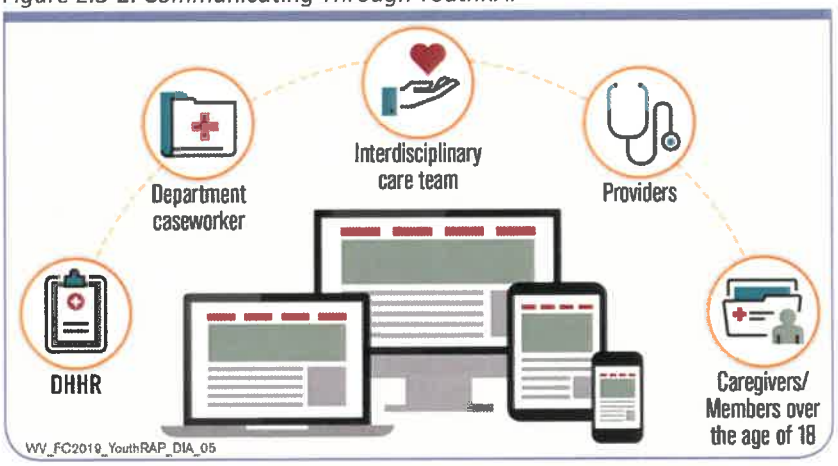
- Our regionally assigned ***Care Coordination teams*** include Care Coordinators with experience in the child welfare system and who will focus on coordinating services and supports as identified through all assessments, care planning, and the State's MDT to promote safety, continuity, permanency, and member well-being. We offer Registered Nurse (RN) Care Coordinators and BH clinicians with pediatric experience to support this child welfare population and work closely with CPS workers.
- Our ***Concierge team*** will answer inbound calls on our Concierge Line from CPS workers and caregivers to schedule assessments, connect to the Care Coordination team, and respond to immediate needs including arranging crisis services when applicable. Our Concierge Line will have extended business hours from 8 a.m. to 8 p.m. ET and after-hours coverage for crisis issues.
- Our ***Social Services Director*** will act as the liaison to DHHR staff and will be the designated contact for facilitating the health plans involvement in MDTs and will serve as a resource to Department caseworkers throughout the MDT process.
- Our ***Community Engagement and Training team*** will develop program-specific trainings to Department caseworkers, caregivers, providers, and other stakeholders on the roles and responsibilities of UniCare and to help meet the Program-specific training needs.

Co-locating Staff to Better Collaborate with Child Welfare Workers

Through our experience, we understand that co-locating staff at BCF offices in greater numbers during program implementation and ongoing during scheduled intervals assures early intervention, shortened response times, and enhanced care coordination. Community-based, co-located staff ensures the system of care is both supportive and adaptive to the ever-changing needs of members, families of origin, caregivers, agencies, and providers. We will collaborate with DHHR to develop the most effective co-location staffing model for West Virginia and, with the approval of BCF, we will co-locate clinical and administrative support staff in select BCF offices based on high-volume or other targeted needs. This arrangement enhances coordination, facilitates transitions in care, increases our understanding of the needs of the state child welfare partners, and provides significant opportunities for building relationships.

Coordination to Avoid Duplication of Services

Figure E.3-2. Communicating Through YouthRAP



UniCare will use our YouthRAP to provide an efficient mechanism to provide essential data, which will reduce administrative burden and facilitate communication and coordination among stakeholders with appropriate authorizations. As shown in Figure E.3-2 YouthRAP provides stakeholders (including Department caseworkers) role-based access to a consolidated view of member data in an easy-to-navigate dashboard; the available member data includes assessments, HEDIS care alerts, authorizations, medications, Care Plans, and claims. By sharing this data, we will prevent service duplication and identify care gaps to coordinate care more effectively. We understand DHHR staff may not always have internet access while working in the community and we can provide specific information to the Department caseworker telephonically as needed to facilitate sharing of immediately needed information.

Establishing Relationships with Child Welfare Workers (CS003)

We provide coordination, support, and communication during the many phases of the Child Welfare workers' processes and will offer support for workers who provide case management, case planning, and permanency planning. We understand there may be additional individuals who maintain these responsibilities as well including West Virginia Supreme Court Division of Children/Juvenile Services workers, child placing agencies, and Department caseworkers. We will work with each of these workers to coordinate care, understanding the Department caseworker has specific authority for each case.

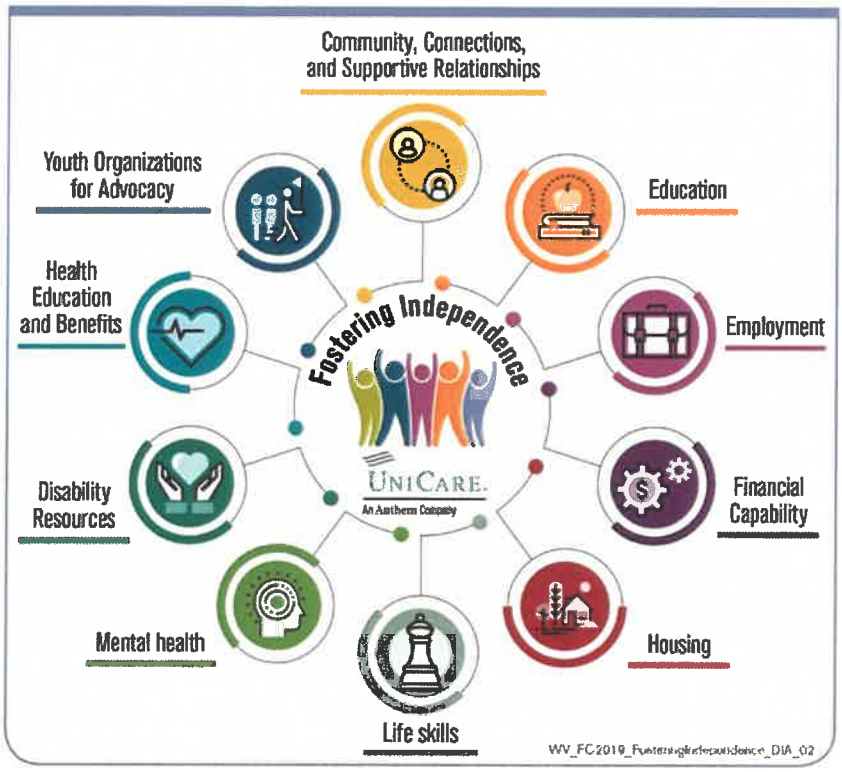
All members will be assigned to a Care Coordinator who understands their background and has experience addressing the member's needs. For families that have siblings in the system, we work to support these members and their families with the same Care Coordinator to assure an integrated, family-centered approach to care. This reduces duplication of services and can decrease the potential for gaps in care.

Coordinating with Workers who Provide Case Management, Case Planning, and Permanency Planning

We will establish and maintain a collaborative relationship with Child Welfare workers through consistent communication and collaboration with BCF. Based on the preferences of the workers providing services, we will offer multiple methods of communication — face-to-face, telephonic, or electronic (which includes our YouthRAP) — to coordinate care. As necessary, we will schedule routine meetings with Child Welfare workers, including those who provide case management, case planning, and permanency planning. To avoid duplication of services and eliminate gaps in care, as the single contact point, we can coordinate care and support transitions between workers based on where the member is along the continuum of services. When a new member enrolls, one of our Concierge Representatives will outreach to collect previous assessments, information in the State's system, and other relevant information about

the member. Collecting existing information can help us confirm appropriate screening and assessments without unnecessary repetition which could re-traumatize a child who has experienced potentially traumatic events or ACEs. Using established intake policies and procedures, our Concierge team will document communications with CPS and other Child Welfare workers, information collected, and assessments scheduled for the member. We will support all areas of case planning to develop permanency goals to support Child Welfare workers of all types in identifying the best treatment options for the member's health care needs. Our Care Coordinators will support Department caseworkers and other Child Welfare workers by creating person-centered transition plans with the member and offer available resources including life skills training, independent living, scholarship opportunities, employment resources, social supports, and education specific to TAY as outlined in Figure E.3-3.

Figure E.3-3. Fostering Independence



We will work with DHHR staff in placement and care planning, permanency planning, assisting families with socially necessary services (SNS), transition between foster homes, between residential and foster care, or out of foster care at any age. While many programs focus on providing services to children while they are in the child welfare system, youth who are transitioning out are in need of care as they move toward independence. To help meet the challenge of engaging and caring for this population, we developed the ***Fostering Independence model.*** UniCare will collaborate with community-based organizations and other stakeholders such as Mission WV, WorkForce Innovation and Opportunity Act (WIOA), National Youth Advocate Program in WV, Council for Community and Technical College Education, Department of Education, WV Division of Rehabilitation Services (DRS), WV National HIRE Network, RCHA Youthbuild, and YMCA's youth entrepreneurship activities to help assure members receive the support they need across multiple focus areas.

Coordinating Care with Judicial and Accompanying Systems (CS004)



UniCare recognizes the importance of collaborating with the judicial and accompanying systems and participants including CPS, court-appointed special advocates (CASA), Guardians Ad Litem (GAL), and judges to help assure that children and youth receive the most appropriate and needed health and social services. We will support judges and court-related entities with comprehensive information and health-related expertise to provide evidence-based treatment

and service recommendations or determinations consistent with best practices that meet the member's needs and support the best outcome for the child. UniCare will provide coordination with judges and other judicial system participants to address needed health care services — a common concern for children and youth in the child welfare system. We will coordinate with our system of care partners to assure that members and families have access to necessary physical, behavioral, and socially necessary services. Coordination will focus on early engagement with these systems to establish trust, to anticipate and address challenges, and to create communication mechanisms — such as routine meetings — to support a successful implementation and ongoing collaboration. Our approach to working with the judicial and accompanying systems begins with this early outreach to build strong relationships with engagement, orientation, and training. Our designated Justice/Court Liaison will serve as a primary contact and will foster strong, streamlined communication pathways with the State's Family Courts, the West Virginia Supreme Court Division of Children/Juvenile Services, and the accompanying systems. The Judicial/Court Liaison will be an experienced licensed BH Clinician who will engage other members of the clinical and network staff to address the questions of the judge regarding best practices, medical terms, medications or other related issues, and will:

> Our affiliate in Georgia partnered with the Department of Juvenile Justice to educate their placement staff on how to request and use psychological testing for members. Staff worked with Department of Juvenile Justice to create the training content and then participated in one of Department of Juvenile Justice's joint meetings with providers to train them on the new parameters. This example represents just one of the opportunities we can leverage from our affiliates' experience to augment our West Virginia model in collaborating with system partners.
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- ***Be a dedicated, single point of contact for judges*** to request information such as clinical, program, and network questions
- Identify key justice system staff and establish ongoing, consistent communications and relationships
- Identify and engage key judicial-related stakeholders across West Virginia including GAL and CASA
- Conduct outreach activities to determine training and educational needs to inform and support stakeholders, the court system, the West Virginia Supreme Court Division of Children/Juvenile Services, GAL, and CASA
- Serve as a conduit for health care information between the judges, BCF, West Virginia Supreme Court Division of Children/Juvenile Services, related stakeholders, and UniCare to address system, organizational, and member issues
- Identify child welfare initiatives and additional partnership opportunities
  - We are exploring partnerships with stakeholders such as the Legal Training for Dependency, Neglect and Abuse Cases Program, West Virginia Supreme Court Division of Children/Juvenile Services Program staff, West Virginia CASA Network

In addition to these tasks, our Judicial/Court Liaison will manage a dedicated mailbox through which judges can ask questions, request trainings, and submit other communications. We use this information to determine further outreach and training. The mailbox may be used to contact the Judicial/Court Liaison to request clinical consultation on health care subjects such as diagnoses, best practices, and medications. In collaboration with the West Virginia Supreme Court Division of Children/Juvenile Services, we will deliver an orientation to the Fostering Healthy Lives program and develop customized trainings and materials to address child welfare specific topics related to health care. Our in-person, Fostering Healthy Lives orientation will educate judicial system partners on UniCare and will address any questions, concerns, or

misconceptions about the Program. The training will focus on clarifying roles and responsibilities for coordinating with other child welfare system partners and stakeholders.

Proposing Alternative Services (CS005)

In managing and coordinating treatment and support services with the child welfare system of care, we will support our system partners through the MDT to develop a clinically appropriate treatment and supportive services plan to meet the needs of the child. As needed, our Judicial/Court Liaison will provide consultation to judges regarding the rationale and evidence for the clinical recommendation and how it supports the best interest for the child, particularly addressing issues related to trauma when changing providers or levels of care. Recognizing that we are responsible for court ordered treatment, we will work with CPS, judges, CASA, and other stakeholders to assure that clinical justifications are clear and that they all have adequate information about services and network availability. If the judge orders a service that we believe is not in the best interest of the child clinically, we will provide a clear, clinically sound alternative first to BCF for their approval and then to the judge. Our Judicial/Court liaison will be the conduit of this process, and we will use the information learned to develop training and messaging.

We will support the Department caseworkers to assure that the MDT proposes the most clinically appropriate services and needed supports to assist the child, families, and caregivers to meet members' short- and long-term goals. Through our experiences in other markets, we learned that judges can develop trust in our recommendations. If necessary, we can quickly escalate a concern to the courts — this can be important for children experiencing trauma.

Fostering Healthy Lives Stakeholder Advisory Committee



We will form a Fostering Healthy Lives Stakeholder Advisory Committee to support collaboration and coordination, inviting members from the judicial system, law enforcement, CASA, and other system partners. This voluntary advisory group will have community stakeholders, providers, and those invested in serving children, youth, and young adults receiving child welfare services, inclusive of SNS. This group will consult and address programmatic and organizational issues as they relate to our Fostering Healthy Lives model. We will use the input and recommendations from this committee to help us identify what works well and any gaps or challenges in the current system of care. We will continue to participate in the established monthly Community Collaborative meetings in four regions. In June 2019, UniCare hosted a Community Advisory Committee meeting with foster parents and foster care placement agencies such as KVC, NECCO, and Children's Home Society. We collected feedback from agencies and community members on the strengths and challenges of the current system, including concerns about moving to managed care.

Establishing and Maintaining Relationships with Department Agencies and State Advocacy Groups (CS006)

We will establish and maintain relationships with DHHR agencies and state advocacy groups such as BCF, Bureau for Behavioral Health and Health Facilities (BBHHF), BMS, BPH, West Virginia Supreme Court Division of Children/Juvenile Services, and the Department of Education. We will engage with these agencies and groups at the following levels:

- **At the member level.** We will develop relationships through care coordination interactions with DHHR agency staff, caregivers, CASA volunteers, and other advocacy entities to address the needs of members and their families.
- **At the community level.** UniCare will develop trainings and attend regional child welfare organizational or system meetings such as the Family Resource Network or Care Consortium to address challenges, issues, and to promote coordinated services. Our Community Engagement Director and Community Engagement and Training

Representatives will establish and maintain relationships with regional DHHR representatives, CASA, and the Child Advocacy Network.

- **At the system level.** We will engage through DHHR, agency State office-level meetings, or activities through our Specialized Managed Care for Children and Youth Contract Administrator or Liaison to DHHR.

We will work with our State partners and advocacy groups to determine the best strategies to collaborate effectively and efficiently. For example, we will respond with immediate support when the West Virginia Supreme Court Division of Children/Juvenile Services informs us that a child is taken into custody by assigning a Care Coordinator to schedule necessary assessments. We reconcile our enrollment reports to verify enrollment and make sure the member's and their family's needs are met. During Program implementation, we intend to continue to work with our State partners to mitigate member issues and expedite enrollment and care coordination. Building on our existing experiences, we will coordinate with the West Virginia Supreme Court Division of Children/Juvenile Services from the time a member enrolls. We will share health-related information, continue our participation in discharge planning, and inform their staff about the details of screening and assessment appointments.

Coordinating with Child Advocacy Centers (CS007) and the Child Abuse Network (CS009)



Child Advocacy Centers and the Child Abuse Network play a key role in the system of care as local experts in addressing child abuse and trauma and in educating providers and other stakeholders to appropriately serve children impacted by trauma. We understand Child Advocacy Centers and the Child Abuse Network respond to CPS and law enforcement requests for forensic interviewing and medical exams. A Child Advocacy Center provides a safe, child-friendly facility where child protection, criminal justice, and child treatment professionals work together to investigate abuse, hold offenders accountable, and help children heal. We value the importance of this critical action for children who have been the victims of abuse to receive this service from their expertise in trauma. We will collaborate with the Child Advocacy Centers and the Child Abuse Network and system partners to provide training to professionals on trauma and providing crisis support services. We will develop open lines of communication to effectively coordinate care through our interactions and will invite a representative from the Child Advocacy Centers and the Child Abuse Network to attend our advisory group meetings. We will participate in the annual Child Advocacy Center conference to support training and other educational outreach. Our Community Engagement and Training team will develop routine meetings or interactions with each location.

- **At the member level.** Our Care Coordinator outreaches to the Child Advocacy Center to obtain treatment information and will facilitate continuity of care for members who receive services through the Child Advocacy Center. The Child Advocacy Centers can contact our Concierge team or Care Coordinator to make referrals for continuing care for members.
- **At the community level.** Our local Community Engagement and Training teams collaborate through training and regional coordination meetings and engage in activities such as community events.
- **At the system level.** We will invite a West Virginia Child Abuse Medical Program (WV-CHAMP) physician to be on our Medical Advisory Committee and will participate in statewide meetings and initiatives.

We will build relationships with these agencies across the state by establishing communication and processes to seamlessly coordinate care by obtaining information to assure continuity.

Coordinating with Court Appointed Special Advocates (CS008)

The CASA organization and individual advocates play a significant role in the West Virginia child welfare system by collaborating with CPS and the GAL to gather information on the child's medical, educational, and social well-being; appear at hearings; and to advocate for the child as a friend of the court. The CASA volunteer can be a key source to identify community child welfare needs and offer support to the member and their family. Our Care Coordinator will collaborate with the CASA volunteer to share information and secure member services. At the regional level, we will engage through system coordination meetings such as the Family Resource Network and Community Collaboratives. Our staff will attend CASA regional meetings as appropriate, will provide trainings during orientation and ongoing, and will partner to identify mutual training activities. At the system level, we will engage through the state office and advisory groups.

We value the vital role of CASAs in giving children and youth a voice and in advocating for their best interests for safety, permanency, and well-being, while assuring necessary services and supports meet the member's health care needs. We began our efforts to engage with CASA and met with leadership regularly in 2018 and 2019 to discuss CASA program strengths, challenges, and address concerns about the transition to managed care. In cases where CASAs have access to a child's medical records, we will collaborate to provide information on specific diagnoses or medications, to better advocate for the child's holistic and social needs. ***UniCare partnered with CASA to expand their outreach of services to Mercer and other counties. UniCare is supporting CASA by covering training expenses, recruitments, and events for CASA volunteer advocates, which included providing $10,000 in 2018.***

Engaging with Foster Parents (CS010)

Caring for Caregivers

Communicating, engaging with, and supporting families is key to creating safe, stable, and permanent settings for children and youth in the child welfare system. We recognize that "family" can include foster parents and kinship caregivers, the family of origin, natural supports, or other designated legal guardians. We focus on building trusting relationships with foster parents and caregivers using a family-centered approach that includes the coordination of physical, behavioral, and SDOH needs. Our Care Coordinators work collaboratively with child placing agencies (CPAs) and value their role and importance to connection and engagement with many foster parents. We are currently working with the West Virginia Foster, Adoptive, and Kinship Parents Network, through a community advisory group that includes CPAs and Circle of Parents. We will continue to develop these relationships, which will enable us to outreach directly to foster parents in a comfortable setting.

We communicate with foster parents based on DHHR's guidelines, including information protected by confidentiality requirement. To support a team-based approach to care that includes foster parents where appropriate, our YouthRAP will facilitate communication and coordination between Care Coordinators, members, foster parents, and those involved in the member's care team, as authorized by DHHR.

Communication and Engagement Means Listening First

First, We Listen

Our priority is always to listen first — assuring that we understand the needs and feedback of foster parents and caregivers, to most appropriately and effectively address needs. From our Concierge team to our Care Coordinators, we communicate to address the needs of both children and families. We are establishing a ***Parent and Caregiver Advisory Group***, which will comprise a voluntary advisory group of foster, adoptive, and kinship caregivers led by the Medicaid Member Advocate. Through the

advisory group, we will use the input and ideas from caregivers to develop solutions. We will engage and support caregivers, including foster parents, to support stability and improved health and social outcomes for children in child welfare, which includes:

- Providing training and communicating with Foster Parents about conditions such as asthma and food allergies including how to use an EpiPen
- Sending EPSDT birthday post card reminders for upcoming visits or needed vaccines
- Partnering with West Virginia Home Visitation Programs to support families
- Providing a Quick Start Guide for families that will contain information, such as our plan benefits, quick links to online resources including searching for in-network providers, VAS, and contact information for vision and dental providers
- Offering easy-to-access and convenient caregiver training on topics like addressing trauma, recognizing BH conditions, preparing for crisis, primary parenting styles, ways to diffuse or redirect behavior problems, ways to engage foster youth, and the importance of self-care
- Offering VAS to support Foster Parents and kinship caregivers including customized toolkits with educational information for new foster care and kinship parents; a foster parent or kinship care application checklist; BH benefit information; State resources for families such as child care, respite care, education, and training vouchers; and clothing resources

Value-Added Services

We will develop relationships with the DHHR Homefinders and Foster-Adoptive Parent Support Groups to learn of new foster-adoptive parents and kinship relatives. We will network through Parent Resources for Information, Development, and Education trainings and Foster-Adoptive Parent Support Group meetings and will include trainings for SNS reimbursements processes such as travel, respite, connection visits, and continuing education units. We encourage stakeholders and caregivers who are a part of CPAs to be a part of SNS focus groups. We are exploring collaborations with the West Virginia Relatives as Parents Program as we recognize that kinship caregivers need advocacy, community resources, and support. Through our trainings and collaborative efforts with community services as described in Table E.3-4, we can further support and collaborate with foster parents and caregivers.

Table E.3-4. Supporting Foster Parents and Caregivers Through Our UniCare Programs

Program	Description
Healthy Grandfamilies	In 2018, we initiated this partnership to support grandparents raising their grandchildren through information, peer support, and connection to resources.
Foster Closets	Foster Closets are free resources for caregivers of children in foster care. Foster Closets are provided by churches and organizations to provide basic supplies and clothing for children when they are placed in care. UniCare collects clothing and purchases hygiene supplies to support children in selected areas.
Starting Points	Serving all WV counties, Starting Points supports families focusing on health, nutrition, development screenings, preschool, and parenting classes. **Since 2014, UniCare participated in over 100 events, outreaching to over 4,000 parents and children.**

Collaborating with the Bureau of Public Health to Increase Enrollment in the West Virginia Home Visitation Program (CS011)

STABILIZING and STRENGTHENING FAMILIES

UniCare will collaborate with BPH to encourage enrollment in the West Virginia Home Visitation Program. We identified BPH as an essential stakeholder who works with families, partners, and communities to assure safety and health. We will explore opportunities to develop our relationship as an essential stakeholder with a shared vision to collaborate and connect members with BPH initiatives. We recognize and value the importance of these quality resource programs which reduce risk and strengthen families by partnering trained home visitors who build on the resiliency of the caregivers, allowing them self-efficacy to

work on their individualized goals. UniCare works closely with the Office of Maternal Child and Family Health (OMCFH) to help assure that Children with Special Health Care Needs (CSHCN) have a medical home. We will build upon our current collaboration with OMCFH and more than 200 community-based organizations across West Virginia to encourage and increase the number of families enrolled in the West Virginia Home Visitation Program. We established collaborative relationships with multiple home visitation programs, as outlined in Table E.3-5, to support members and their families.

Table E.3-5. Collaborating with Home Visitation Programs

Program	Description
West Virginia Birth to Three	Our 10-year collaboration with this organization provides a system of services and supports for children who have a delay in their development or are at risk for a delay. **From Spring 2014 to February 2018, UniCare participated in nearly 150 events including baby showers, health fairs, and other parent engagement activities.**
Right from the Start/West Virginia Healthy Start and Helping Appalachian Parents and Infants (HAPI) Project	HAPI — integrated with Right from the Start — works with local agencies that employ Designated Care Coordinators, licensed professional social workers, and registered nurses to provide education, resources, and services to members to reduce infant mortality. UniCare has a long-standing relationship with the HAPI project and has partnered with them on community baby showers and mom and baby events.
Parents as Teachers	This statewide program promotes early development, learning, and the child's health by supporting parents and caregivers. UniCare collaborates with Parents as Teachers to provide health and benefit presentations to parents and caregivers, engagement activities for children, and sponsored their literacy initiative Roll & Read.

We will leverage our Social Services Director an expert on all community resources and social services, to assure our interdisciplinary care teams (ICT) are aware of the West Virginia Home Visitation Program, its various program components, and how to access the resource directory. Our ICTs will receive training regarding all of the West Virginia Home Visitation programs available and will document referrals made with the member's permission. Engagement in the West Virginia Home Visitation Program will be incorporated into the Care Plan to measure the progress of individualized goals. The Social Services Director and Community Engagement and Training team will learn of program changes or expansion of specific programs through communication with staff at meetings and on their websites in order to educate our staff regarding these changes. To further promote and inform members about the program details and how to become involved, we will use the following methods:

- Distributing materials and verbally providing information to members during community events and care coordination activities with members and their families
- Producing and distributing printed materials at community-based service locations

Through our community and stakeholder relationships, we will use these opportunities to outreach and encourage members to engage directly with the West Virginia Home Visitation programs. We will help members connect to this program through our community partners and will collaborate directly with these organizations to promote participation.

Engaging Community-Based Child Welfare Organizations to Provide Family-centered Treatment (CS012)

Our UniCare Fostering Healthy Lives model of care recognizes the important role CPAs and child welfare organizations play in the overall child welfare system. When children are unable to safely remain in their home of origin, they require placement in the least traumatic environment that is most normalizing and integrated and that provides for their holistic needs until they achieve permanency. We understand CPAs provide certified foster homes, case management, and the administrative structure to support these processes. Licensed child welfare agencies have similar responsibilities with children placed in residential care facilities. While both types of organizations have case management responsibilities, they work with the Department caseworker in the development of a Care Plan that includes physical and BH care. UniCare considers these agencies essential partners in our team-based approach for care coordination and our community-based stakeholder engagement and outreach.

Ensuring Family-centered Treatment

We currently contract with CPAs as network providers for non-child welfare related services and have existing relationships which we will build on. In 2018, we engaged in conversations with agencies including KVC, Children's Home Society, and Pressley Ridge to learn more about their structures and services for children in child welfare. Family-centered principles of family empowerment and participation, a focus on strengths, and community-based support are part of our model of care and we will actively promote their use in treatment. Our Care Coordinators incorporate a family-centered approach which focuses on working with the family unit to strengthen capacity and assure the best possible outcomes for the member. At each level, we will encourage family-centered treatment to best serve the child and their family.

- **At the member level.** As our member's single point of contact, the Care Coordinator will engage with community-based child welfare organization case managers or treatment Managers to promote and ensure that the member's treatment providers are engaging in family-centered treatment. We will support the agency case managers in linking members to providers that engage in treatment that adheres to family-centered principles. When the member's permanency plan is reunification, families of origin should be included in treatment as authorized by Department caseworkers. When we review provider treatment plans for members and as requested participants by DHHR in the MDT process, we will promote treatment provided using family-centered principles.
- **At the community level.** We use our Community Engagement and Training team to engage with community-based child welfare organizations to support training needs on family-centered treatment. Representatives will attend regional stakeholder meetings and committees such as Family Resource Networks and Community Collaboratives. With our Social Services Director, Community Engagement and Training team, and Care Coordination teams, we will engage with organization staff to review data, issue clarification and resolution, and to maintain and develop collaborations with community organizations who encourage family-centered care.
- **At the system level.** We will participate in and facilitate routine, collaborative interactions, committees, or meetings that address family-centered treatment with the DHHR, CPAs, and child welfare agencies and other related stakeholders.

We are currently working with several family-centered treatment organizations, mirrored after the DHHR's Safe at Home Program, including Prestera which helps children placed in a Psychiatric Residential Treatment Facility (PRTF) to return home, or children who are at risk of

PRTF placement, giving the child and family a foundation for trust and growth. We will collaborate with the Family Advocate and Support Training (FAST) Program through Legal Aid. FAST is a statewide parent and youth network that engages families in the planning, management, and evaluation of their child's mental health treatment and service needs. We will collaborate with our existing relationships to provide family-centered care such as the Safe at Home WV project, National Youth Advocates, and WV Children's homes.

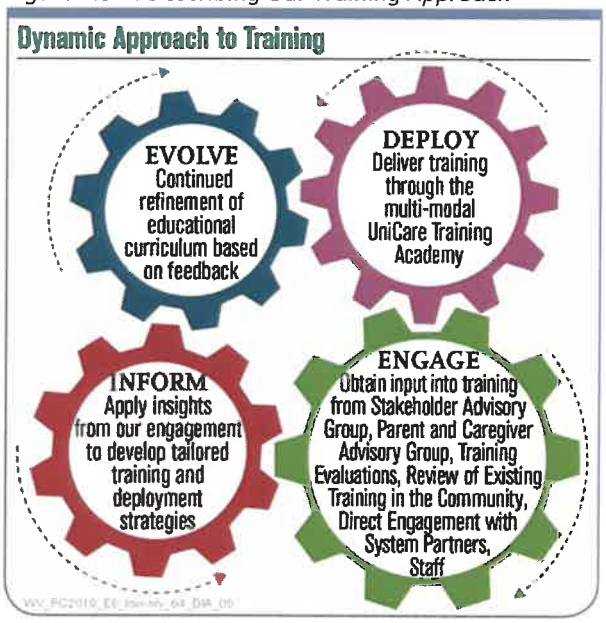
Providing Training for Advocates and Stakeholders (CS013)

UniCare supports DHHR's Program goals, including the improvement of communication and training among stakeholders. Our comprehensive training strategy reflects our understanding that child welfare programs — delivered through a system comprised of many stakeholders — can work collaboratively to positively impact the health and social outcomes for members and their families. We understand that a system-wide transition such as that required by the Program can be challenging, and we will support that transition through coordinated training and education that includes a dedicated Community Engagement and Training team. Our UniCare Training Academy (Academy) acts as the vehicle to facilitate the delivery of a consistent and comprehensive approach to stakeholder training. It streamlines the development, delivery, and reporting of training into one easy-to-use, scalable system, and it incorporates multi-modal training and mechanisms for tracking, monitoring, and reporting training completion.

We designed a comprehensive training program for stakeholders, including child welfare staff, child-serving agencies, community stakeholders, advocates, the judiciary, and educators. We will provide comprehensive and coordinated training to providers, caregivers, and youth as described in detail in our provider services response in PS001 and PS002. We recognize stakeholders will differ in their learning styles and preferences. We offer multi-modal options to make it easy and convenient to access training including in-person group trainings, live interactive webinars where participants can actively engage and ask questions, and pre-recorded webinars available on demand. We will offer orientation trainings in-person and through live interactive webinars twice monthly for one year after the Program start date. After one year, we will provide orientation trainings monthly or more frequently as requested.

We will develop and refine the trainings we offer using an ***Engage, Inform, Deploy, and Evolve*** approach (Figure E.3-4). We will collaborate with stakeholders to obtain feedback and identify training needs. For example, we will use input from our Stakeholder and Parent and Caregiver Advisory Groups, training evaluations, and staff input to develop trainings to reinforce areas covered in orientation or enhance topic areas already covered.

Figure E.3-4. Describing Our Training Approach



Easing the Transition Through Our Initial Training Topic Areas

We have learned from our affiliates' experience in 13 markets serving approximately 84,000 children, adolescents, and young adults in child welfare programs that providing comprehensive orientation prior to implementation is beneficial for stakeholders and advocates and helps ensure a smooth transition for children, youth, caregivers, and families. We will work with DHHR to obtain approval to begin scheduling Program orientation training for stakeholders 60 days prior to implementation. We will work with our existing partners in the community such as West Virginia Legal Aid-FAST, West Virginia Mental Health 1st Aid, Mission WV, and West Virginia University Centers for Excellence in Disabilities to identify opportunities, forums, and settings to provide training to stakeholders and advocates as well as promote the availability of training through their communications. To maximize training opportunities and ensure we can provide initial orientation training to as many stakeholders and advocates as possible, our Community Engagement and Training team will work to identify meetings, conferences, and other gatherings where training can be added to an existing agenda. Orientation trainings will be provided in person by our Community Engagement and Training Representatives and through interactive and pre-recorded webinars and presentations. In Figure E.3-5, we outline the orientation training topics for stakeholders and advocates.

Figure E.3-5. UniCare's Training Topics to Inform Stakeholders and Advocates

West Virginia Fostering Healthy Lives Orientation Training Topics for Stakeholders and Advocates

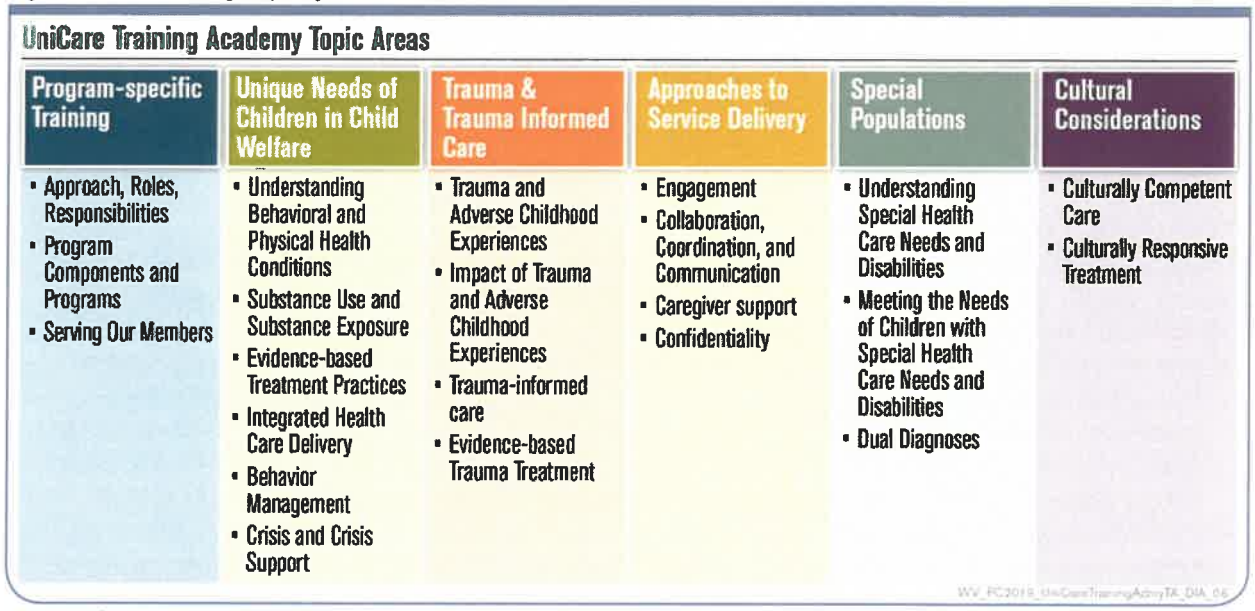
Approach, Roles, and Responsibilities	• Program goals • UniCare approach to working with child welfare system • UniCare approach to trauma, trauma-informed care, and ACEs	• Roles and responsibilities of each system partner including the MCO, State Agencies, judiciary, community child welfare agencies, placement agencies, providers, caregivers, and others
Program Components and Processes	• Organization and staffing • Utilization management and authorizations • Socially necessary services and processes • Complaints, grievances, appeals, and role of the Medicaid Member Advocate • Provider network • Quality and performance improvement • Member benefits, including Value-Added Services	• Access to care standards, transition to the MCO, and care transitions • Role of care coordination and how to access care coordination services • Training, engagement, Stakeholder Advisory Group, Parent and Caregiver Advisory Group • Enrollee handbook and ID Cards • Transition to the MCO (continuity of care)
Serving Our Members	• Care coordination and management including intensive care management and chronic condition management • Intake, screening, and care planning • Children with Special Health Care Needs - outreach at enrollment, care coordination, and resources • How we serve members with disabilities • Transition Age Youth	• Requesting out-of-network referrals • Right to change PCPs • Participation in care planning • Tools and resources (including websites, handbook, and YouthRAP) • Crisis services

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Providing Ongoing Trainings

We will provide ongoing training to reinforce areas covered in initial training and provide updates to stakeholders and advocates on changes in programs, policies, and procedures — offered in person by our Community Engagement and Training Representatives and through interactive and pre-recorded webinars and presentations. We will enhance ongoing training by increasing our focus on improving system capacity to best serve the needs of members, caregivers, and families through specialized, on-demand training on identified topics highlighted in Figure E.3-6.

Figure E.3-6. Training Topics for Stakeholders and Advocates



We recognize there are West Virginia entities that provide topic trainings important for child welfare. Our goal is to enhance and build upon existing training, not replicate it. We will engage those entities for consultation and possible collaborations to support existing, and develop new trainings, and identify opportunities for joint trainings such as with WV ACES Coalition, WV Children's Advocacy Network, WV Dept. of Education Kid Strong Conference, WV Primary Care Association, and Handle with Care WV.

Deploying Our Regional Community Engagement and Training Team

Our model for West Virginia will establish a dedicated Fostering Healthy Lives Community Engagement and Training team to oversee development of our stakeholder education and training. This team will focus on unifying the local system of care by bringing training, support, and expertise to promote shared understanding of the new single managed care program and the needs of children and families. Led by our Community Engagement Director, our team will include a Judicial/Court Liaison, a Career Development Specialist, and five regionally focused Community Engagement and Training Representatives. These representatives will be strategically positioned statewide to identify local opportunities for engagement and partnerships, identify training needs, collaborate with local subject matter experts, and provide trainings in local forums. This team will communicate regularly with staff responsible for other health plan functions — Provider Relations, Quality, and Clinical Services — to assure alignment of messaging and community educational programming. This local team will have the support of our national resources and experts who can support the creation of West Virginia-tailored trainings based on best practices and evidence-based trainings. The team's three primary training responsibilities include:

- To develop and provide program-specific training, such as orientations related to Program- or plan-specific functions, an important component of the training strategy as West Virginia moves to a single managed care plan. Program-specific training initially during implementation and ongoing for advocates and stakeholders across the system (to include members, parents, caregivers, child welfare staff, providers, law enforcement, judges, and other stakeholders). We understand the transition can be difficult and want to make it as easy as possible through this coordinated training and education.

- To foster relationships with subject matter experts and organizations across West Virginia to develop, support, or enhance training efforts and identify opportunities to disseminate training in the community. These partnerships may include partnering to support related trainings identified as needed. It can include identifying local trainers, organizations, and educational institutions such as universities to develop and provide instructor led-training.
- To evaluate training and gather input from system partners, and incorporating it into our training strategy to identify training needs and improve training.

Providing Trauma-informed Care

Our approach to training promotes holistic, person-centered and trauma-informed care for the children, youth, and young adults we serve. UniCare will provide several types of stakeholder and advocate training on this foundational principle:

- We will introduce trauma-informed care, ACEs, and our trauma approach in orientation.
- Using the Academy, we will provide access to web-based trauma and trauma-related trainings, including content purchased from Children's Trauma Assessment Center (CTAC) and Omni Behavioral Health and trainings from National Child Traumatic Stress Network. These courses offer foundational trauma training and training on more in-depth topics.
- Consistent with our approach to support rather than duplicate existing training efforts and to create meaningful partnerships with stakeholders, our Engagement and Training team will identify local experts to partner in training such as those identified through the National Child Traumatic Stress Network as well as local Community Mental Health Centers, CPAs, and others with expertise in addressing and providing training on trauma and related topics.
- To support evidence-based practices for addressing trauma, we engaged in a partnership with Dr. Cheryl McNeil, Ph.D., Professor of Clinical Psychology at West Virginia University and Parent-Child Interaction Therapy (PCIT) International Master Trainer, to develop parent-facing and provider/Care Manager facing webinars on PCIT.

Ensuring Child Placement Agencies Have Access to Up-to-Date Records (CS014)

We understand the importance for child placement agencies to have up-to-date records to support their responsibilities for foster care children they place. We support their requirement to maintain accurate records, which include information such as the child's allergies, medical conditions, current medications, and other physical, behavioral, or SDOH information. Our care coordination staff will collaborate with child placement agency staff, as authorized, so they have the up-to-date information on children they serve. We can provide child placement agencies with information needed to conduct and complete individualized strengths-based assessments, make sure children receive needed services, and provide foster families with crucial information on a child when they are placed. By sharing and exchanging information, we can help close care gaps, and can help agencies ensure children receive needed health care services such as a comprehensive EPSDT exam within 30 calendar days of placement in foster care, and a follow-up visit within 90 calendar days of placement in foster care. We want CPAs to have access to up-to-date information by leveraging our "no wrong door" approach. With appropriate authorization, child placement agency staff can reach out to the member's Care Coordinator or our Concierge Representatives to obtain needed information.

Using Technology to Share Information

In addition to providing access to information through our Concierge team and Care Coordinators, we will use information technology capabilities and sharing procedures to deliver a solution to ensure CPAs have access to up-to-date records. We will implement our YouthRAP to facilitate notification, alerts, and secure messaging among our clinical staff and child placement agencies. Building upon our existing information sharing platform, we will implement an electronic health record solution that will serve as a system of record for children and youth in child welfare — a repository of member health information, aggregating data from our internal systems (such as claims, encounters, and authorizations) with external data sources.

YouthRAP will provide authorized users access to a consolidated view of member PH, BH, pharmacy, and care planning data in an easy-to-navigate dashboard. Accessible screenings and assessments will include UniCare's Foster Care Health Risk Screener and provider-completed assessments such as the Child and Adolescent Needs and Strengths Assessment (CANS), as well as HEDIS care alerts, authorizations, pharmacy, and claims organized by type. It will provide a multifaceted perspective on member utilization and pharmacy patterns to prevent service duplication and identify care gaps and trends to coordinate more effective care.

Through YouthRAP, with appropriate role-based authorizations, CPAs can readily access the member's complete health information, which is especially vital during placement transitions. A health and service record that travels with children over time and across placements can improve communication, avoid redundant assessment processes, and reduce service duplication and fragmentation. We will work with CPAs to share information that may be important for smooth care coordination and completion of the member's medical record, such as the health history form, information on the child's birth, health authorizations, medication forms, and level of care determination forms, among others.

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4. MEMBER SERVICES

The Vendor should refer to the relevant specifications located in **Appendix 1: Detailed Specifications** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in **Section 4: Project Specifications** in this RFP, and then describe its approach to Member Services below. The Vendor's narrative response should not exceed 50 pages.

MS001	The Vendor should identify and reach out to members (or their caregiver or caseworker as appropriate) with the most Immediate service needs leading up to and immediately following implementation of a program.	The Vendor should describe how it will meet this specification.
MS002	The Vendor should provide outreach and training on an ongoing basis to youth and young adults and their respective caregivers who are eligible for services.	The Vendor should describe the audience(s), frequency, method(s), and topic(s) for this outreach and training.
MS003	The Vendor should collaborate with community partners to help design materials that best meet the needs of the populations being served.	The Vendor should describe how it will meet this specification.
MS004	The Vendor should leverage information technology (IT) solutions to improve access to information, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
MS005	Member health records (by the member, caregiver, and/or provider as appropriate)	See the parent specification.
MS006	Appeal processes	See the parent specification.
MS007	Other member rights and responsibilities	See the parent specification.
MS008	The Vendor should distribute an Informational welcome packet to families impacted by the transition.	The Vendor should describe any particular communication strategies it would use or information it would include in this welcome packet, including, but not limited to, the Vendor's appeals process.
MS009	The Vendor should develop a community resource library, including, but not limited to, member handbooks, newsletters, and/or care coordinators.	The Vendor should describe how it will meet this specification.
MS010	The Vendor should facilitate connecting members to community resources and social services.	The Vendor should describe how it will connect members to community resources and social services, and should demonstrate its understanding of available community resources and social services in the State.
MS011	The Vendor should develop materials for members, including, but not limited to, members with special healthcare needs, in accordance with federal and State marketing regulations.	The Vendor should describe how it will meet this specification.

MS012	The Vendor should consult with persons with disabilities and advocacy groups while developing materials for members with special healthcare needs.	The Vendor should describe how it will meet this specification.
MS013	The Vendor should use a methodology, including, but not limited to, claims history and proximity, to assign members in applicable populations to a primary care provider (PCP)	The Vendor should describe in detail its proposed methodology for primary care provider (PCP) assignment particularly for new members when auto-assigning to a PCP.
MS014	The Vendor should notify members in applicable populations of primary care provider (PCP) assignment.	The Vendor should describe how it will meet this specification.
MS015	The Vendor should educate members in applicable populations of the right to change primary care providers (PCPs).	The Vendor should describe how it will meet this specification.
MS016	The Vendor should conduct follow-up communications to ensure members in applicable populations are aware of the primary care provider (PCP) assignment.	The Vendor should describe how it will meet this specification.
MS017	The Vendor should conduct outreach and transition planning efforts directed toward members with special healthcare needs.	The Vendor should describe how this outreach will be conducted.
MS018	The Vendor should mail member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:	The Vendor should provide a proposed turnaround time for mailing, on an ongoing basis, updates to the member handbook and ad hoc handbook requests.
MS019	Updates to the member handbook	See the parent specification.
MS020	Handbooks requested ad hoc by a member	See the parent specification.
MS021	The Vendor should provide enabling services-including, but not limited to, assistance with complaints and grievances--to members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.
MS022	The Vendor should ensure the Contract Liaison/Medicaid Administrator monitors grievances-- including, but not limited to, grievances related to subcontractors--for enabling services for members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.
MS023	The Vendor should provide methods for members to contact the member services department, including, but not limited to, the following:	The Vendor should: 1) Describe methods for members to contact the Vendor member services department. 2) Describe hours of operation. 3) Describe its member services hotline call transfer protocols and decision trees.
MS024	An emergency hotline	See the parent specification.

MS025	A toll-free number	See the parent specification.
MS026	The Vendor should transfer calls between the member services department and subcontractors for review, if applicable.	The Vendor should describe how it will meet this specification.
MS027	The Vendor should educate members about the ability to request out-of-network referrals.	The Vendor should describe its processes and mechanisms—including, but not limited to, the member handbook—for meeting this specification.
MS028	The Vendor should educate member services representatives on the out-of-network referral process.	The Vendor should describe how it will meet this specification.
MS029	The Vendor should train member services representatives on topics including, but not limited to, the following:	The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum.
MS030	Serving members with disabilities and chronic conditions	See the parent specification.
MS031	The culture of disability	See the parent specification.
MS032	Resources available to members	See the parent specification.
MS033	The Vendor should, on an ongoing basis and at a set frequency, provide training to staff who perform outreach to members with special healthcare needs upon enrollment.	The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum.
MS034	The Vendor should use and report to the Department on customer service performance standards, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
MS035	Member-to-representative ratios	See the parent specification.
MS036	Call answering time, with a minimum of 83% of calls answered in 30 seconds	See the parent specification.
MS037	Call abandonment rate not to exceed five percent (5%)	See the parent specification.
MS038	Single contact resolution	See the parent specification.
MS039	Turnaround time for member requests	See the parent specification.
MS040	The Vendor should use warm transfer protocols for its member services and other applicable departments.	The Vendor should describe how it will meet this specification.
MS041	The Vendor should establish and implement a new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment. This process should include, but not be limited to, the following:	The Vendor should describe its new member enrollment and education process, including member contact, from the time of initial notification of the member's enrollment through the first month of actual enrollment. This description should establish the order of steps and associated timeframes.

MS042	Member contact, including, but not limited to, welcome calls, welcome letters, and/or home visits	See the parent specification.
MS043	Outreach to members who are difficult to contact, including but not limited to, disabled members and members without telephones	See the parent specification.
MS044	Processing and issuing identification cards	See the parent specification.
MS045	Distributing member handbooks	See the parent specification.
MS046	The Vendor should distribute to members preferred drug list (POL) and formulary changes affecting members' care.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date. This description should include, but not limited to, timeframes and methods of delivery.
MS047	The Vendor should work with the State health exchange during the first six months of the contract to deliver to the Department an implementation plan for an electronic health record (EHR) system that serves as a health passport for members.	The Vendor should describe how it will meet this specification. Per the American Academy of Pediatrics (AAP), the health passport should include, but not be limited to, the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunizational information.
MS048	The Vendor should provide a publicly accessible, secure website with information targeted to members that adheres to federal and State marketing regulations.	The Vendor should describe how it will leverage its website to help meet the needs of members.
MS049	The Vendor should provide a secure member portal that allows members to log in and access benefit information, including, but not limited to, the following:	The Vendor should describe the abilities of its member portal and how the portal will be leveraged to help meet the needs of members.
MS050	Medical records	See parent specification.
MS051	Authorization status	See parent specification.

Member Education

UniCare Health Plan of West Virginia, Inc.'s (UniCare's) member education model is comprised of outreach calls, mailed materials, online videos and resources, face-to-face interactions, and over-the-phone contact with our Fostering Healthy Lives Concierge and Care Coordination Teams. We know that members who understand their benefits have improved health outcomes. We also know that many of these members may be new to managed care, and we want them to feel confident in their understanding of the program and our ability to serve them. In this section, we describe our approach and specific methods in adapting materials to optimally communicate with our members in West Virginia. We also discuss our outreach efforts — directly to members over 18 years of age and to caregivers, Department caseworkers, and foster parents for those under 18.

Member Material Development (MS011)

Figure E.4-1. Our Affiliate in Indiana's ClearMark Award for Plain Language



UniCare, in conjunction with our ultimate parent company Anthem, Inc. (Anthem), produces all member materials in plain language at or below a sixth-grade reading level, as verified by the Flesch-Kincaid readability formula (see Figure E.4-1 for our affiliate in Indiana's ClearMark Award) for plain language. To assure broad accessibility, comprehension, and understandability, we understand that in addition to being clearly written and understandable, materials must also be tailored in terms of language, cultural and community nuance, inclusive photography, and other elements of content and messaging in order to appeal to each unique membership we serve.

Children and Members with Special Health Care Needs

We develop materials to meet the needs of all members, including those with special health care needs. Materials can be adapted to meet the communication needs of members and for those who may have difficulty accessing material due to other physical limitations. We remediate all documents on our websites to meet World Wide Web Consortium (W3C) accessibility standards and assure all web and mobile content is compliant with Section 508 of the Rehabilitation Act. Our Concierge Representatives are prepared to support any ad hoc requests for assistance, as well.

Our adaptation of materials and information to accommodate special needs includes:

Individuals with visual impairment and those who are hard of hearing. We create materials in alternative formats, including large print, braille, and auditory translation, upon request and at no cost to the member. If a member desires, a Concierge Representative is available to read material to them if they are unable to see printed material or computer screens. All videos, webinars, and recorded presentations with audio have accessible captioning when they are made available to members in their original formats. We also apply our TTY number to all documents.

Individuals with complex health needs. To assist members with questions about managing specific health conditions (for example, diabetes), we have a "Health and Wellness" page on our website that serves as a gateway to condition-specific information, interactive tools and related apps, and guidance for accessing specialized UniCare programs. For callers without internet access, our Concierge Representatives are trained to assist them with their condition-specific information needs and questions. Members who are not physically able to manipulate materials in order to read them will have access to a Concierge Representative who can assist with handling the materials or in reading the materials to them.

Pregnant members. We will provide pregnant members with appropriate educational materials to pregnant members focusing on the importance of prenatal and perinatal care. If a pregnant member is residing in a foster or group home, this information will also be provided to the designated caregivers in that setting. Concierge Representatives and Care Coordinators will work with these members to verify that they have received the materials and understand them, and will assist them, if necessary.

Limited English Proficiency

We produce materials in English and other languages spoken by a high concentration of the population in the area where we are hosting an event. We know that most West Virginians speak only English, but we also understand that there may be areas where there are concentrations of individuals and families who may speak another language, such as Spanish.

For example, in the eastern panhandle there is a growing population of migrant farmworkers, many of whom speak Spanish. In these instances, we will produce materials in the languages that our members require. We will also provide a tagline on state-required English language material stating that, when requested by a member or caregiver, we can produce materials in different formats and languages and provide additional assistance in understanding the material at no cost to the member.

We also make sure that our English language materials are readable, understandable, and meaningful to the intended audience. Many of our West Virginia members live in rural areas, with their own customs and local colloquialisms. We have developed a pictorial Care Plan aid to help all members and caregivers play an active role in care planning and goal setting. In addition, our translators are able to read material to members using local customary language so that the message about the health plan and available services is clear.

Imagery

We represent varying ages, family structures, abilities, and races in our photography. For example, in our West Virginia member materials, we depict children living with their grandparents. Use of diverse imagery makes our message more inclusive of our audience. We continue to add to our library of proprietary photography to assure we can achieve diversity in our materials and reflect the communities we serve.

Infographics and images are used wherever possible to help clarify complex concepts and convey important information quickly. We also use icons, animation, and all-type versions of materials, when appropriate. In addition, we are cognizant that certain colors and words mean different things in different cultures. For this reason, we tailor our colors and content to the intended audience in terms of region of residence, culture, race, and ethnicity. Our designs include high-contrast colors, appropriate use of white space, and font no smaller than 12-point for those with low vision.

Communication Channels

In West Virginia, we are currently communicating with members and providing education through multiple channels including radio, local television, print media outlets, and in local shopping malls. Our most impactful communication method is face-to-face engagement with West Virginia members and their caregivers and parents. UniCare's Engagement and Training Representatives spend the majority of their time outreaching to members, potential members, and caregivers, explaining our health plan benefits and services and providing information and referrals to community resources. As youth transition out of foster care, we encourage them to remain UniCare members so that their evolving health care needs can be met effectively and efficiently.

For West Virginia, we are creating educational materials in video format. These are foster care-specific videos that will explain the program benefits, how to access social supports, as well as other information relevant to youth in foster care, foster parents, and other caregivers. We recognize that some members and caregivers may prefer and respond better to an audio/visual learning experience rather than print.

In addition, we developed a printed Quick Start Guide (an abridged version of the member handbook with information critical to using benefits) and new member video content to highlight important first steps, such as making an appointment with a primary care provider (PCP). This video content can be modulated for use in email and social media to promote lasting engagement. By using closed captioning, we are also able to make our content more accessible to people with varying abilities.

Our Concierge Representatives are also accessible to our members via phone, fax, email, and online options to seek information about the program or to get help with understanding the member materials. Our Concierge Representatives are trained to serve the unique needs of Specialized Managed Care for Children and Youth Program (the Program) members and are evaluated on quality of interaction as opposed to call volume, encouraging them to stay on the line as long as necessary to meet the caller's needs.

Ensuring Proper Content and Form of Materials

To make certain the content and form of our member materials complies with the Service Provider Agreement requirements, we will continue to use our well-established, structured, and rigorous review process known as our Collateral Materials Approval Process (CMAP). Through CMAP, all materials for external distribution (verbally, in written form, or by electronic means) are reviewed by a multi-disciplinary team of subject matter experts, regulatory and compliance staff, and legal counsel prior to submission to DHHR for approval.

CMAP includes a review of content accuracy and understandability, incorporating guidance from the CMS Toolkit for Making Written Material Clear and Effective. Furthermore, to optimize the readability and understandability of our materials, we use an innovative, interactive literacy software tool that replaces hard-to-read medical terms and phrases with plain language and scores documents on their general readability. We also review materials for cultural sensitivity.

Once materials receive internal approval, we submit them to the the Department of Health and Human Resources (DHHR) for approval prior to use. We regularly audit and review approved materials to help assure accuracy and effectiveness and to update and retire materials, as appropriate.

Member Enrollment and Education Process (MS041)

Our process for reaching out to members includes contact through live welcome calls and mailed materials. We strive to reach members and caregivers as quickly after notification of enrollment as possible to provide information about the Fostering Healthy Lives program, gather information regarding the member's needs, and prioritize interventions. We also provide information on how to contact our Fostering Healthy Lives Concierge Line (Concierge Line), the 24/7 nurse advice line, and the behavioral health (BH) hotline.

The activities described in this section will follow a defined timeline, which we have included as Figure E.4-2.

Figure E.4-2. New Member Enrollment and Onboarding Process

Days from MCO Receipt of State Enrollment File	Audience			
	Foster Youth Member	Dept. of Justice (DOJ)	Department caseworker	Caregiver
0-5 days	1. UniCare-branded, age-appropriate **comfort item** for youth to hold during court hearing (e.g. stuffed animal, stress ball) 2. Trauma-informed **brochure/bookmark:** "We're here for you" – educates youth on stress/anxiety symptoms, how to identify and communicate them to caregiver. Includes blank area for Guardian Ad Litem's contact info 3. Trauma-informed **brochure/flier:** "What happens when you go to the doctor" 4. Member Website and Portal, including access to trainings, videos and important documents	DOJ Reference Guide	DHHR Reference Guide	1. Caregiver Quick Start Guide addressing kinship caregivers and emergency placement. Content includes EPSDT milestones, Value-Added Services 2. Member ID card, carrier letter 3. New member packet including: foster care Quick Start Guide, member handbook, privacy doc 4. Welcome calls start 5. Member website with online trainings, member portal, resources library to foster youth member
Any time after enrollment If UniCare Care Coordinator can update contact info that triggers the following communication… these welcome materials would be helpful to the new caregiver				1. **Postcard** informing new caregiver how to request a new member welcome packet – points them to online resources, training, member portal and info sharing portal 2. **EPSDT flier** informing new caregiver of screening milestones, how to change PCP

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Member Contact (MS042)

When we receive a notification of member enrollment (generally through the enrollment file), Concierge Representatives will conduct welcome calls for all members as quickly as possible, but no later than within five business days of enrollment, with the goal of contacting members within two business days. When the member is under 18 years of age, the Concierge team contacts the Authorized Representative or caregiver to gather initial information and invite completion of the Fostering Healthy Lives Health Risk Screener (HRS). This would generally be completed by the Department caseworker or foster parents/kinship caregivers. If the member is 18 years of age or older, the Concierge team will outreach directly to the member.

If we do not have contact information, or correct contact information, for the member or caregivers, we will outreach to the Department caseworker to determine how to make contact with the member, their foster parents, or other caregivers.

New members are sent a welcome packet within five business days of our receipt of their information in the 834 file. If the member is age 18 years of age or older, the welcome packet is sent directly to them. If the member is under 18 years old, the welcome packet will be sent to the Department caseworker, caregiver, foster parent, or kinship caregiver.

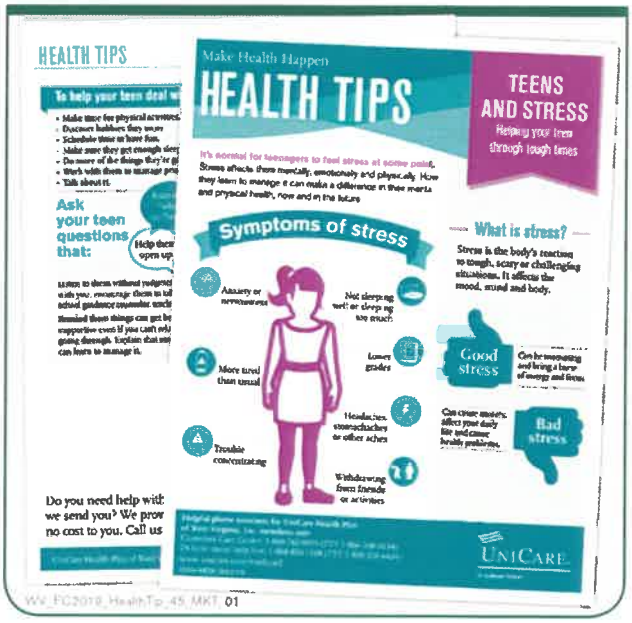
Member Outreach (MS043)

UniCare continues to make sure all members — regardless of location of residency, language spoken, literacy level, culture, health status, or age — have access to information about our covered services and benefits. For members and caregivers without access to computers,

smartphones, or the internet, we produce and disseminate print versions of all materials otherwise accessible on our website.

We accommodate a variety of communication methods such as traditional mail, email, text, and other avenues to reach members and caregivers. We recognize that there may be a variety of barriers to member outreach, including the remote and rural nature of a significant portion of the state, as well as spotty coverage for wireless phones and internet availability.

Provided below is a description of some specific member populations and how we address their information needs. In all cases, the development of materials is accompanied by outreach and distribution that includes partnering with community-based organizations that also serve these populations. For instance, our Community Engagement and Training team strategically distributes materials at community events such as school fairs, child and family events, and health fairs.



Individuals with limited English proficiency. We continually inform members about the availability of translation services (in more than 200 languages) on the member website, in our member blogs, and in other distributed materials. In other markets, we have encountered low literacy among communities that prefer to be served in non-English languages. In this case, we work with our language vendors to create informational materials in simplified English prior to translation. We also work with them to make certain translations maintain the intent, tone, and context of the original messaging (transcreation). To accommodate varying levels of basic literacy and health literacy, we strive for brevity and clarity in our materials, using infographics to pictorially represent important or complex topics. For example, in our Health Tip flyers, we use infographics to compare symptoms, show escalation of issues, and sort information into easily understandable segments.

Individuals living in rural communities and/or without internet access. We have connected with local resources, including community-based organizations and initiatives to locate and connect with members and caregivers, such as the Kanawha County Emergency Ambulance Authority (KCEAA). Our Engagement and Training Representatives also rely on public libraries as important locations where we can find members, including transition age youth (TAY), and facilitate their usage of computers and internet availability to access our online resources.

Tackling Internet Disparity

We are exploring the opportunity to impact internet disparity by sponsoring mobile routers in rural communities that do not have reliable internet connections. These mobile routers can be attached to cars and located overnight in these communities so members, their families, and their neighbors can gain access to the internet. Improved internet access for our members results in telemedicine opportunities, access to member materials including our member handbook and Care Plans, and numerous other advantages that internet access can offer such as the ability to complete schoolwork, schedule doctor appointments, perform online job searches, and complete online job applications.

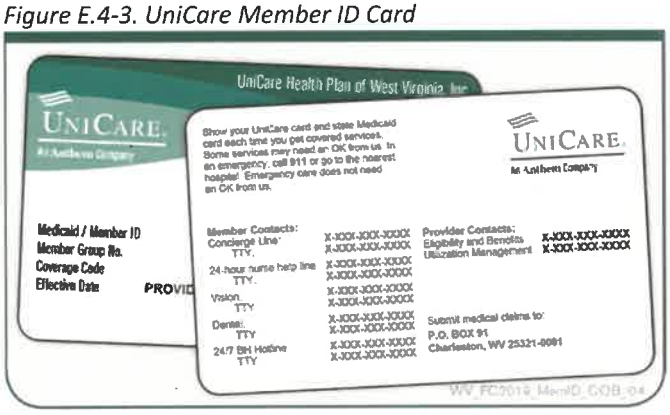
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Our Engagement and Training Representatives spend a significant amount of time in the field. During this time, their efforts include attempting to locate and connect with members who may be residing in rural areas or who may not have smartphones, internet access, or other connectivity where they can receive our outreach calls and materials. Compounding the difficulty of locating these members and caregivers is the fact that children and youth in foster care may move frequently as a result of placement changes. In these cases, we typically contact the Department caseworker directly, obtaining caregiver or foster parent phone numbers and addresses so that we may complete the welcome call and mail information. Department caseworkers are also a good resource to obtain current contact information for TAY, although these youth may be transient, to a degree, and continue to be difficult to locate. By frequenting locations in the community where these youth may gather, our Engagement and Training Representatives will have greater success in contacting them.

Member Identification Cards (MS044)

Our Enrollment department sends the information received on the 834 file to our member ID card vendor on a daily basis. The vendor then generates a digital copy of the member ID card, making it available on the Youth Records Access Portal (YouthRAP) within five business days of enrollment. Members, caregivers, and Department caseworkers can also request hard copies of member ID cards electronically through YouthRAP or by calling the Concierge Line.

Figure E.4-3. UniCare Member ID Card



The ID card will include all of the information required in SPA Section 4.4.2, including the effective date of enrollment, the member's ID and group number, contact information for the Concierge Line, as well as the name and phone number for the member's assigned PCP. The ID card also includes contact information for our 24/7 nurse help line and 24/7 BH hotline, along with dental and vision coverage contact numbers. A draft member ID card is included as Figure E.4-3.

The system will also generate a new ID card in the following circumstances:

- Name change (except for middle initial)
- PCP change
- Group number change
- Re-enrollment after a lapse in coverage

The new information will be included on the daily file sent to our member ID card vendor, and the updated ID card will be posted to YouthRAP within five business days.

Member Handbook Distribution (MS045)

Our member handbook is a clear and practical guide to our members, their caregivers, families, and Department caseworkers. For the Program, we will use the model enrollee handbook supplied by DHHR and include material specific to our Fostering Healthy Lives model, as directed in the handbook template. We will also verify that definitions included in the model handbook are included in our Fostering Healthy Lives member handbook and in all member communications.

The member handbook serves as an important ongoing reference document for members, caregivers, Department caseworkers, and others relating to a wide variety of key information points, such as choosing a PCP, how to access urgent care and emergency services, covered benefits, specialty services such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and socially necessary services (SNS), important contact information, and Value-Added Services (VAS).

We will distribute member handbooks within five business days of enrollment notification as part of our new member welcome packet. We will also make members, caregivers, and the Department caseworkers aware that the most up-to-date version of the member handbook is always available on our member website and is available to be mailed at any time, by request.

Mailing Member Handbooks on an Ongoing Basis (MS018)

We provide updated member handbooks on an ongoing basis as contractually required. Updates to the member handbook are typically incorporated within 24 to 48 hours of the change.

Member Handbook Updates (MS019)

Periodic updates are made to the electronic version of the member handbook on our website. Members are able to access the electronic version of the member handbook 24/7/365. On an annual basis, we will notify members and caregivers that an updated handbook is available.

Member-Requested Handbooks (MS020)

Members may request a printed version, in any language or format, by calling the Concierge Line. We mail member-requested handbooks within five days of the request.

Member Welcome Packets (MS008)

A welcome packet is sent to new members and caregivers within five days of notification of enrollment. We recognize many foster parents and caregivers may not have previous experience with managed care or Medicaid benefits. By providing an easy-to-understand Quick Start Guide, Figure E.4-4, we make it easier for members and caregivers to take prompt action to address health needs and concerns. The Quick Start Guide includes information on covered services and benefits, selecting a PCP, receiving their medications, obtaining a member handbook and provider directory, the benefits of preventive health care, our role as a health plan, VAS, and how to contact us.

Figure E.4-4. Quick Start Guide



In addition to the Quick Start Guide, the new member welcome packet will include:

- A welcome letter
- A member handbook
- A description of our appeals process
- Notice of Nondiscrimination
- HIPAA Notice of Privacy Practices
- Babel sheet, which informs the member of the availability of translation and accessibility services

Distributing Preferred Drug List and Formulary Changes (MS046)

Per the Vendor Response Guidance on the Detailed Specifications from Addendum 3, we are providing a general description of the strategies we would use to meet these specifications if pharmacy benefits are carved in at a future date.

UniCare will make sure members and their caregivers fully understand their pharmacy benefit and the programs available to assist with appropriate medication use and adherence. We will include the preferred drug list (PDL) on our website to allow our members, their caregivers, and providers to locate preferred drugs as well as formulary-appropriate alternatives and required criteria. We will provide a hardcopy of the PDL to the member and caregiver upon request. UniCare encourages members and their caregivers to contact us through our Concierge Line for information about their pharmacy benefit.

If there is a formulary change that will impact a member's care, we will send a notification to the member and/or member's caregiver within the timeframe required so they can work with their provider to change the medication to a preferred medication. Notification of formulary changes will be sent to DHHR for review and/or approval, if required, in advance of sending out the communications to members. Members affected by formulary changes will be notified by UniCare at least 30 days in advance of the effective date of the formulary change. Providers will be notified of formulary changes via blast fax, website, or provider newsletters. Additionally, providers and members can access the most up-to-date formulary information on our website.

We will assure all members and their caregivers have easy access to information, tools, and programs that will address their diverse needs. We will also provide multiple additional resources, such as the member handbook. Members and their caregivers will be able to obtain 24/7 guidance related to drug coverage by calling the Concierge team.

Community Collaboration to Design Member Materials (MS003)

We believe that engagement is not just interacting during issues, but proactively engaging with the community where we serve. To prepare and plan for the inclusion of children and youth in a managed care child welfare system, we have participated in, and provided panel experts for, a series of round table discussions focused on improving the health of all kids at risk. For example, we participated in the West Virginia Kids Health Partnership, a subgroup of the West Virginians for Affordable Health Care. As active participants in the community, we have played a role in local councils and events that support the population being served, which has given us a familiarity with the community partners available to help us design useful materials. We will also coordinate regular meetings with providers and community partners to brainstorm, discuss programmatic issues, and to review member materials.



We will convene an ongoing Fostering Healthy Lives Stakeholder Advisory Group, which will be comprised of stakeholders who are invested in serving children, youth, and young adults receiving child welfare services from across the community. The group will provide a forum to consult on and help address programmatic and organizational issues as they relate to the Fostering Healthy Lives model, including providing input on member and caregiver materials.

We will also engage a Parent and Caregiver Advisory Group, which will include foster, adoptive, and kinship caregivers. This group will also provide input into any issues they are encountering, recommend solutions, and review and provide input on member and caregiver materials.

Consultation with Members with Disabilities and Advocacy Groups (MS012)

We actively look and listen for ways to improve our communication for members with disabilities. We often approach this subject while facilitating our West Virginia member advocacy committee. In addition, we host an annual Disability Mentoring Day. Past partners in this event include West Virginia State University and Marshall University. We have also worked with the West Virginia Statewide Independent Living Centers (WVSILC) to host a community health and wellness event, to which representatives for WVSILC and the Fair Shake Network, a disabilities advocacy group, are invited to attend, giving them an opportunity to educate a large diverse audience. These events and contacts provide opportunities for the advocacy community and members with disabilities to offer feedback on our member materials.

Anthem also collects feedback on member materials on a national level. Anthem has partnered with the following organizations in a variety of activities, including participation in policy workgroups, sponsorships, conferences, and seeking their input on our materials and programming:

- National Federation of Families for Children's Mental Health
- Association of University Centers on Disability
- Family Voices USA
- National Association for Councils on Developmental Disabilities
- Easter Seals

Member Outreach and Education

We recognize the success of our program is directly tied to our ability to outreach and communicate with our members. We know that the children, youth and young adults who are served by the Program may need specialized outreach and training support that goes beyond general training. In order to assure success we are developing a special outreach team, our Fostering Healthy Lives Concierge Team, that is dedicated to the unique members that are challenged by unique and often difficult situations.

Fostering Healthy Lives Concierge Team

UniCare's dedicated Concierge Representatives will reach out to all new members upon enrollment. They will gather information through the HRS process, identify members with immediate needs, and work with the Care Coordination team to facilitate Care Coordinator assignment. In addition, they will be fully prepared to take calls from Child Protective Services (CPS) workers, Department caseworkers, or other individuals who indicate that a new member may need continuity of care coordination, so that we can escalate the referral to the Care Coordination team right away.

Having a dedicated Concierge team enables us to tailor our intake process so we gather unique information about new members in child welfare while simultaneously connecting them with the initial array of services in accordance with DHHR's mandatory requirements, such as rapid identification and coordination of missing EPSDT services. It also supports prompt identification of new members for whom we need to orchestrate care and services with other state agencies, such as Children with Special Health Care Needs (CSHCN), who receive support from the West Virginia Office of Maternal, Child, and Family Health (OMCFH).

Our Concierge Representatives serve as an extension of our Care Coordination team and go above and beyond the duties of a typical call center. Some of the activities that they will perform for our child welfare members include:

- Contacting the member's Department caseworker to update our system with information essential to coordinating care, including:
  - Member demographic information
  - Placement information
  - Current providers, including PCP or any specialty providers
  - Available medical or behavioral information
  - DHHR-specific programs in which the member is enrolled, such as CSHCN
  - A copy of the DHHR case plan
  - Gaps in care related to EPSDT services or existing diagnosed conditions
- Assisting in making appointments for assessments and other services, such as EPSDT, and obtaining assessment results, including Trauma Screening and Assessment, Child and Adolescent Functional Assessment Scale (CAFAS), and Child and Adolescent Needs and Strengths (CANS) assessments
- Conducting the HRS with the member and family or caregiver (biological, foster care, kinship caregiver, or adoptive) or, if appropriate for the child's case, the Department caseworker

Once the intake process is complete, our Concierge Representative consults with our Care Coordination staff, and a Care Coordination Manager will assign an appropriate care coordination level and identifies a lead Care Coordinator based on the unique needs of the member. For example, members with complex BH conditions will be assigned to a lead Care Coordinator who is a clinician with BH expertise. The Care Coordinator will partner with the Department caseworker to facilitate each member's transition to UniCare to maintain continuity of care, as necessary.

Upon receiving the enrollment file in our system, the Concierge team will launch welcome calls and initial outreach to new members or their caregivers if the member is under age 18. These calls and outreach will include specific education and information for members with special health care needs and their caregivers as they are identified in the enrollment files. We will also begin hosting training sessions for members and caregivers in geographically convenient community forums and will continue to do so throughout program implementation. Initial training and continued ongoing training is necessary to create a truly coordinated system of care.

We understand the critical importance of reaching members and caregivers with accurate information about eligibility and enrollment, covered services, and health improvement opportunities. Figure E.4-5 summarizes our 2019-2020 Outreach and Communications Strategy, purpose, goals, and key activities.

Figure E.4-5. Fostering Healthy Families Outreach and Communications Four-prong Approach



Outreach to Members with the Most Immediate Needs (MS001)

As a current MCO for the West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid) programs, UniCare brings an established implementation infrastructure to this program along with an understanding of West Virginia, its residents and their health care needs, and strong relationships with state agencies. In addition, we are poised to leverage best practices from our affiliates, including our Georgia affiliate who has been the sole source MCO for children and youth in foster care since the inception of the Georgia Families 360° program.

During implementation, we will work with DHHR to gather information and data, such as current services and utilization history, on new members as soon as possible to expedite outreach so that we can identify those with the most immediate needs and rapidly initiate contact. As part of our implementation, we will review the identified high-risk members and prioritize outreach to these individuals and their caregivers. If we have difficulty reaching the member, we will contact the transitioning entity or Department caseworker for additional or updated contact information and to discuss the situation. These types of concerns can be brought to daily or weekly rounds where we will review each high-risk member during transition.

We will also work with DHHR to detail the criteria for immediate needs such as pregnant teens or CSHCN, for whom we will prioritize contact. We will work collaboratively to refine this criteria, and continually review to make sure it is capturing members with significant needs and identifying opportunities for modification. We will additionally prioritize outreach based on referrals that we receive from Department caseworkers, foster parents, members, other MCOs, and providers, knowing that the needs of members, families, and caregivers frequently change. We will remain responsive to this and will encourage members and their caregivers who are currently receiving services to contact our Concierge Representatives directly.

We begin our outreach by not only identifying a member's initial service needs and risks, but also continually monitoring members and their caregivers for increased risk and changes in condition and placement. We use multiple sources to identify and assess members' immediate care and service needs. These sources include our predictive modeling reports, member medical history data, and internal or external referrals. Our Care Coordinators can readily access this information in our Health Insight platform. Health Insight aggregates and shares actionable data across systems and organizations promoting effective, efficient, and collaborative care coordination — particularly for complex, high-risk individuals. The Health Insight platform uses risk stratification to systematically identify and designate members with increased risk who need priority attention. We supplement these risk stratification procedures with predictive modeling to stratify members further for outreach.

We automatically queue a member for outreach when predictive modeling returns a high-risk category for the member. Our outreach to the member or their caregiver may result in assigning a Care Coordinator or enrolling the member in an appropriate clinical program. As there is no "one size fits all" approach, we use our suite of tools, systems, partnerships, and programs to meet each member's specific needs.

First, We Listen

Outreach to Members with Special Health Care Needs (MS017)

We are experienced in leveraging all available data to identify and connect members with special health care needs (MSHCN) to appropriate services and programs. As described earlier, we have established processes to identify these members and initiate outreach activities. Key elements to the success of our model are:

- Comprehensive strategies to identify and risk-stratify members who are most likely to benefit from interventions
- Evidence-based, person- and family-centered approach

- Trained and qualified West Virginia-based Care Coordination team members with local knowledge and expertise for members with Special Health Care Needs
- Qualified provider network partnerships engaged in care coordination and population health
- Technology driven solutions based on analytics and actionable data that support timely, comprehensive interventions
- Emphasis on identifying and addressing all barriers to health care outcomes

We will offer our dedicated Concierge Representatives who will conduct the intake process when a new member is identified. The Concierge Representatives will provide support and help members, caregivers, and the Department caseworkers navigate the system of care.

Continuity of care for these members is a priority. Our Care Coordination team collaborates closely with Department caseworkers to conduct outreach to identify existing treatment and transition planning efforts so we can prioritize authorizing care for a seamless transition.

Ongoing Outreach and Training to Youth, Young Adults, and Caregivers (MS002)

We educate caregivers and youth on a variety of Fostering Healthy Lives topics once they enter the program and on an ongoing basis. Our aim is to familiarize them with the benefits of and resources available through the Fostering Healthy Lives model, as well as provide health education and condition-specific information. Figure E.4-6 shows our Fostering Healthy Lives training topics.

Figure E.4-6. Fostering Healthy Lives Training Topics

West Virginia Fostering Healthy Lives Orientation Training Topics for Caregivers and Youth

Approach, Roles, and Responsibilities	• Program goals • Roles and responsibilities of each system partner, including the MCO, State Agencies, judiciary, community child welfare agencies, placement agencies, providers, caregivers, and others	
Program Components and Processes	• Organization and staff • Utilization management and authorizations • Socially Necessary Services and processes • Complaints, grievances, appeals, and role of the Medicaid Member Advocate • Provider network • Quality and performance improvement • Member benefits and Value-Added Services	• Access to care and transition of care • Role of Care Coordinator and how to access care coordination services • Training, engagement, Stakeholder Advisory Group, Parent and Caregiver Advisory Group • Member handbook and ID Cards • Transition to the MCO (continuity of care) • Information sharing, including YouthRAP
Serving Our Members	• Care coordination and management, including ICM, ICT, chronic condition management, and CSHCN • Intake, screening, and care planning • How we serve members with disabilities • Transition Age Youth • Requesting out-of-network referrals	• Right to change PCPs • Participation in care planning • Tools and resources (including websites, handbook and YouthRAP), contact information • Telemedicine/telehealth • Crisis services
Special Program Topics	• Health plan approach to trauma-informed care	• Providing trauma-informed care and recognizing ACEs

WV_FC2019_OrientationCaregiversYouth_DIA_07

Our approach brings a specialty population-focused training offering that goes beyond UniCare's traditional approach. This specialized training is designed to better understand the needs of the population and includes a coordinated and consistent approach to training, using a variety of delivery methods and learning modalities. This is further supported by UniCare's Community Engagement and Training team, who will be responsible for developing and providing training that is state- and plan-specific to ensure that members, families, caregivers,

and other stakeholders understand plan services and systems. Our UniCare Training Academy is built on evidence-based BH services and best practices such as trauma-informed care, wraparound services and supports, and individuals experiencing both physical health and BH challenges. Our topics on trauma and trauma-informed care include materials from the Harvard University Center on the Developing Child related to Adverse Childhood Experiences (ACES), and preventing and addressing toxic stress.

Our Community Engagement and Training team actively engages with organizations by sponsoring health fairs, church fairs, disability and aging-related events, independent living and self-determination, disability competency and educational events, and activities that promote social opportunities for children and youth at risk or in placement, transitional age youth, and their families and caregivers. When appropriate, Community Engagement and Training team staff may deliver DHHR-approved presentations to members reiterating important topics and training.

We want our members' families and caregivers to have the information they need to successfully support our members throughout their lives, from young childhood to adolescence and as they transition to independence. We will provide customized training to members, families, and caregivers about how they can access available resources, manage their health care, and encourage overall well-being. Our goal is for the entire system of care to have the knowledge, tools, and resources to support our members.

Outreach and Training for Youth and Young Adults

We understand that older youth and young adults face a different set of challenges and encounter many life decisions as they transition to adulthood. To see that they receive and understand important health care and plan information, we will solicit input from those who have already aged out of foster care to help us develop meaningful training materials and strategize location and presentation of the information to older youth and young adults. Their input will inform our current array of education and training opportunities for TAY. We will also offer TAY Care Coordination through our Fostering Independence Coordinators, who will work with members beginning at age 14, and provide training on employment and life skills to facilitate future independence.

Audience

Our outreach and training for youth and young adults is designed for young members beginning at age 14. At this age, youth are entering transitional age and require information to lead them to independent health care management, as well as help developing life skills for adulthood.

Frequency

Youth-focused webinars and training modules are available 24/7/365 on our website. We also have a fully dedicated Community Engagement and Training team who will be posted throughout the state. This team will be conducting ongoing orientation trainings, based on locally arranged training sites, as well as topic-specific trainings, as needed. Trainings will be held in person or via instructor-led webinars, and take place twice a month during implementation and once per month thereafter. We will also have pre-recorded webinars available on demand.

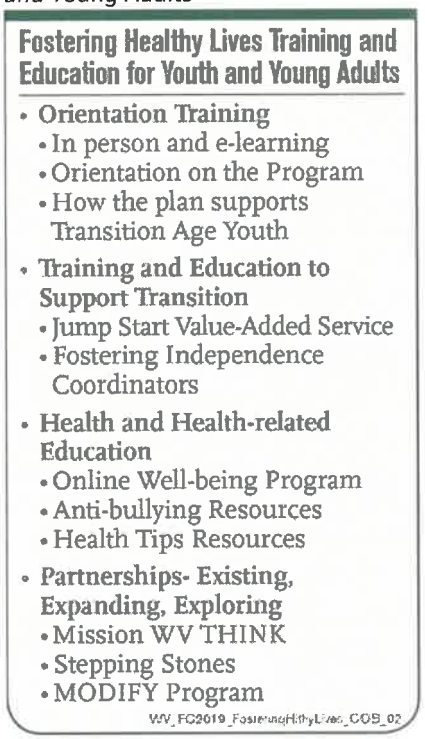
Method

Direct training is provided by our Community Engagement and Training Representatives. We will also leverage our Fostering Independence Coordinators who can provide direct education and training to TAY.

Topics

The various Fostering Healthy Lives Training and Education topics we will provide for youth and young adults are depicted in Figure E.4-7.

Figure E.4-7. Training Topics for Youth and Young Adults



We have a strong relationship with community organizations and will continue to partner with them to promote transition-related training for TAY. Examples of these partnerships and training opportunities include:

- Stepping Stones "It's My Move – Youth Transitional Coaching Services" for health promotion and wellness for those with complex needs. This program offers resources and hyperlinks for easy access on their itsmymove.org website. Stepping Stones is also planning the future creation of a tiny homes village for youth in transition.
- Project Teaching Health Instead of Nagging Kids (THINK) through Mission WV, which has served over 600 youth.
- Chafee Foster Care Independence Program to promote and provide training to youth.

UniCare Fostering Healthy Lives also offers, through our VAS:

- **Jump Start Program.** Our Jump Start Program provides access to our online learning platform to complete a skills assessment to identify and expand on their current skills and see where they rank on health and financial literacy.
- **Online Well-being Program.** Our Online Well-being Program, accessed on computer or via a mobile app, is an online community designed to help members cope with emotional health issues and misuse of drugs and alcohol (described in detail in the Leveraging Technology for Education and Training section below).



Focusing on Workforce Opportunities

UniCare shares DHHR's focus on ensuring members have access to workforce opportunities. We will work as a bridge between multiple organizations to make sure barriers are quickly removed, the workforce system and partners are trauma informed, and that the foster care system has the tools to support youth who are seeking a career. We will have a Career Development Specialist on our team to confirm that programs have support, connections are made, and barriers are removed for youth in care. We will support our members by attending workforce partnership meetings with training providers, businesses and colleges, and being a thought leader in West Virginia regarding workforce issues. Our work and investment in West Virginia for our members is highlighted in Table E.4-1.

Table E.4-1. Workforce Investment in West Virginia

Employment Program	Description
Statewide Regional Workforce Innovation	We are investing in each region of the State to launch or scale programming, including specific employment navigation resources for foster youth and resources that address social barriers, including housing and childcare, so that our members will have the supports they need to bridge into stable employment.
UniCare Whole Person Employment Academy	Based on our affiliate's successful Foster Care Apprenticeship program in Georgia, we will provide technical assistance to Workforce Development, Training and Employment Providers, and support agencies to help leverage all resources available to foster youth, including braided funding, to maximize resources for Members.
Technology for Youth Program	We know that not having access to technology can be a barrier for finding employment and/or participating in educational and training programs. Through Technology for Youth, we will be able to provide laptops to youth entering the workforce or participating in education or vocational training programs.
WRAPS Partnership Program	Coalfield Development's Workforce Development and Professional Success (WRAPS) is a six-month program providing employment, job training, certifications, and life and professional skill development. UniCare's funding would be used to help address social barriers for the participants, as well as expand capacity for the program.
EnAct Community Action Workforce Development Program	EnAct Community Action works in partnership with the Regional Workforce Investment Boards, Bureau of Employment Programs, and the Workforce West Virginia Centers. We are working with this program to potentially expand programs for homeless youth and provide additional resources to address housing and transportation.

Outreach and Training for Caregivers

Our Community Engagement and Training team offers education and training opportunities specifically developed to address the unique information needs of caregivers and support and enhance the ongoing care they provide for children, youth, and young adults who rely on them for guidance. We will also partner with West Virginia organizations that support foster and adoptive parents to facilitate successful outreach to caregivers for training.

We have successfully partnered with a variety of organizations in West Virginia to disseminate information. Many of these organizations have also graciously offered their meeting spaces to us so that we can provide health information to members and families at a place that is convenient to them. We also are often able to coordinate our activities with events they already have scheduled so that members and caregivers do not have to make multiple trips. We rely heavily on public libraries throughout the community and their mission to provide information and resources to the communities we jointly serve.

Casey Hudnall, UniCare Associate

Almost four years ago, my 15-year-old daughter introduced me to Decker, a friend she met at school. Decker was 16 years old and a high school freshman. Soon after meeting him, I learned he didn't have a "home" and bounced from friend's house to friend's house in order to have a place to stay. One evening, after realizing he had nowhere to go that night, I offered to let him stay in our home. The relief shown on his face was something I really can't explain. He immediately asked if he could wash his clothes and take a shower, and I was happy to oblige. He stayed a few nights, and each night I said he could stay, I could see he was again relieved.

After learning more about Decker, my husband and I decided to offer him a permanent place in our home. We asked him how he felt about moving in with us, and the look of joy on his face was priceless. We promised him he would forever have a home with us and he would never have to wonder where he would lay his head each night.

When Decker came to live with us, his GPA was below 2.0 and he had missed nearly 70 days of school in a single year. His first report card after moving in with us showed significant improvement in his grades and his GPA increased to 3.25. He graduated with a GPA of 3.0. Decker graduated with his certification in plumbing and plans to attend Carver Career Center in the fall to complete his HVAC certification. **This is one of the proudest moments of my life. MY WHY is knowing that our family was able to help Decker improve his life.**

Audience

The caregiver-focused training is appropriate for foster parents, kinship caregivers, parents, grandparents, and others who may be in a caregiver or guardian role for children involved with the child welfare system.

Frequency

As with our training and education for youth and young adults, caregivers can access much of this information on demand and it is available 24/7/365. Orientation trainings will be ongoing and provided across the community based on locally arranged training sites. Training will be provided twice per month during implementation and once per month on an ongoing basis, and done in-person or via webinar. Pre-recorded webinars will be available on demand.

Method

In addition to our online, on-demand webinars and eLearning training modules through our Learning Management System, caregivers will also be able to access educational opportunities in person. These opportunities will be presented by our Community Engagement and Training team throughout the local communities where caregivers reside.

Topics

We have key trainings for caregivers that include the needs of children involved with child welfare, the impact of trauma, our approach to service delivery, understanding special populations, and the cultural issues that may impact the children and youth in their care. In addition, we have a partnership with Healthy Grandfamilies which provides education and support for grandparents caring for their grandchildren. This is especially relevant in West Virginia, where the rate of grandchildren residing with their grandparents is high. We currently have over 100 trainings available to caregivers in the following core competencies:

- Program Orientation
- Trauma
- Protection and Nurturing of Children
- Working as a Member of a Professional Child Welfare Team
- Adolescent Trauma
- Behavioral Health
- Physical Health
- Recovery

Incorporating Individualized Training and Education in Care Planning

Our Care Coordination team is trained to recognize when referrals for behavioral supports should be included in the member's service planning. As such, they are able to educate and train members on the various resources that help address social determinants of health (SDOH)

— whether the barriers are transportation, job training, employment supports, educational opportunities, access to fresh food, or safe housing.

Leveraging Technology for Education and Training

UniCare will offer a variety of web-based trainings that can be accessed via computer, tablet, or smartphone. As evidenced by their heavy use of electronic devices, this is often the media of choice for youth, so we make these opportunities as easy and attractive to access as possible. Training will be available through links on our member website and instructions on how to access them will be included in the member handbook and publicized through our blog. Although most of our training is accessible online, we also offer training in mailings, welcome packets, health fairs, pamphlets, and other platforms.

Web-based training is a convenient modality for members and their caregivers to access training; however, we also realize that there are many locations throughout West Virginia where wireless phone service or internet access is unreliable or unavailable. Public libraries are often places where members and caregivers can access computers and the internet or free wireless service so that they can watch a training module. Our Community Engagement and Training team will arrange for group training sessions at community locations, such as libraries. By partnering with community organizations, we are not only able to provide a convenient place for members and families to participate in education and training, we can also outreach by making information available at these organizations that can be accessed when our outreach staff are not there.



We will also offer our Online Well-being Program as a VAS. The Online Well-being Program includes a convenient tool easily accessed via a computer, tablet, or mobile app, and helps members manage stress, anxiety, depression, substance use, chronic pain, sleep disruption, and other challenges. Additionally, this VAS comprises a suite of self-help resources that incorporate cognitive behavioral therapy, motivational interviewing, positive psychology, and mindfulness. The VAS is also available to support foster parents and kinship caregivers.

Members and their families or caregivers will be educated about how to contact UniCare through the new member welcome packet, the member website, and all other educational materials, which will be developed in collaboration with community partners to assure they meet the needs of young members, caregivers, and families.

Training and Education Through Community Resources

To identify the most effective communication methods and tools for youth and young adults, we will also partner with stakeholders and community or faith-based organizations that have already developed and tested communication strategies. For example, we will continue our work with the Court Appointed Special Advocate (CASA) program, Healthy Grandfamilies, child advocacy centers, and Alliance for Children to develop ways to maximize outreach to older youth and young adults. We will also connect with State and participating agencies, as well as providers such Stepping Stones, and leverage our relationships with community-based organizations that have specific programs for youth in foster care, including Mission WV.

Our partnerships with community organizations have allowed us to support educational and training opportunities, which we will leverage for youth and young adults in the Specialized Managed Care for Children and Youth Program. We have close relationships with Overdose Lifeline Training, Mission WV, Stepping Stones, Healthy Grandfamilies, and Jump Start which is a value-added service. Section MS010 describes these organizations in greater detail.

Connecting Members with Community Resources and Social Services (MS010)



UniCare has been part of the West Virginia community for 16 years, and we understand the challenges our communities face and the importance of building partnerships to expand the broader network of care to help address those challenges. We believe that staying healthy means not only having access to doctors and medical care, but also having access to resources that address SDOH, such as education, healthy food, transportation, and job supports. These non-medical factors, such as social and economic conditions, can drive up to 40% of an individual's health[1]. To help address social barriers, we have continually sought partnerships to strengthen community health care and the social support system. Our multi-layered approach of active engagement and capacity-building with community partners aligns with a number of evidence-based recommendations[2], as well as supports the DHHR's goal of improving health and social outcomes for youth and impacts on families. Our methods to support our members, their families and caregivers, and help them connect with the services they need will include:

- Identifying a member's holistic needs through our Fostering Healthy Lives program and incorporating community supports into their unique Care Plan, as further discussed in our Care Management response (CM018)
- Reviewing and authorizing SNS
- Participating in community health programming and collaborative group initiatives
- Investing in local community organizations and projects
- Supporting expansion of shared capacity-building efforts
- Placing local staff at community-based organizations (CBOs) to expand access to available resources

Supporting and Engaging with Community Organizations

In addition to our own experience, we know and value the importance of local organizations and their full understanding of the needs of our communities. Our approach takes an active role in listening to our partners and helping identify and provide assistance towards opportunities that improve community and individual health outcomes. Our partnership with Mission WV's THINK program supported a staff position that resulted in comprehensive needs screenings of 394 young adults in 2018. The screenings included follow-up referrals to support services for any identified needs.

> *UniCare of West Virginia's continued support of our Programs and kids is truly remarkable...this environmentally and resiliently rich project will touch the lives of our kids in innumerable ways. Not only will our kids be involved in the gardening aspect, they will also be able to use surplus produce to help decrease food insecurity for groups such as the homeless and other local food pantries. This in and of itself will increase our youth's awareness of the community needs and of the soul heartening feeling gained by helping others.*
> — **Susan Fry**, Executive Director, Stepping Stones
>
> WV_FC2019_Fry_46_TST_01

Similarly, we sponsored a Transition Coach at Stepping Stones as part of their It's My Move program. The trauma-informed program model empowers youth to manage their own life and be in control of their own destiny. Our partnership with Stepping Stones continues to grow and we are now proud to support their Youth Transitions Project (YTP) through our contribution of a greenhouse and aeroponic tower farm as

[1] https://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

part of their tiny homes community. The YTP is a collaboration of community partners and builds a foundation of supports for West Virginia foster care youth, such as housing, healthcare treatment, employment assistance, and life skills. With the partnership of the Department of Education, Department of Corrections, Marshall University, and others, the tiny homes community and greenhouse is a new and innovative approach to engagement, education and job exploration that will guide transitioning youth into adulthood and support Stepping Stone's mission to end the cycle of homelessness, addiction, poverty, incarceration, and hopelessness.

We will continue to build active partnerships and expand our relationships with organizations like Mission WV and Stepping Stones, including Family Resource Networks, Children's Home Society, Healthy Grandfamilies, Comfort Cases, to support them as they work to support West Virginia's children and families. For example, we are currently supporting the statewide expansion of Healthy Grandfamilies, which offers education and support for grandparents raising children, through health literacy education and financial support. Additionally, we will have a Career Development Specialist on our team to confirm that programs have support, connections are made, and barriers are removed for youth in care. Our Career Development Specialist will help implement several initiatives, which are further discussed in our Community Stakeholder Engagement response (CS002 and CS003), include: Statewide Regional Workforce Innovation program, UniCare Whole Person Employment Academy, Technology For Youth Program, and EnAct Community Action Workforce Development Program.



A Community-focused Approach

Organizationally, our structure and processes promote engagement with state agency partners, stakeholders, and CBOs. We have well-established relationships within the community that will enable us to effectively coordinate both services and communications with members and caregivers. We will have three primary ways of developing solid community connections as further outlined and discussed in CS001, CS002, and CS003: our Community Engagement and Training team, our Social Services Director, and direct involvement of our Fostering Healthy Lives Care Coordinators as they interact with providers and CBOs during their normal course of business.

To determine appropriate community resource needs, our teams identify a member's needs using both internal data and operational processes, as well as a variety of critical secondary and external sources, such as provider referrals, community engagement referrals, Department caseworkers, call center contacts, caregiver referrals, and specific community-based outreach. We will also source information received as part of a member's Youth Learning/Transition Plan or Individualized Educational Plan to identify appropriate community supports and document it in their Care Plan. Likewise, our teams will also contract or share appropriate information with CBOs, providers, and agencies, both directly to improve care coordination (such as through authorizations and member referrals), and indirectly to enhance community awareness (such as community events and school-based support). We will also follow up with members and organizations to ensure services have been received, as well as to track progress and outcomes. We will continue to provide community education and training offered through our UniCare Training Academy, which offers individual or group training, in both in-person or on demand/online formats, further detailed in our Provider Services response (PS001 and PS002). Our Training Academy will develop new offerings and will persistently refine content to support non-medical, clinical and SNS providers, and SDOH-focused partners.

We will leverage the strength of our existing relationships throughout West Virginia, and our local teams will continue to build our resource network to include the organizations we know are critical to the everyday coordination of services and supports for our members. Led by our Community Engagement Director, we will incorporate feedback, best practices,

recommendations, and opportunities for improvement that we receive from our Fostering Healthy Lives Stakeholder Advisory Group, as well as other collaborative initiatives, to improve upon our program. A key focus in our work across every organization and stakeholder is to avoid duplication and communicate effectively to help make it easier for members and their families and caregivers to get the services and supports they need. We will continually assess our programs and community engagement as a whole to assure we have evolving and sustaining partnerships with organizations that support our members and families we serve. We value our close connections across West Virginia and are committed to promoting open communication so we can help create the best possible outcomes and consistent services to assure we are stabilizing and strengthening families.

Community Resource Link



Our Community Resource Link, which we will offer as a VAS, will provide a reliable source of information about the wide range of programs and services available for members. Much more than a simple search engine, this proprietary model uses dedicated resources to make sure that information is always up to date. This easy-to-use online tool promotes increased personal responsibility and self-management by educating members about locally available supplemental supports and services. Additionally, our web-based system includes an internal component that links directly to our care coordination system, which enables our teams to track the resources members search for and use most. This helps our Care Coordinators recommend resources and supports that our members will find the most useful, such as supports for bullying and suicide prevention, back to school resources, drug and alcohol resources, and resources to help members quit vaping or smoking. Our unique model allows us to monitor and measure care coordination in conjunction with community resources, so that we can continually make sure we are addressing members' needs and social barriers.

In addition to our Community Resource Link, we also promote the use of West Virginia 2-1-1 as another valuable resource for finding help and services. With this information available on our member website, we encourage the use of both tools and know that providing direct and up-to-date information will extend the reach, expedite the process, and maximize the impact of assisting individuals with connection to local resources in the community the way they choose.

Providing Comprehensive Digital Resources (MS048-MS051)

Today, UniCare provides our Medicaid members with an accessible and secure website that complies with federal and State marketing regulations, enabling them to access information about their health care services at the time and place most convenient for them. Recognizing the unique needs of the Program, we are designing a new Fostering Healthy Lives website that will provide members, their caregivers, and Department caseworkers access to Program and benefits information, as well as secure access to individual health data, including medical records and authorization status. This mobile-friendly site will comply with federal and State marketing regulations, and will follow industry web accessibility design standards, including Section 508 of the Rehabilitation Act and Web Content Accessibility Guidelines (WCAG) 2.0 level AA Accessibility standards.

UniCare Member Portal Design and Functionality (MS048-MS051)

Our websites use up-to-date, secure, and modern coding technology and practices, with established and robust tools to afford us the latest available features and technology in content management. Our Digital Solutions team uses responsive design so that users can access all the information, features, and functionality of our website regardless of device (smartphone, tablet, or computer) or connection speed. Our website usage statistics show that nearly half of

all users accessing our West Virginia Medicaid site do so using a mobile device. Since we know users visit our sites using devices with different platforms and operating systems, we code and cross-browser test for the latest versions of Google Chrome, Firefox, Safari, and Internet Explorer, as well as compatibility with iOS® and Android™ mobile browsers.

As part of our Digital Solutions team, the User Experience Design (UXD) team is responsible for making sure site users have a positive and compelling experience that gives them the information they need quickly and intuitively, and encourages repeat usage. With more than 40 years of combined experience in web design and usability, this team refines the layout and labeling of navigation on each page and between pages. We also have an internal team that reviews our member website content to verify that information presented is culturally appropriate, written at or below a sixth-grade reading level without health care jargon, oriented toward our members' needs with relevant content, and meets plain language standards.

Providing Enhanced Access to Health Records

We will work closely with DHHR as we complete the design for the new YouthRAP, our electronic health record (EHR) solution, taking into account the special needs and considerations necessary to protect the welfare of children and youth and aligning portal functionality with Program objectives.

On Day 1, our public website will provide Program members and caregivers with access to important plan information and our secure portal will enable Department caseworkers to login on behalf of a member to request a hard copy of an ID card or view member and benefits information. Additional functionality will be deployed in tandem with our work on YouthRAP, linking caregivers to their assigned members and providing designated stakeholders with role-based access to the Care Plan and medical record data, including notifications and alerts.

As detailed in Table E.4-2, UniCare's member website provides comprehensive information to help users navigate their care and coverage, manage their health conditions, and understand their rights and responsibilities.

Table E.4-2. Fostering Healthy Lives Website and YouthRAP will Provide Members and Key Stakeholders with Access to Key Information

Website Content and Functionality	Description	Role-based Access
Day 1 Functionality		
User Registration and Account Maintenance	Users can create a secure login and maintain account information, including password and security questions.	• Authorized Representative, Department caseworker, or member as appropriate
Eligibility Information	Users can access eligibility information, including ID number, coverage effective date, and renewal date.	• Authorized Representative, Department caseworker, or member as appropriate
View Information	Users can view member name, address, and phone number.	• Authorized Representative, Department caseworker, or member as appropriate
View primary care provider (PCP)	When logged into the website, users can view the name of the member's PCP.	• Authorized Representative, Department caseworker, or member as appropriate
Member ID Card	Users can download and print a copy of the member ID card, or request that we send them a hard copy.	• Authorized Representative, Department caseworker, or member as appropriate

Website Content and Functionality	Description	Role-based Access
Member Handbook	Users can download a PDF version of the member handbook, and print it if they desire.	• Public Information
Contact Information	Users can find hours of operation, and the Concierge Line, TDD/TTY, 24/7 nurse advice line, and BH hotline phone numbers.	• Public Information
Complaints and Appeals	Users can access and print information about how to submit a complaint or appeal, how to get help filing one, and what to expect after filing.	• Public Information
Health Resources	The member website offers information and tools designed to engage users in managing their health: • Community Resource Link • 211.org — a collaborative project of the United Ways of West Virginia that connects users to an online database of local health and human resources services and programs	• Public Information
Future Enhancements Aligned with our YouthRAP EHR Solution		
User Registration and Account Maintenance	Designated site users can create a secure login and maintain account information including password and security questions.	• Caregiver • Department caseworker • State administrators
Establish CPS Worker Rosters	Designate members assigned to specific CPS Workers.	• State administrators
Establish Caregiver Rosters	Designate members assigned to specific caregivers.	• Department caseworker
Health Information	Role-based access to health record information (MS050-MS051) for assigned members, including: • Care Plan • Medical records • Authorization submission and status • Digital ID Card	• Authorized Representative or member as appropriate • Caregiver • Department caseworker

Website Content and Functionality	Description	Role-based Access
Additional Health Resources	Online Well-Being Program — a web and mobile online community designed to help members cope with emotional health issues such as depression, anxiety, stress, and misuse of drugs and alcohol. Our program incorporates a suite of self-help resources that incorporate computer based training, motivational interviewing, positive psychology, and mindfulness.	• Authorized Representative or member as appropriate
Secure Messaging	Enables secure communication with the Fostering Healthy Lives Concierge team.	• Authorized Representative or member as appropriate • Caregiver • Department caseworker
Gap Notifications and Alerts	Dashboard access to notifications regarding services that should be scheduled or alerts for identified care gaps for assigned members.	• Caregiver • Department caseworker
View Caregiver Roster	Provides caregivers streamlined access to information for their assigned members.	• Caregiver
View Department Caseworker Roster	Provides Department caseworkers with streamlined access to information about their member assignments.	• Department caseworker

Development of a Community Resource Library (MS009)

We consider our member website to be our community resource library. It is a powerful tool to maintain an active and informed membership who prefer to use the website as a way to connect to health plan and health information. By maintaining a robust, secure, and user-friendly member website, we provide greater ease of access to information and facilitate more active management of the member's health care. Available 24/7/365, our website features vital tools and resources for all our members, where they can access a broad range of information and capabilities in both English and Spanish via computers, tablets, and smartphones.

On the website, we provide comprehensive information to help members navigate their care and coverage, manage their health conditions, and understand their rights and responsibilities. In addition to the information described in our response to MS048 through MS051, members can search for providers, retrieve brochures, read member blogs, complete their HRS, and obtain a variety of information, including:

- Preventive care and wellness information, including preventive care services
- Information on how to access dental benefits and services
- UniCare's searchable provider directory, with each identified by specialty, service location(s), hours of operation, phone numbers, public transportation access, and other demographic information
- UniCare's contact information and detailed instructions for member inquiries, as well as complaints, grievances, and appeals processes
- Information on how to access oral interpretation services

- A description of UniCare's care coordination services
- The member's rights and responsibilities, as enumerated in 42 CFR 438.100, which relates to enrollee rights
- Informational videos that easily explain how to access benefits and services
- Notification letters to members and caregivers regarding UniCare decisions to terminate, suspend, or reduce previously authorized covered services
- The HIPAA privacy statement
- Recommendations of the Fostering Healthy Lives advisory group, including explanations of why changes have or have not been made based on them
- The executive summary of UniCare's Annual Quality Management and Improvement Program Plan Summary Report
- Information on BH covered services, SNS, and related resources

Educating Members About PCPs

We know that the relationships our members have with their PCP are critical to accessing care. We give members and their caregivers the freedom to choose from our entire network of PCPs upon enrollment and the flexibility to request PCP changes at any time. This will be a part of our Concierge Representatives' early interactions with foster families to assure the PCP meets the child's needs, but also is appropriate for the caregiver, considering other children in the home, accessibility, and previous care.

Matching Members and PCPs (MS013)

At the time of enrollment in the Program, our Concierge Representatives will be available to assist DHHR staff, members, and caregivers 24/7/365 through our Concierge Line to help with PCP selection. As a first step in the process, our Concierge Representatives will confirm callers are authorized to make a member's PCP selection in accordance with DHHR requirements. Our trained Concierge Representatives will assist all authorized callers with the selection of a member's PCP based on the member's needs, and provide callers with detailed information regarding PCP options including physician specialty designation, hospital affiliation(s), office locations, and languages spoken. In making initial PCP assignments and encouraging members to make proactive PCP selections, we work with the Department Caseworker, Adoptive Parents, and authorized foster parents (Caregivers), to enable members to maintain relationships with their PCPs. Our Concierge Representatives will be able to assist both during the Program enrollment process and after enrollment when authorized callers request a change in PCP.

If the new member does not select a PCP and there is not a continuity of care scenario driving the PCP assignment, we will auto-assign members to the optimal PCP within 5 days of enrollment, based on information we obtain from the 834 eligibility file such as the member's location, age, language needs and gender. We will also incorporate member claims history into our auto-assignment process, if data is provided by DHHR. If multiple providers are within geographic proximity and match the member's needs, a PCP will be assigned based on factors such as quality and training/expertise to appropriately treat and manage any conditions or special health care needs the member may have.

Our members may change PCPs at any time by calling our toll-free Concierge Line. Our Care Coordination team will also be available to assist members, and confirm that they have the most appropriate PCP for their specific needs, upon enrollment into the Program and if their needs or placements change.

Accommodating Placement Changes

We understand children and youth enrolled in the Program will have placement changes and these changes may impact their PCP assignment. We will work closely with DHHR and child

placing agencies to provide support for placement changes and track member placement changes closely. If a PCP no longer meets access standards due to a change in a member's location, we will assign the member to a new PCP using Caregiver or Case Worker input or our algorithm to find the best available provider.

Notifying Members of PCP Assignment (MS014)

The member ID card, which includes the member's PCP name and phone number, will be made available on YouthRAP within five days of enrollment. During that same time period, we will kickoff our outreach with a welcome call from our Concierge Representatives informing members and caregivers, if the member is under 18, of their PCP assignment.

Educating Members on Changing PCPs (MS015)

Because the right PCP can help to increase their use of primary and preventive care services, we work with our members and their caregivers to confirm they have the most appropriate PCP for their specific needs. We conduct proactive outreach to assure that members are educated on their right to change their PCP. During welcome calls, our Concierge Representative will ask the member or caregiver if they are happy with their assigned PCP, or if there is a different provider they would prefer (for example, a provider that a foster care family is using for other children or one with specific experience in trauma-informed care). If there is, the Concierge Representative will verify that the provider meets accessibility standards, and then make the change to the member's record. This change will automatically prompt the system to include the member's information on the daily report that is submitted our member ID card vendor, and an updated member ID card will be posted to YouthRAP within five business days.

We also educate members about their right to change their PCP at any time by providing instructions on the materials in our member welcome packet, including the member handbook and new Quick Start Guide, on our member website, via reminders in member blogs, and other outreach activities.

If a PCP change request from a member is made within 30 days of the initial PCP assignment, we make the reassignment retroactive to the date of the member's assignment to our plan.

Verifying Members Know Their PCP Assignment (MS016)

PCPs serve as an important resource to our members and their families and caregivers. Assigned Care Coordinators will review PCP assignment during every contact with the member and their caregiver and will explore any access issues. The Care Coordinator will also address any barriers such as transportation as part of their assessment and Care Plan. In addition to verifying that members and caregivers are aware of their assigned PCP during welcome calls, our Concierge Representatives will inquire if they need assistance obtaining PCP services each time they interact with a member through our Concierge Line.

Educating Members About Out-of-Network Referrals (MS027)

Information about how to obtain an out-of-network referral, when indicated, will be included in the member handbook and on the member website. Members and caregivers can also contact the Concierge Line or their Care Coordinator to obtain this information.

Educating Member Services Representatives on Our Out-of-Network Referral Process (MS028)

We will conduct initial and ongoing training for our Concierge Representatives around continuity of care and our referral process, including out-of-network referrals. Members may be referred for BH, medical, or SDOH services, so understanding the internal protocols around connecting members to the resources appropriate to the situation is vital. Teams will be trained on policies, procedures, and protocols, including the fact that it is not necessary for members or providers to

contact us prior to treatment for out-of-network emergencies. Training will also include how to work with Care Coordinators to provide access to services from out-of-network (OON) providers for the following situations:

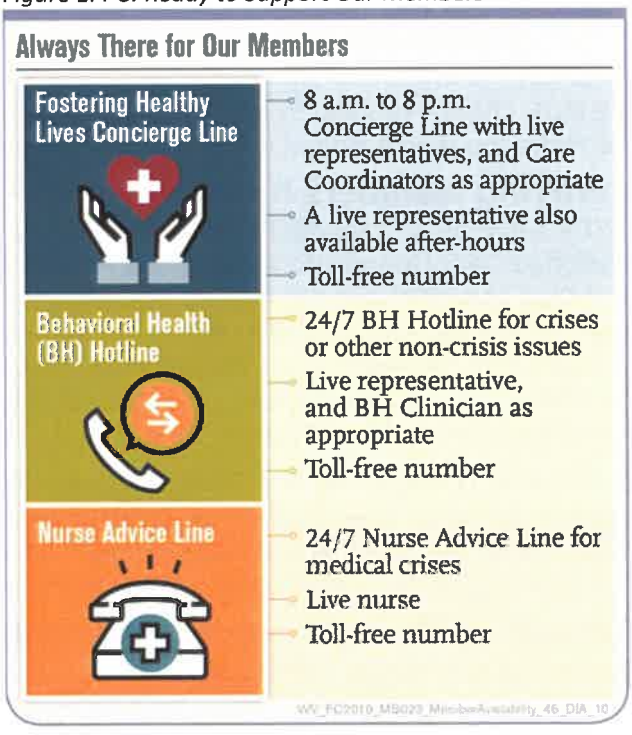
- There is no available network provider within the applicable GeoAccess® standards to meet a member's non-emergency medically necessary need for covered services
- A Member requires specific services that are not available through a participating provider
- To maintain continuity of care with an OON provider for new members
- A court order
- Post-stabilization Services (emergency medical services provided after a member is stabilized to maintain a stabilized condition or to improve or resolve the condition)

Member Methods to Contact the Member Services Department (MS023) (MS025)

Our approach to successfully delivering the Program starts with our local West Virginia-based Concierge Representatives which will be accessible to all members, authorized caregivers, providers, and DHHR staff, through our dedicated Concierge Line. Our toll-free Concierge Line will be available Monday-Friday from 8 a.m. to 8 p.m. ET. ***We will also provide enhanced support to our members and their caregivers by making an on-call Care Coordinator available at all times after business hours.*** Upon hire and quarterly thereafter, all of our Concierge Representatives will be trained on the Program and West Virginia's child welfare system. With this approach, we will assure that properly trained West Virginians with intimate knowledge of the Program are helping our members.

In addition to being trained to appropriately answer all member inquiries related to topics such as PCP assignment, program benefits, claims payment, and VAS, Concierge Representatives will also serve as an extension of our Care Coordination team. Concierge Representatives will be trained in trauma-informed care and ACEs and have extensive knowledge of our network providers including qualified assessment providers, our members' benefits and rights and responsibilities, medical, BH, SNS, and dental providers, community-based organizations that provide social supports and resources that promote resilience and recovery such as peer and family supports, after-school programs, and tutoring.

Figure E.4-8. Ready to Support Our Members



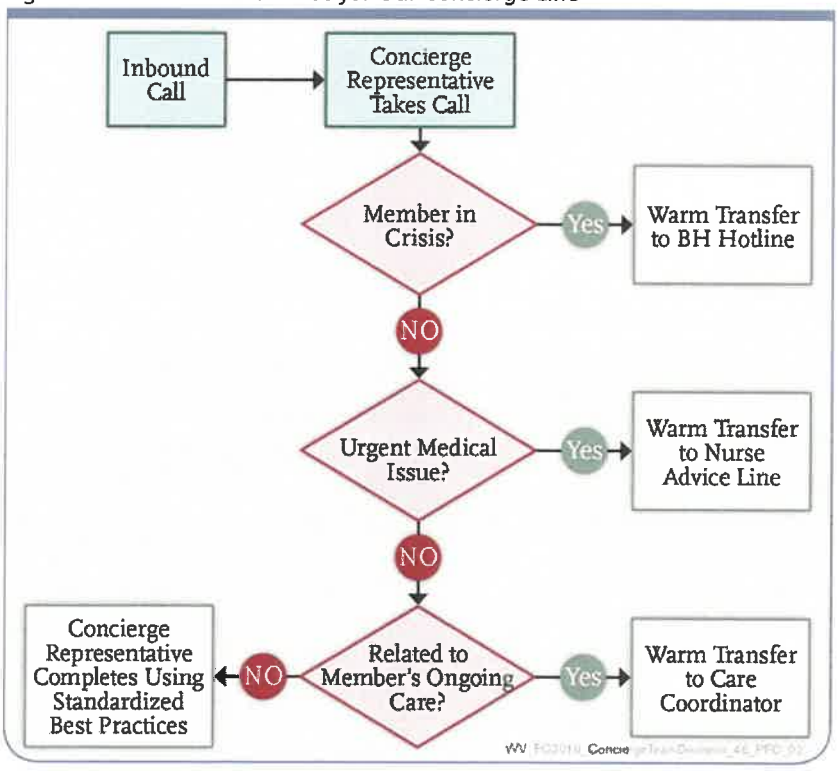
Concierge Representatives will conduct welcome calls for all members as quickly as possible, but no later than five business days of enrollment, with the goal of contacting members within two business days of enrollment. During this call, Concierge Representatives will identify any urgent needs for rapid follow up by a Care Coordinator, and schedule the member's Health Risk Screening (HRS). They will also conduct activities that will help build a more holistic picture of the member's health, including gathering clinical data from the member's Department caseworker

and entering it into the Health Insight platform, our care management system. This information will be available for review by the care coordination team to support member stratification.

In addition to our Concierge Line, we will also have a 24/7 toll-free BH hotline and a 24/7 toll-free nurse advice line for the Program. Members can call these lines directly or be warm transferred to these lines by a Concierge Representative. The resources available to our members are listed in Figure E.4-8, and our Concierge Line decision tree that outlines our transfer protocol is represented in Figure E.4-9.

Providers will also be serviced by our Concierge Line. Concierge Representatives will be trained to address provider questions, and will receive specific training for assisting SNS providers to assure their specific needs are met.

Figure E.4-9. The Decision Tree for Our Concierge Line



For callers with limited English proficiency or who are hard of hearing, we provide access to TDD/TTY and a language line service able to interpret in more than 200 languages. We will also require our Concierge Representatives, BH Hotline Representatives, and nurse advice line Nurses to successfully complete cultural competency training upon hire and quarterly thereafter.

In addition to calling these toll-free numbers, our members will also be able to contact our Concierge Representatives through email and secure messaging on our member website.

Emergency Hotline (MS024)

Emergency calls will be handled by live BH Hotline Representatives on our existing toll-free 24/7/365 BH hotline, which currently serves our West Virginia Medicaid population. We understand the importance of responding to all calls from members, caregivers, and Department caseworkers presenting with a crisis. ***There is no wrong way to access crisis care.*** We encourage our members and caregivers to use our dedicated toll-free BH hotline in times of crisis, but we anticipate that crises may present through our Concierge Line. For this reason, our Concierge Representatives are trained specifically to identify crises and warm transfer appropriately.

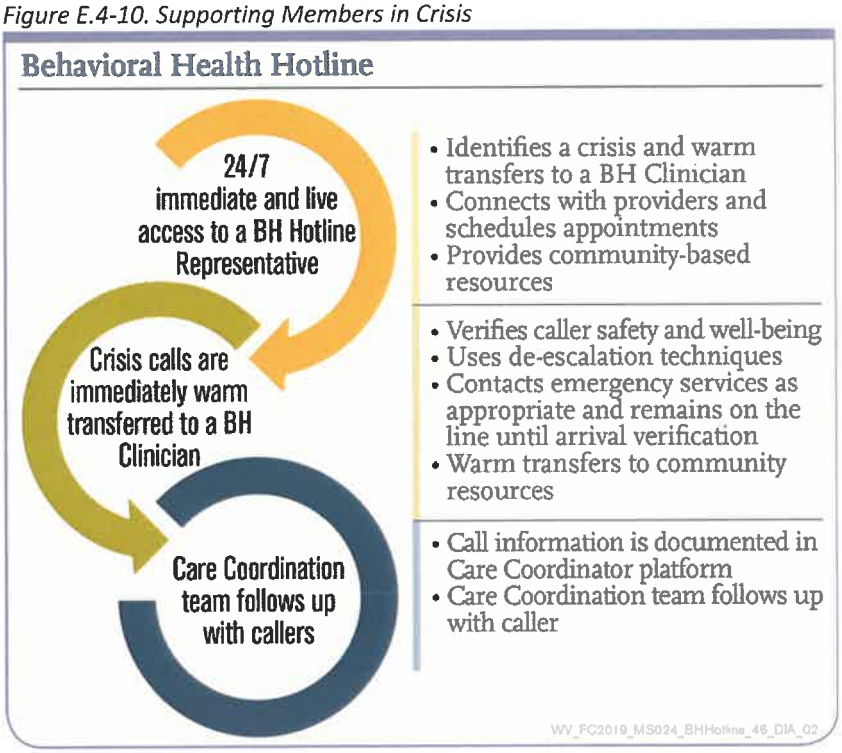
Caring for Caregivers

We are committed to making sure anyone who calls our BH hotline in crisis receives care. It is not uncommon for caregivers to call for crisis assistance. For the benefit of the caregiver and the member, we will work closely with the caregiver to establish a plan for

crisis resolution and follow-up that is appropriate to their needs and the services or supports available to them, often connecting them with community resources.

Our BH Hotline clinicians will maintain continuous, active engagement with the youth and caregiver to assist in de-escalation and stabilization. As depicted in Figure E.4-10, BH hotline callers will never be put on hold, and we will make every attempt to provide continuous support throughout the resolution of the crisis, including communication with the youth's Care Coordinator, when appropriate. We do this by leveraging our BH support staff who may initiate contact with the Care Coordinator, the Department caseworker, or emergency services and relay needed information. We do not impose maximum call duration limits and will allow calls to be of sufficient length to help assure adequate information is provided to the member. Consistent with our Concierge Line, our BH hotline meets cultural competency requirements and provides linguistic access to all members, including interpretive services as required for effective communication.

Figure E.4-10. Supporting Members in Crisis



Additionally, through Health Insight, all of our staff has immediate access to the member's records on a minimum necessary basis; if there is an established crisis plan and history, clinicians can quickly review relevant history. Care Coordinators, if not already involved in the call, are informed of the call via a referral from the clinician, which includes the services the member received, referrals provided, and notes for follow-up.

Transferring Calls Between Our Member Services Team and Subcontractors for Review (MS026)

The primary subcontractors our team would transfer calls to include dental and vision. We list the phone numbers for our dental and vision subcontractors on the member ID card so that members can call these subcontractors directly without the need to call our team first. However, when members call our team first, they benefit from our trained team members who determine the members' needs and transfer members, as appropriate, to any of our subcontractors.

Using Warm Transfers to Maintain Continuous Engagement (MS040)

Our Concierge Representatives, nurse advice line Nurses, and BH Hotline Representatives will maintain continuous, active engagement with the youth and caregiver by using warm transfers. We will make every attempt to provide continuous support throughout the call, including

communication with the youth's Care Coordinator, when appropriate. All points of contact for our members can warm transfer to one another, as shown in Table E.4-3.

Table E.4-3. Continuous Engagement

Methods to Reach Our Team	Staffing	Warm Transfer to
Concierge Line	Dedicated Concierge Representatives	• BH hotline • On-call Care Coordinators • Nurse advice line
BH Hotline	BH Hotline Representatives	• BH clinicians • On-call Care Coordinators • Concierge Line • Nurse advice line
Nurse Advice Line	Nurse Advice Line Nurses	• BH hotline • On-call Care Coordinators • Concierge Line

We currently serve West Virginia Medicaid members, and we already have the call center technology and infrastructure that supports members and their caregivers and other support teams. Our call center platform fully supports warm transfer capability via the representative's computer screen, and is scalable, replicable, and already operational. We will extend and tailor our call center infrastructure to support the Program.

Using and Reporting Customer Service Standards (MS034)



Our robust knowledge of using and reporting customer service standards enables us, through frequent measurement, to continuously improve our customer service, which includes resolving issues in a timely manner. We have staff familiar with West Virginia reporting requirements and submission procedures that are dedicated to collecting data and submitting reports for customer service standards to DHHR for the West Virginia Medicaid programs, and we will continue this work with the new Program.

Member-to-representative Ratios (MS035)

Our focus is to make sure we successfully support our members with the right number of representatives, and once staffing of our dedicated concierge line is complete, we will be able to report details on this to DHHR for the Program. We will develop a forecast of monthly call volumes and average handle times for member and provider calls by using:

- Membership projections
- Comparisons to historical contact rates and call lengths from a combination of markets presumed similar for various factors
- Factors applied for initial, short-term, often extreme variances at program go-live, with ramp patterns/paths to eventual "normal" expected levels
- Seasonal variations

Our forecasts will then be used to develop staffing requirements and hiring/training plans. The drivers include:

- Call volume
- Average handle time
- Service level requirements
- Planned Maximum Occupancy
- Shrinkage – activities, events, or time off the phone lines or not at work, including time off, absences, leave(s), paid breaks, meetings, training, coaching, unplanned/adherence assumptions

- A small Risk/Volatility/Schedule Effectiveness factor to account for natural volatility across like days and intervals, peaks first-of-the-month for Member and end-of-the-month for Provider
- Assumed attrition as well as loans, borrows, or promotions
- Hiring plan/schedule

From our staffing requirements, associate schedules will be created and maintained, and time off and off-phone activities will be planned. Independent processes will be instituted at regular intervals to review and adjust forecasts to changes in membership, daily and interval actuals and patterns, planned ramp from go-live to "normal", and seasonal factors. We understand that excellent customer service drives overall satisfaction, and we will continually evaluate and adjust staffing levels to adapt to evolving call trends and assure adequate staffing during peak call periods.

Additionally, we have learned that new members typically call more frequently in their first 60 days, so we staff accordingly and stand ready on day one. Our technology tools enable real-time monitoring of call-handling metrics, so we can rapidly re-deploy team members to maintain call service levels within DHHR performance standards. We continuously evaluate existing call center processes and make necessary adjustments to meet or exceed all service level requirements to improve the quality of our service.

Answering Calls Within 30 seconds with an Abandonment Rate Below 5% (MS036) (MS037)

Results & Successes

In 2018 we answered over **43,900** West Virginia Medicaid calls with more than **93%** of calls answered within 30 seconds by a live agent and an abandonment rate of **0.6%**.

WV_FC2019_MS036_CallCenterRate_46_RESU_03

We make it easy for our Medicaid members to get the assistance they need by offering comprehensive, personalized customer service using Anthem's fully-integrated call center technology. ***For MHT, our member call center has an 11 second average speed of answer rate.*** Our system currently supports these reports now and we will continue to do so under the new contract.

Our locally West Virginia-based Concierge Line will be specifically developed to support the needs of individuals in the West Virginia child welfare system. Our Concierge Line will be structured similarly to our Georgia affiliate's call center as the single MCO providing services to Georgia's foster care, adoption assistance, and juvenile justice participants. The performance of our Georgia affiliate's call center, which exceeds the DHHR requirement of answering 83% of calls within 30 seconds by a live agent and an abandonment rate below 5%, is highlighted in Table E.4-4.

Table E.4-4. Our Georgia Affiliate's Success

Call Center Metric	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Calls Answered Within 30 Seconds by a Live Agent	97.00%	96.90%	95.48%	96.05%	96.45%	96.18%
Abandonment Rate Below 5%	3.00%	4.10%	4.52%	3.95%	3.55%	3.82%

Single Contact Resolution and Turnaround Time for Member Requests (MS038) (MS039)

We make every effort to resolve our member's inquiries in a single call, and we have the mechanisms in place to retrieve single contact resolution information from our system to report to DHHR. While we do not currently report on these items for the MHT program, our system has the capability to track this data and we will work collaboratively with DHHR to understand the format and frequency in which they would like to receive this information.

We also understand the importance of promptly responding to requests from our members, and we have set specific turnaround times to assure our members' needs are met in a timely manner. Member, caregiver, and DHHR requests received by our Concierge Line will be sent to the assigned Care Coordinator for follow-up in one of three priorities:

- Urgent Immediate Response: contact member, caregiver, or DHHR within two hours
- Non-Urgent: follow-up with member, caregiver, or DHHR within 24 hours
- Follow-Up Call: call member, caregiver, or DHHR within 48 hours

The Care Coordinator will receive an email notification in Health Insight, and a copy of the request will be sent to a mailbox managed by team leads. The Care Coordinator will be tasked with following up with the inquiry within the requested time by completing a Response Form in Health Insight, and those timeframes can subsequently be reported to DHHR.

Training Member Services Representatives (MS029)

We recognize that child welfare programs are delivered through a system of care that includes multiple stakeholders, who significantly impact the lives, well-being and outcomes of our members. As a partner with DHHR and the local system of care, we will provide comprehensive and coordinated program training, through our UniCare Training Academy (the Academy), for our team members that will preserve and support continuity of care. The Academy, which will be designed specifically for this Program, will build on our core Medicaid Training Academy and offer additional trainings, including:

- Serving members with disabilities and chronic conditions
- The culture of disability
- Resources available to our members

All of our team members who interact with child welfare members, stakeholders, or providers will also receive foundational training on ACEs trauma and trauma-informed care. A high-level overview of our training topics for team members is included in Figure E.4-11.

Figure E.4-11. Assuring Our Team Provides the Best Service to Our Members

West Virginia Fostering Healthy Lives Orientation Training Topics for Staff

Approach, Roles, and Responsibilities	• Program goals • System-based approach, collaborating and coordinating with system partners • Privacy and safety regarding information sharing	• Roles and responsibilities of each system partner, including the MCO, State Agencies, judiciary, community child welfare agencies, placement agencies, providers, caregivers, and others
Program Components and Processes	• Organization and staffing • Utilization management and authorizations • Socially Necessary Services and processes • Complaints, grievances, and appeals	• Provider network • Quality and performance improvement • Member benefits and Value-Added Services • Access to care and transition of care
Serving Our Members	• Care coordination and management, including Intensive Care Management and chronic condition management • Intake, screening, and care planning • Children with Special Health Care Needs – outreach at enrollment, care management, and resources • How to provide services to members with disabilities	• Transition Age Youth • Training and engagement • Out-of-network referrals • Right to change PCPs • Culture of disability • Resources available to members
Special Program Topics	• Approach to trauma-informed care	• Mandated reporting requirements

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Additionally, all team members who accept member calls in any capacity must successfully complete formal training on recognizing and responding to member crisis calls, including how to

recognize suicide warning signs, triage situations, and identifying appropriate actions to take. We have developed specific training in collaboration with the Zero Suicide Institute and the National Action Alliance on Suicide Prevention to implement a best practice for suicide risk prevention. Based on these trainings, team members are equipped to utilize Zero Suicide standards to screen and support members at risk or in crisis. Our Academy will also provide Concierge Line, BH hotline, and nurse advice line team members with access to a number of trainings that support them in meeting the unique needs of members in the child welfare system.

All of our trainings will include timeframes for completion and tests for individual and organizational comprehension. Depending on the particular training and mode of delivery, our monitoring mechanisms to verify completion will include completed training schedules from managers and system records of web-based trainings. We will also have various methods and tools for monitoring and assessing comprehension after a particular training or course of training. These may include:

- Pre- and post-test scores: examples include our web-based compliance and cultural competency trainings
- In-process audits during and after training: for example, ongoing audits of newly trained BH Hotline Representatives to measure the frequency of errors made with the goal of correcting issues early
- Audio call quality monitoring of all representatives through formal processes
- Member and Provider complaints, Appeals, and Grievances
- Member satisfaction surveys

Serving Members with Disabilities and Chronic Conditions (MS030)

Leveraging our Academy, we will confirm that our team members who work within our child welfare plans and programs are trained in all necessary areas (including members with disabilities and chronic conditions) and understand the unique needs of the population as well as the West Virginia-specific system of care. Beyond standard employee, job-specific training, and required program training (including comprehensive training on child welfare and related topics), we will also provide specialized training on serving members with disabilities and chronic conditions to our team members. This will increase our team's capacity to serve children, youth, and young adults in the Program. Specific trainings for serving members with disabilities and chronic conditions will include:

- Asthma
- Diabetes
- Autism Spectrum Disorder
- High Blood Pressure
- Substance Use Disorder
- Supporting Children With Disabilities
- Understanding and Responding to the Role of Mental Health Diagnosis in Challenging Behavior
- Intellectual and Developmental Disabilities
- Dual Diagnosis — ID/DD and Mental Illness

Additionally, as part of our strategy to engage with existing training in the community, we have identified training on Appalachian Culture and Disability Etiquette through the West Virginia University Center of Excellence in Disabilities (CED), and we will reach out to explore ways to bring this training to our staff.

The Culture of Disability (MS031)

We recognize the importance of understanding and responding to the cultural needs of the diverse populations we serve. Our Concierge Representatives must demonstrate a mastery of cultural competency skills (including the culture of disability), and our cultural competency training plan fully supports this goal. We will require all newly hired employees to participate in diversity training during their orientation, and all team members must complete cultural competency training annually.

Our training includes a specific Disability Literacy course, which provides the skills our team will need to communicate effectively with people with disabilities, because we know that being able to communicate effectively is essential to the success of our members and the Program. The course will inform our team on the characteristics of the Independent Living Philosophy, Principles of Self-Determination, the contrast between "medical" and "social" approaches to disability, and the legal implications of the Olmstead Decision. Our team will also receive tips on common and specific courtesies for interacting with individuals with disabilities from this course.

Our team members will be required to pass an exam at the end of the course, including the Disability Literacy course, to demonstrate their understanding that delivering services to people of all abilities requires recognizing and respecting the member's worth and dignity. Our policies and procedures will also fully support all 15 federal culturally and linguistically appropriate standards regarding cultural issues, languages, and readability.

Resources Available to Members (MS032)

Our team members will be trained on all available member resources, including our member website, Community Resource Link (which provides a reliable source of information about the wide range of programs and services available for members), West Virginia 2-1-1 for finding help and services, the role of our Social Services Director, and the many new VAS we will be providing for our members in the Program. Our training will confirm that our team members fully understand these VAS so that they can assure our members' needs are met. Our VAS are listed in Figure E.4-12.

Figure E.4-12. Our Value-Added Services

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

Tools for Transitions	Educational Supports	Tools to Strengthen Families	Healthy Behaviors
1. New Placement Welcome Wardrobe	7. In-home Tutoring Services	11. Foster Care Toolkit	17. Extracurricular Support
2. New Placement Welcome Portfolio	8. Educational Milestone Program	12. Kinship Care Toolkit	18. Youth Club Memberships
3. Comfort Kit	9. Toddler Development Kit	13. Medicine Safety Kit	19. Online Well-being Program
4. Jump Start Program	10. Summer Reading Benefit	14. Gas Card	20. Scholarships to Camp Catch Your Breath
5. Home Essentials Kit		15. Family Activity Coupon Book	21. Scholarships to Camp Kno-Koma
6. Lifeline Smart Phone Benefit		16. Community Resource Link	22. Healthy Rewards Program

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Training Staff Who Perform Outreach to Members with Special Healthcare Needs (MS033)

We understand that CSHCN are at increased risk for chronic physical, developmental, behavioral or emotional conditions. For this reason, upon hire and quarterly thereafter we provide comprehensive training to our team members who perform outreach to CSHCN. We also recognize the importance of outreach for these members, and we have focused training that helps staff effectively communicate with CSHCN during their outreach. Specific trainings our outreach team members will receive through our UniCare Training Academy, include:

- Person Centered Training
- Motivational Interviewing
- Supporting Children With Disabilities
- Understanding and Responding to the Role of Mental Health Diagnosis in Challenging Behavior

- Intellectual and Developmental Disabilities and Dual Diagnosis
- Dual Diagnosis — ID/DD and Mental Illness
- Zero Suicide
- Trauma, Trauma-informed Care, and ACEs
- De-escalation and the crisis cycle
- BH Conditions prevalent in children in foster care

Member Rights, Grievances and Appeals

UniCare respects and works to protect member rights and understands that robust grievance and appeals processes are critical to protecting the rights and health of our members. We recognize that navigating the health care system can be daunting for members and their caregivers and, in response, we have established a streamlined process. This tech-enabled process provides members with convenient ways to submit a grievance or appeal and check its status. As a testament to this, ***we received a 100% compliance score from the most recent External Quality Review Organization (EQRO) report for our grievance systems supporting the MHT program.***

Using Technology to Improve Access to Member Health Records (MS004, MS005)

In order to facilitate better care coordination and engage members and their caregivers in their health care options, UniCare provides access to a complete picture of a member's medical history. Access to current and historical member health information is crucial to coordinated, targeted, and expedient communication, care coordination, and service delivery.

Key components of our Management Information System (MIS) will provide access to aggregated member data from all available sources, including member utilization data, such as claims history, authorizations, immunization records, lab results, and care and chronic condition management data. Everything is collected and stored in the Health Insight platform, our integrated care management system, and then made available in an organized format to key stakeholders including:

- Providers via the secure provider portal
- Members, caregivers, and case workers via YouthRAP, a new portal being developed to support our child and family-centered Fostering Healthy Lives interdisciplinary care team (ICT) and Intensive Care Management (ICM) teams

Facilitating Better Communication with Data Sharing

To foster collaboration with local CPS teams, caregivers, and other stakeholders and to inform our utilization management (UM) decision-making efforts and coordinate care, we are expanding our member website through design and development of YouthRAP. YouthRAP is designed with a flexible architecture that supports a seamless consumer experience, including role-based access that restricts unauthorized users and limits protected health information (PHI) access to the minimum necessary to accomplish the intended purpose.

YouthRAP provides access to all member data that is part of our Health Insight platform, including data collected from our care management and claims processes along with encounters and other electronic medical record (EMR) data from relevant providers. Our approach to collect and disseminate health data is designed to facilitate care coordination and communications both internally and externally, via Health Insight and member and provider portals, providing a complete picture of a member's medical history to all team members, including members, their care team, and providers. This holistic picture of each individual's service utilization and Care Plan made available through data sharing can lead to identification

of gaps in care as well as improved continuity of care and reduction in duplication and fragmentation of care.

Maintaining Effective and Compliant Grievance and Appeals Processes (MS006)

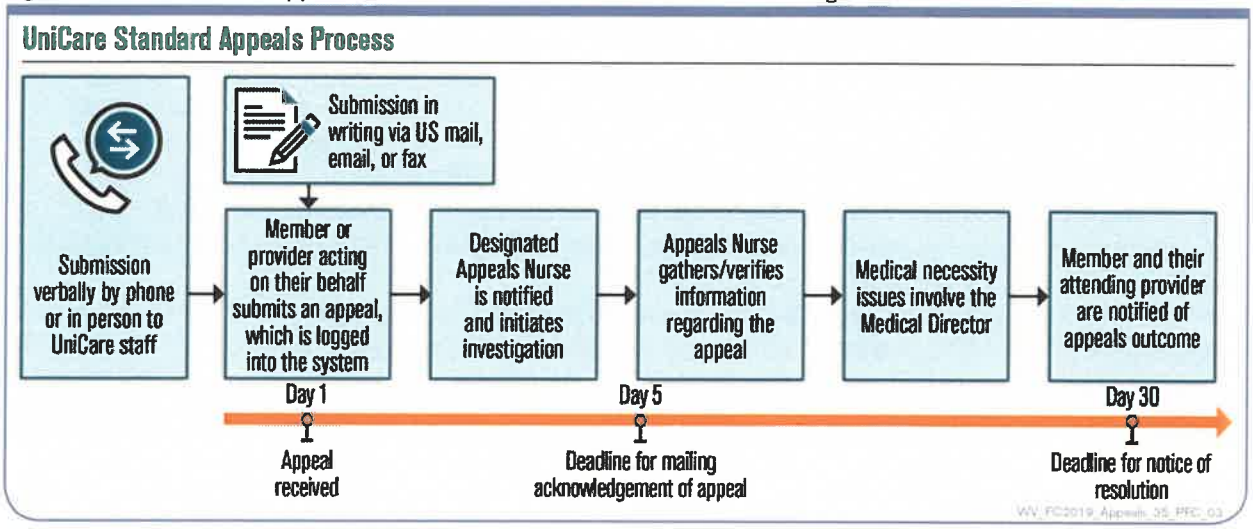
Our grievance and appeals system aligns with NCQA requirements and our technology facilitates tracking grievances and appeals from receipt of initial request to resolution, generating data that allows us to measure our timeliness as related to DHHR standards. No matter how members or their caregivers choose to contact UniCare — via our Concierge Line, nurse advice line, BH hotline, in person, or in writing — we respond quickly and competently. At every turn, a trained staff member will be available to guide them through the process. The grievance and appeals process is closely linked to our quality program.

Once a formal grievance or appeal is initiated, the information is filed in our Core Services System and the request follows a well-defined process until it is resolved. See Figure E.4-13 for a summary of our standard appeals process.

Recent UniCare Grievance and Appeal Successes:
- Zero member grievances in 2018 related to Quality of Care
- Member appeals per 1000 decreased by 36% from 2017 to 2018

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Figure E.4-13. UniCare's Appeals Process is Accessible to Members and Caregivers



Additionally, UniCare's Medicaid Member Advocate will review grievance and appeal data to solve for systematic problems on members' behalf. They will support any members or caregivers in need of assistance with grievance or appeal activities and connect them to enabling services as described in the following section.

Making Follow-up Easier

We are currently enhancing our member website capabilities so that members or caregivers will be able to view the status of a filed grievance or appeal via the member website. This functionality will be available in late 2020. Once a grievance or appeal has been filed, users will be able to log in to the secure member website to view the status of any grievance or appeal they have filed. Until this web functionality is live, members can call the Concierge Line to receive a status update.

Communicating Member Rights and Responsibilities (MS007)

UniCare's member website provides a quick, personal way for members to learn about and research their health plan services and benefits, including information about their rights and responsibilities. Our member handbook is available on the website and informs members of their rights and assures them that our associates and network providers will take them into account when furnishing services.

We will also communicate these rights and responsibilities through other venues, including meetings with a Care Coordinator regarding a member's Care Plan. Assuring members are fully supported in exercising their rights and responsibilities will be a key responsibility of the Medicaid Member Advocate. Additionally, with DHHR approval, we can design an outreach campaign using our HealthCrowd text messaging capability to send caregivers a link to the document outlining member rights and responsibilities.

Providing Enabling Services (MS021)

UniCare understands that offering enabling services is essential in increasing equitable access to health care and improving health disparities. Through our Academy, all UniCare staff are trained to be respectful of member wishes and aware of physical, developmental, cultural, and socioeconomic differences.

We strive to make all member communication with UniCare and access to clinical and non-clinical services as seamless as possible. To support members with any type of disability who may need assistance with language or communication, we offer a wide variety of supports, including:

- Providing materials in audio CD, braille and large print format, in both English and non-English languages, upon request and at no cost to the member
- Remediating all documents on our websites to meet WC3 accessibility standards
- Ensuring all web and mobile content is compliant with Section 508 of the Rehabilitation Act
- Use of TTY for hearing impaired members
- Offering a language line with access to over 200 available languages
- Concierge team prepared to support any ad hoc requests for assistance

Members can request in-person interpretation and sign language services for medical appointments by calling our Concierge Line or talking with their Care Coordinator.

For people with literacy barriers, in some cases due to intellectual and developmental disabilities, we have developed a pictorial Care Plan aid to help them play an active role in care planning and goal setting.

For all written materials, we ensure:

- Text is written at or below sixth-grade reading level, assessing each document using industry-accepted software
- Designs include high-contrast colors, appropriate white space, and font no smaller than 12 point for those with low vision
- Infographics and images are used whenever possible to help clarify complex concepts and convey important information quickly
- All materials include an offer for translation, alternate formats, or any other assistance in understanding the material at no cost to the member

With a focus on responding to inquiries in a courteous and professional manner, we make every effort to resolve issues that may arise through a well-defined process that supports the member every step of the way. Our staff training includes skill development in addressing member needs in a culturally competent way before an issue escalates to a formal grievance. Our staff handling member inquiries focus on excellent customer service in striving for first call resolution of member concerns.

All staff who interact with members receive in-depth training on our grievance and appeals policies and procedures. We recognize that members with physical or developmental disabilities may need additional assistance to file grievances and appeals. ***In whatever way the member wishes to express the grievance or appeal, our staff are prepared to receive it*** and will submit it for processing. For example, if a member is unable to submit a grievance or appeal through the portal or fax, Concierge Representatives will take information from a member or caregiver over the phone and will fill out the grievance or appeal form for them. We can also provide an email address monitored by the Grievance and Appeals team if the member or caregiver prefers. The staff will promptly return calls to members should we need further information surrounding the case.

Monitoring Internal and Subcontractor Grievances on Enabling Services (MS022)

Recognizing that individuals may have difficulty accessing enabling services, we have built robust processes to monitor grievances to identify issues when they arise across the entire spectrum of services we provide (including those provided by our subcontractors). We hold ourselves accountable to make sure members can access enabling services, and we mandate our subcontractors who work directly with our members to do the same. Through our grievance and appeals system, which interfaces with our UM and claims system, we track all grievances and appeals by provider ID and also subcontractors (through a distinct report using data from subcontractor entries). As a result, our Quality Management team can sort and track complaints related to enabling services by subcontractor so we can promptly address and provide a resolution. The report breaks down the entries by NCQA-defined categories for each provider. A summary of all grievances and appeals is submitted to the Quality Management Committee (QMC) for review and oversight on a quarterly basis.

The Contract Liaison/Medicaid Administrator will also review qualitative and quantitative data for indications of problems with enabling services, including PCP change requests, CAHPS® scores, Care Coordination Satisfaction surveys, the Fostering Healthy Lives Parent and Caregiver Advisory Group findings, and Focus Group findings. If any such issues are discovered, UniCare and our Medicaid Member Advocate will conduct root cause analysis and make improvements together with the relevant department or subcontractor.

Collaboration on Health Information Exchange to Create a Health Passport for Members (MS047)

As a partner to the State of West Virginia, we fully support and commit to work with the State health exchange during the first six months of the Contract and will deliver, at a minimum, an implementation plan for an EHR system that will serve as a health passport for members in the Program.

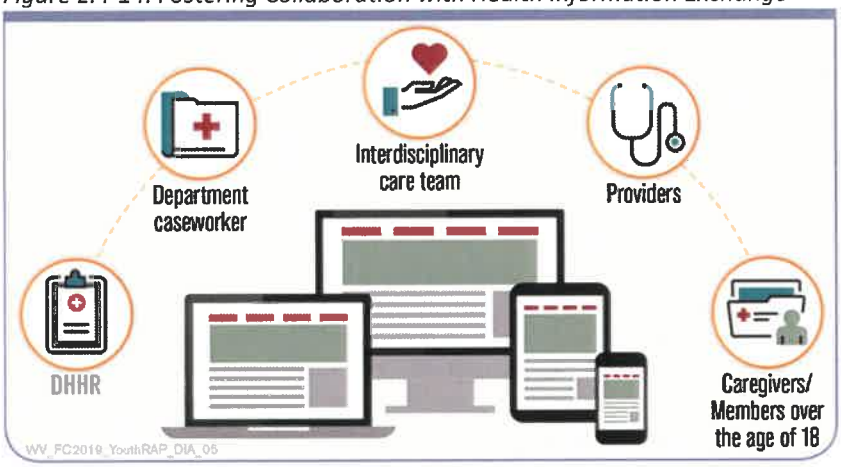
As part of the member website for our Fostering Healthy Lives model, we have specifically designed YouthRAP, introduced in our response to MS048 through MS051, to enable children and youth and their Authorized Representatives, caregivers, Department caseworkers, ICT members, and other appropriate parties, access to necessary health information.

We understand the importance of using health information technology to facilitate integrated care and interoperability by enabling data sharing and providing full visibility of the entire member record for all physical health (PH), BH, and SNS, as well as clinical review and care management activities. With the goal of reducing fragmentation and offering seamless continuity of care to our members, YouthRAP will serve as a repository of member health information, integrating internal data with clinical data collected from other program participants. ***This record of information is being designed to follow children and youth regardless of placement, presenting a complete picture of their medical histories.*** The flexible system design will

include an option for members to download their patient health records to serve as a health passport as defined by the American Academy of Pediatrics, including the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunization information.

Providers currently have access to this same patient health record information via the secure provider portal, with a real-time dashboard that gives them a picture of their patients' health and treatment history, including Care Plans, service utilization, and pharmacy information. As depicted in Figure E.4-14, information exchanged through the Health Information Exchange (HIE), EHR, and personal health records (PHR) connects all stakeholders and fosters collaboration in the care management process.

Figure E.4-14. Fostering Collaboration with Health Information Exchange



5. NETWORK DEVELOPMENT

The Vendor should refer to the relevant specifications located in **Appendix 1: Detailed Specifications** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in **Section 4: Project Specifications** in this RFP, and then describe its approach to Network Development below. The Vendor's narrative response should not exceed 50 pages.

ND001	The Vendor should establish a statewide provider network containing providers that can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers.	The Vendor should provide a detailed description of how it will meet this specification.
ND002	The Vendor should establish a statewide provider network that Is accessible to children and their caregiver(s).	The Vendor should provide a detailed description of how it will meet this specification.
ND003	The Vendor should establish a statewide provider network that incorporates evidence-based best practices and interventions.	The Vendor should provide a detailed description of how it will meet this specification.
ND004	The Vendor should establish a statewide provider network that provides for continuous communication with stakeholders.	The Vendor should provide a detailed description of how it will meet this specification.
ND005	The Vendor should establish a statewide provider network that has capacity in rural areas.	The Vendor should provide a detailed description of how it will meet this specification.
ND006	The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health.	The Vendor should provide a detailed description of how it will meet this specification.
ND007	The Vendor should address deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.	The Vendor should describe what constitutes a deficiency in the Essential Provider and Specialty Provider networks, based on its understanding of Department provider network standards, and its approach to addressing these deficiencies.
ND008	The Vendor should measure and regularly verify network compliance standards.	The Vendor should describe its methods and how often it will verify network compliance standards.
ND009	The Vendor should take action if notified of inappropriate wait times before a member Is seen by a provider.	The Vendor should describe its standards for member wait times.
ND010	The Vendor should continue to build upon the provider network and credential new providers across the State for applicable populations.	The Vendor should provide a detailed description of how it will meet this specification, including, but not limited to a

		general recruitment plan with mechanisms to build network access.
ND011	The Vendor should provide monthly reports to the Department on underserved areas of the State where the Vendor believes additional socially necessary services (SNS) providers should be permitted to enroll to address a gap in care.	The Vendor should describe how it will meet this specification.
ND012	The Vendor, and/or any benefits management subcontractor(s), should monitor and evaluate ongoing access to services, including, but not limited to, the following:	The Vendor should provide a detailed description of the methods it will use to meet this specification.
ND013	Time/distance	See the parent specification.
ND014	Appointment timeliness, by provider type	See the parent specification.
ND015	The Vendor should ensure member access to covered services in areas where the provider network standards do not require a specialist.	The Vendor should describe how it will meet this specification.
ND016	The Vendor should recruit specialty care providers and hospitals, for applicable populations.	The Vendor should provide a detailed description of how it will meet this specification.
ND017	The Vendor should offer crisis response to children and their caregiver(s), as well as families at risk, to the extent that these services are covered under the Bureau for Medical Services (BMS) Children with Serious Emotional Disturbance Waiver (CSEDW).	The Vendor should provide a detailed description of how it will meet this specification.
ND018	The Vendor should develop and implement a recruitment strategy for the following providers:	The Vendor should describe how it will meet this specification.
ND019	Federally Qualified Health Centers (FQHCs)	See the parent specification.
ND020	Rural Health Clinics (RHCs)	See the parent specification.
ND021	If the Vendor elects not to contract with Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), the Vendor should develop and implement a strategy to ensure that members in applicable populations can access these providers.	The Vendor should describe how it will meet this specification.
ND022	The Vendor should develop and implement a recruitment strategy for the following publicly-supported providers:	The Vendor should describe how it will meet this specification.
ND023	Local Health Departments	See the parent specification.
ND024	Critical Access Hospitals	See the parent specification.
ND025	Primary Care Centers	See the parent specification.

ND026	School-Based Health Centers (SBHCs)	See the parent specification.
ND027	Right from the Start (RFTS) Providers	See the parent specification.
ND028	Bureau for Public Health (BPH) Laboratories	See the parent specification.
ND029	Children with Special Health Care Needs (CSHCN) Program	See the parent specification.
ND030	If the Vendor elects not to contract with the publicly supported providers, the Vendor should develop and implement a strategy to ensure all members have access to services.	The Vendor should describe how it will meet this specification.
ND031	The Vendor should develop and implement recruitment strategies for new or modified provider types.	The Vendor should describe how it will meet this specification.
ND032	The Vendor should establish and implement guidelines for which specialists will be able to serve as a primary care provider (PCP) for applicable populations, including, but not limited to:	1) The Vendor should provide proposed guidelines. 2) The Vendor should describe its proposed processes to meet these specifications.
ND033	The circumstances and process under which a member may select a specialist as his/her primary care provider (PCP)	See the parent specification.
ND034	Any managed care organization (MCO) approvals required	See the parent specification.
ND035	Any restrictions on the types of specialists that can serve as primary care providers (PCPs) for foster care members or other members with complex needs	See the parent specification.
ND036	The Vendor should ensure that the contracted network has a suitable range of pharmaceutical therapies to meet member needs including, but not limited to the following:	The Vendor should provide a general description of how it would meet these specifications, if pharmacy benefits are carved in at a future date.
ND037	Availability of compounds	See the parent specification.
ND038	Availability of specialty drug pharmacies	See the parent specification.
ND039	The Vendor should make additional outreach efforts to the following types of pharmacies:	The Vendor should provide a general description of how it would meet these specifications, if pharmacy benefits are carved in at a future date.
ND040	High volume	See the parent specification.
ND041	Rural	See the parent specification.
ND042	Public health entities administering the Vaccines for Children (VFC) program	See the parent specification.

ND043	The Vendor should ensure that pharmacy services are available to members in a timely manner, including, but not limited to, nights	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.
ND044	The Vendor should establish and implement a provider re-credentialing cycle for physical health and behavioral health providers.	1) The Vendor should describe the proposed provider re-credentialing cycle. 2) The Vendor should indicate if this cycle would be different for pharmacy providers, if pharmacy benefits are carved in at a future date.

Establishing a Statewide Network

UniCare Health Plan of West Virginia, Inc. (UniCare) has been a trusted partner serving Medicaid members in West Virginia for 16 years through the Mountain Health Trust (MHT) program. Our long history of partnering with the West Virginia Department of Health and Human Resources (DHHR) and developing and maintaining comprehensive provider networks that meet the evolving needs of our members is testament to our ability and commitment to provide a multi-disciplinary and comprehensive network and services for the Specialized Managed Care for Children and Youth Program (the Program).

UniCare's Comprehensive Physical and Behavioral Health Network



UniCare offers a well-established, comprehensive, statewide Medicaid network ***of more than 14,000 unique Medicaid-enrolled providers and facilities.*** We know that many of our network providers currently provide services to children and adolescents in the child welfare system. Maintaining a robust provider network assures member have timely access to quality care from qualified providers.

Our network includes ***more than 2,200 primary care providers (PCPs), including 500 pediatricians, and more than 180 pediatric/child/adolescent specialists. In addition, we have contracts with 27 urgent care center locations across the state. Our network also includes more than 680 behavioral health (BH) providers as well as all West Virginia residential treatment providers. In addition, we currently contract with all 75 West Virginia Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), and 12 West Virginia Comprehensive Behavioral Health Centers (COMPs) as well as Licensed Behavioral Health Centers (LBHCs).***

We also contract with all West Virginia acute care and tertiary hospitals, including children's hospitals. Our network provides access to the full range of specialty and facility service providers for members in applicable populations with complex needs. We will engage our existing West Virginia network providers with the requisite experience to serve youth and families. Our network currently includes BH providers with experience in recognizing and treating conditions prevalent in the child welfare population, such as trauma and abuse, as well as 14 parent-child interactive therapists and 25 trauma-focused cognitive behavioral therapists.

UniCare brings a strong record of developing and maintaining a provider network that meets or exceeds current network adequacy standards for the West Virginia Health Bridge and MHT (West Virginia Medicaid) programs (except in certain limited cases when there are no providers

available for contracting). We summarize our current West Virginia network and compliance to access standards established for MHT in Table E.5-1.

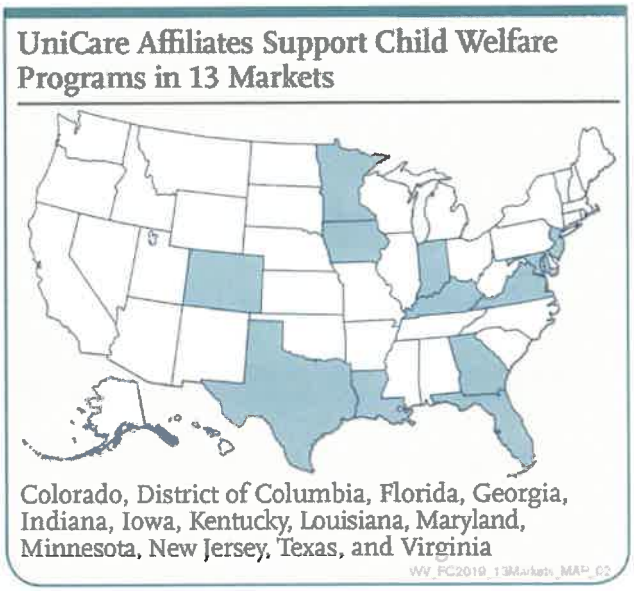
Table E.5-1. UniCare Brings a Comprehensive, Contracted Network to Our Fostering Healthy Lives Model

Primary Care Providers	Providers / Locations	Access %
PCPs	2235 / 1035	100%
Pediatricians	500 / 1212	98.8%
FQHC / RHC	75 / 347	100%
Hospitals	**Providers / Locations**	**Access %**
Acute Care Hospitals	75 / 95	100%
Children's Hospitals	3 / 3	100%
Inpatient Tertiary Facilities	30 / 37	100%
Behavioral Health Providers	**Providers / Locations**	**Access %**
Inpatient Psychiatric Facility Services	12 / 13	100%
BH Rehab Facilities	17 / 111	100%
Pediatric Residential Treatment Facilities	3	100%
Freestanding Pediatric Psych Facilities	8 / 8	100%
BH Clinics (including COMPS and LBHCs)	32 / 154	100%
Specialty Providers	**Providers / Locations**	**Access %**
Allergists & Immunologists	27 / 55	100%
Audiologists	38 / 32	100%
Cardiologists	310 / 259	100%
Dermatologists	42 / 56	100%
Gastroenterologists	100 / 88	100%
Hematology	121 / 68	100%
Nephrologists	99 / 115	100%
Neurologists	126 / 104	100%
Neurosurgeons	51 / 43	100%
Obstetricians/Gynecologists	342 / 240	100%
Oncologists	192 / 100	100%
Ophthalmologists / Optometrists	358 / 276	100%
Otolaryngologists	95 / 90	100%
Orthopedists	239 / 181	100%
Podiatrists	80 / 107	100%
Pulmonary Specialists	132 / 107	100%
Physical Therapy	194 / 160	100%
Speech Therapy	98 / 74	100%
Surgeons	349 / 244	100%
Urology	88 / 93	100%

Experience with Children, Youth, and Young Adults in Child Welfare

UniCare affiliates serve approximately 84,000 children, adolescents, and young adults in foster care, adoption assistance, and juvenile justice in 13 markets nationwide. Our Georgia affiliate serves as the single provider of child welfare services in the state and our Louisiana affiliate is the preferred managed care organization (MCO) for this population.

We understand the challenges associated with differing focuses, requirements, and regulations faced by the multiple systems responsible for the well-being of these members and the need to build programs that proactively address and respond to these variables. A key component of our model for these children, adolescents, and young adults is the whole-person approach, focusing on the integration of physical and behavioral services with a trauma-informed focus.



We will continue to maintain an effective, high-quality network of providers in West Virginia. We recognize that youth involved in child welfare have unique and diverse needs that can be met through a variety of services and supports provided at varying levels of intensity, including traditional and non-traditional interventions. We will maintain, and expand as needed, a statewide provider network that coordinates health services and social supports to meet the needs of West Virginia's youth and families in a comprehensive manner.

Supporting Our Network Providers

We collaborate with providers through our local Provider Relations staff who offer one-to-one support, technical assistance, and proactive training and education on processes that simplify the administrative component of member care. We couple this with sound reimbursement practices and accountable Alternative Payment Models (APMs) and other incentive programs to enhance providers' fiscal ability to deliver high-quality, outcomes-driven care. We help support referrals between providers, providing tools and analytics that facilitate information-sharing while supporting all providers to successfully navigate covered and non-covered benefits, care gaps, and opportunities for improved health outcomes.

Our collaborative provider engagement strategy creates an integrated system of care, and drives improved access and health outcomes for members. We embed our Network Relations Consultants in communities in each region of the state, allowing them to meet face-to face with providers to develop relationships and build trusting, open communication. Our collaborative approach facilitates identification of opportunities to improve the effectiveness and efficiency of their practices, through education and practice tools.

Our knowledgeable locally based provider network staff has more than 80 years of combined experience in recruitment and provider services in Medicaid in West Virginia. Our Director of Provider Solutions has been with UniCare in provider services for more than 15 years.

Providing a Multi-disciplinary and Comprehensive Service Array (ND001)

Provider Pledge

Our Network Management strategy complements DHHR's goals for member access to high-quality care, innovation, a culture of continuous quality improvement, and service excellence by assuring members are cared for by high-performing, engaged providers. We know the best way to achieve healthy communities in West Virginia is through our resolute commitment to simplify health care so providers can focus on health. We are committed to our ***Provider Pledge to deliver a best-in-class provider and network experience by simplifying health care so our providers can focus on member health.***

Recognizing the prevalence of BH conditions in children and youth in child welfare, we have a robust network of more than 680 BH providers including specialists with a focus on children, adolescents, and families, such as psychologists, psychiatrists, therapists, and counselors. Our network includes more than 400 Children with Special Health Care Needs (CSHCN) providers at more than 410 locations comprising over 1,070 CSHCN access points. ***A key component of providing a multi-disciplinary and comprehensive service array are our contracted COMPs, LBHCs, and FQHCs. More than 87% of contracted FQHCs offer both physical and BH services to members. We recently collaborated with three of our contracted COMPs and they now offer integrated physical and BH services to members.***

In addition, coordinating dental and vision for this population health (PH) requires extra attention, which is why we contract with SKYGEN USA, LLC (SKYGEN) and VSP Vision Care (VSP) to provide dental and vision services to our members. Today, our network includes more than 660 dental providers (including pediatric dentists) and more than 140 vision providers across the state.

Assuring a Comprehensive Child Welfare Network

Our Provider Relations team includes our Network Relations Consultants, who are responsible for developing, monitoring, and enhancing our network to meet the needs of our members in the child welfare system. This team of experienced network development professionals brings a successful record of network development and recruiting providers for participation.

If we identify a network gap, our Network Relations Consultants develop an action plan to address it, including:

- Identifying network gaps to maximize member access
- Deploying strategies to increase provider capacity to meet the needs of members where gaps have been identified
- Monitoring the network to assure compliance with Contract requirements
- Recruiting and retaining providers, and monitoring their success in meeting goals for quality and access
- Assuring our network meets the multilingual, multicultural, and disability needs of our members

To supplement our current Medicaid network, our Network Relations Consultant team will design and implement a network enhancement and targeted recruitment work plan focused on providers already serving children, youth, and young adults in foster care, juvenile justice, and adoption assistance. This plan will be driven by various components including ongoing analysis of members' health status and membership compositions (such as age groups), which will help us focus our identification of providers to contract. We outline our child welfare network development activities in Table E.5-2.

Table E.5-2. Child Welfare Network Development Activities

Task	Description	Status / Timeframe
Analyze list of traditional West Virginia child welfare providers	Identify providers who traditionally provide the high volume of services to the child welfare population. Compare this list against those providers already contracted with UniCare.	Initial analysis completed
Review child welfare enrollee data for health status and age composition	Use enrollees' data from State to identify provider specialties on which to focus, review current network composition.	Beginning upon receipt of enrollee data
Prioritized recruitment of traditional and non-traditional providers based on highest volume providers and providers needed to fill potential network gaps	Targeted recruitment of additional providers and provider types as needed to support child welfare member needs. Potential non-traditional child welfare providers will be prioritized to expedite processing and addition to the network.	Ongoing beginning upon award
Recruitment status tracking and reporting	Weekly analysis of progress to goal by provider types/specialty.	Ongoing through project completion
Process new provider applications and contracts	Route all new applicant documents for credentialing, contract execution, and loading of providers into our provider database.	Ongoing through project completion
Provider orientation training	New provider orientation model. Training of all providers on Fostering Healthy Lives.	Beginning approximately 60 days prior to go-live

Meeting the Cultural Needs of Members

UniCare is committed to assuring that our provider network is able to meet the multi-lingual, multi-cultural, and disability needs of the individuals and families in the communities we serve. As a testament of this commitment, we received NCQA's Multicultural Health Care Distinction, which is awarded to organizations that engage in efforts to improve Culturally and Linguistically Appropriate Services (CLAS) and reduce health care disparities. The Multicultural Health Care Distinction recognizes how well UniCare is improving quality by adhering to collection standards for race/ethnicity and language data, facilitating language assistance, cultural responsiveness, quality improvement of CLAS, and reducing health care disparities.

We are committed to making sure our providers are fully trained in the delivery of culturally appropriate services for our members, their caregivers, and their communities. Through our UniCare Training Academy (the Academy), all providers receive cultural competency training during initial onboarding, ongoing educational outreach, and annual training thereafter. Through our provider website, providers have on-demand access to training and other resources related to cultural competency, such as:

- Our Cultural Competency Plan
- Examples of best practices
- A review of the 15 national CLAS standards with a link to the US Department of Health and Human Services website for more information
- *My Diverse Patient Trainings*, including *Breast Cancer Screening for African-American Women* and *Creating an LGBT-friendly Practice*

- Intentional training programs that support foster care, adoption assistance, serious mental illness (SMI), intellectual/developmental disabilities (I/DD), *Moving Toward Equity in Asthma Care*, and other person-centered topics that facilitate improved quality and outcomes
- A new program created by the Industry Collaboration Effort Cultural & Linguistic workgroup regarding culture and the impact on health care
- A link offering providers no-cost medical education credits from Georgetown University for further study of cultural competency topics

Our Cultural Competency Toolkit provides resources to help address the very specific operational needs that often arise in a busy practice because of the changing service requirements and legal mandates. It also helps providers assess their level of competency.

UniCare assures that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills. For example, while we understand that 99% of West Virginia households prefer English as their chosen language, our network is ready to respond to evolving membership needs. UniCare contracted network providers speak 59 different languages in addition to English — 686 providers speak one other language in addition to English, and 242 providers speak two other languages in addition to English. The top three non-English languages spoken by providers include Spanish, Hindi, and Arabic.

Supporting Members with Physical or Mental Disabilities

UniCare assures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. UniCare's provider contracts require providers to comply with all applicable federal and State laws in assuring accessibility to all services for members with disabilities, pursuant to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973.

Assuring that our network management and care coordination strategies meet the disability needs of our members is a key priority for UniCare. We expect all of our network providers to meet federal and State accessibility standards and those standards defined in the ADA of 1990. Our Provider Relations team also verifies physical accessibility for members with disabilities during visits to provider offices. Through our Academy, we educate providers about identifying and working with members with physical disabilities and I/DDs.

We also allow certain members, including persons with multiple disabilities, to select their attending specialists as their PCP as long as the specialist is willing to perform the responsibilities of a PCP. Credentialing site visits with PCPs, OB/GYNs, and high-volume specialists include documentation of a structured site review and ADA compliance, including:

- Location free of physical barriers
- Means for effective communication with people who have vision, hearing, or speech disabilities, including providing auxiliary aids as needed
- Evidence of flexibility in scheduling to accommodate people with disabilities
- Provision of extra time for members with disabilities to dress and undress, transfer to examination tables, and extra time with the provider in order to ensure the individual is fully participating and understands the information
- Existence of reasonable modifications to policies, practices, and procedures

Establishing a Statewide Provider Network Accessible to Children and Caregivers (ND002)

We have contracts with many providers who currently serve children and youth in child welfare, and upon Contract award, we will work with DHHR to identify all providers who currently care for children and youth in child welfare and target them for recruitment, along with providers contracted with the Bureau of Children and Families. Our relationships with West Virginia providers and expert knowledge of West Virginia's health care landscape will enable us to deliver and maintain a robust provider network that meets the needs of our West Virginia members in the child welfare system.

UniCare recognizes that children and youth in child welfare have unique, diverse, and in many cases, complex needs that must be met through a variety of services and supports provided at varying levels of intensity, including traditional and non-traditional interventions. Our network includes providers trained in trauma-informed care, evidence-based practices (EBPs) such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT), or those that have experience in trauma-responsive care and treating individuals with complex special needs as well as providers with experience identifying child abuse and neglect.

UniCare works diligently to monitor network adequacy, anticipate future needs, and promptly identify gaps to verify members have access to care from providers with expertise in areas as such as trauma, sexual assault, and abuse. We also seek input from various sources (members, foster parents, caregivers, providers, stakeholders, Fostering Healthy Lives Care Coordinators, and internal data) to make sure our network meets the needs of our members, including children, youth, and young adults in child welfare and adoption assistance.

There are several ways we identify target providers for inclusion in our network, including:

- **Input from members, caregivers, and State workers.** We may receive a request from a caregiver that a member see a provider not included in our network. Often, these are non-traditional Medicaid providers, and the member is already receiving services from them. We will incorporate input from both our Stakeholder Advisory Group and Parent and Caregiver Advisory Group related to providers not currently included in our network.
- **Internal Data.** We use internal data sources to identify providers, traditional and non-traditional, that are not currently included in our provider network. Our Care Coordination team provides feedback when they receive a request for a provider that is not included in our network. In addition, we continuously analyze claims data to identify out-of-network providers.
- **Existing relationships.** We look to our existing relationships to identify providers that are not included in our network. We also rely on our Medical Directors as well as external strategic alliances with individuals such as judges to help identify sources of non-traditional Medicaid services and providers.

Establishing a Statewide Provider Network That Incorporates Evidence-based Best Practices and Interventions (ND003)

Our Fostering Healthy Lives model will include training on specific EBPs related to youth in child welfare, including trauma-informed care. We work closely with PCPs to share EBPs, such as screening tools, which enable them to assess their members' needs and provide targeted treatment or referrals. We support the provider network deployment of EBPs, such as Peer Support services and medication assisted treatment (MAT).

We offer provider education and administrative supports, including integrated PH and BH service management and tools, such as evidence-based screenings and virtual specialty

consultations, to help identify members' holistic needs, make timely referral to services, and effectively coordinate clinical care.

We provide training to network PCPs for screening and identifying BH disorders and referring members for BH services. This includes clinical coordination and BH Screening, Brief Intervention, and Referrals to Treatment (SBIRT) techniques. We work closely with PCPs to share EBPs and offer the tools and training to complete SBIRT processes, and we reimburse PCPs for SBIRT services as permitted. As described in our response to QU002, we also share best practice methods and programs with PH and BH providers through our multi-modality approach to provider training and education.

We collaborate with providers to make sure they have access to pertinent clinical information, evidence-based support tools, and care management support. For example, to effectively battle the opioid epidemic and decrease the number of children being taken into care in West Virginia, we promote the utilization of EBPs from nationally recognized organizations, such as the American Society of Addiction Medicine (ASAM®) and the Substance Abuse and Mental Health Services Administration (SAMHSA). We also stress collaborative approaches that engage stakeholders, including members, providers, payers, the pharmaceutical industry, and state and federal governments.

Training on Evidence-based Approaches

We believe health care should be delivered locally and driven by evidence-based approaches to keep up with the evolving health care system. We support network providers in the incorporation of EBPs and interventions through our comprehensive provider training program delivered through our Academy.

We know from experience that the best way to ensure that the provision of trauma-informed care and use of EBPs in the care of our members in the child welfare system is to expand provider capabilities and network capacity through training and oversight. Our approach to ensuring providers are effectively utilizing EBPs includes the following:

- Delivering training, monitoring of training, certification, and recertification through our credentialing processes
- Providing information on available trainings and certification programs to providers through our provider website, newsletters, and other communication channels
- Monitoring the effectiveness of our trainings by conducting post-training surveys to obtain feedback and determine if our training objectives were met or require any necessary adjustments



The Academy offers specially developed content to address the need to build capacity to serve specialized populations such as youth in child welfare and incorporates training on EBPs. Through the Academy's robust features, we will offer required, regionally identified, population-specific, and culturally competent trainings. We provide detailed information about the Academy and our approach to provider education in our response to Attachment E.6, Provider Services.

We will also systematically communicate information to network providers through multiple avenues including electronic newsletters and special bulletins, network provider update meetings, our provider website, and social media.

To assure providers are knowledgeable about EBPs, we will continually inform them about training programs available through our Academy. Providers also have access to EBPs and clinical practice guidelines on our website. We will monitor the effectiveness of our trainings by conducting post-training provider surveys to determine if our training objectives were met and identify any necessary adjustments to a training module.

UniCare's Quality Management (QM) processes will help to assess the extent to which providers are effectively utilizing EBPs. We will use an audit tool specifically designed to assess the effectiveness of how EBPs are being used by our providers, which will include various data points, such as:

- Was the member screened for trauma?
- Did a member with a positive screen receive a comprehensive trauma assessment?
- Was the member referred for trauma-specific services?
- Did the provider confirm member acceptance of the referral and follow up to assure attendance for the referred services?

Findings of the audits will inform the refinement of training modules and supports.

Provider Toolkits

Our Academy will offer a robust array of Provider Toolkits on various topics critical to caring for Program members, including:

- Screening and identification of BH disorders
- Neonatal abstinence syndrome (NAS)
- Adverse Childhood Experiences (ACEs)
- Child and Adolescent Needs and Strengths (CANS)
- Family First Prevention Services Act
- Understanding Medical Informed Consent Laws
- Substance use disorder (SUD)
- EBPs: Parent-child interaction therapy (PCIT), TF-CBT, multi-systemic therapy, functional family therapy, motivational interviewing, Families Facing the Future, effects of intrauterine assault, fetal alcohol syndrome, and shaken baby syndrome

Promoting Expansion of Parent-child Interaction Therapy

INNOVATION

PCIT is a recognized evidence-based best practice for working with children, their families, and caregivers in the child welfare system. UniCare currently contracts with 14 PCIT-certified therapists in West Virginia. PCIT is typically offered on a weekly basis over a number of months to an individual parent-child dyad (including foster parent-child dyads). While proven effective, this delivery mode can present a number of logistical challenges for parents and caregivers, such as lack of transportation, taking time off work, or securing childcare for during the weekly sessions. These issues can contribute to a high PCIT attrition rate and undermine the therapy's effectiveness.

To improve access and delivery and lessen program costs while maintaining effectiveness, through collaboration with Dr. Cheryl McNeil of West Virginia University and FMRS Health Systems Inc., UniCare has adapted the typical PCIT program delivery model for Fostering Healthy Lives, as follows:

- UniCare will provide one initial eight-hour in-person session, followed by four weekly phone consultations (generally in the evening hours when caregivers are available). A second eight-hour in-person session will then be conducted with four additional weekly phone consultations.
- Further, our in-person PCIT sessions will be delivered to up to 10 families concurrently, because group sessions are more cost-effective than working individually with each foster family. During these sessions, we will provide additional services including childcare for biological or other foster children in the care of participants, and snacks and meals as appropriate.
- UniCare is collaborating with Dr. McNeil to develop training materials and methods to expand delivery of the program through a "train-the-trainer" model. Initial PCIT train-the-

trainer materials will be given to PCIT-certified therapists in person during the first eight-hour PCIT session. These therapists will then work with additional therapists to develop their PCIT expertise and replicate the model across multiple West Virginia sites.

- UniCare will also work to expand awareness of PCIT and its benefits within our provider network by offering providers access to online PCIT training, including continuing education courses such as those offered through PCIT International (PCIT.org) as part of our Academy.

Gold Star Provider Recognition



UniCare's Trauma-responsive Care Provider Recognition program identifies providers who complete a specified series of Academy trauma-informed care/system of care trainings by placing them in a "Gold Star" status and on a trained provider list for reference by staff, stakeholders, and families. Additionally, we will provide a small financial incentive upon completion of training. By obtaining Gold Star status, providers demonstrate a greater comprehension of the effects of trauma and approaches for treatment and services and meeting the complex needs of children and families who have experienced a traumatic event. Our affiliate in Georgia has offered this incentive and recognition, and we are excited to strengthen our community-based services and supports for our members with this initiative.

Adverse Childhood Events Provider Champion Program

UniCare will partner with leading West Virginia providers to implement our ACEs Provider Champion program. The goal of the program is to increase the resiliency of our communities and address ACEs though provider partners who serve as role models and mentors for other providers. Each Provider Champion partner will receive funding to accelerate and expand the impact of their innovative programming. The amount of funding will be determined based on the anticipated scale of the project and is intended to expand the scale and reach of innovative strategies and is not meant to replace existing Medicaid-reimbursable services or activities.

Establishing a Statewide Provider Network That Provides for Continuous Communication with Stakeholders (ND004)

UniCare has developed a strategy for the Fostering Healthy Lives model that facilitates continuous communication with stakeholders. Local teams across various departments listen to and work closely with members, providers, partners, advocates, and stakeholders to accomplish what is needed to serve members. UniCare understands the importance of communication and collaboration with our State and provider partners.

UniCare knows from experience it is critical we maintain open lines of communication with network providers. We engage providers in a number of ways and will maintain open, ongoing communication about the program and our Fostering Healthy Lives model. We will do this through our Provider Relations team, Academy trainings, tool kits, the provider manual and provider bulletins, and webinars and town halls. This knowledge is crucial for providers as they are often the main point of contact with stakeholders, such as youth and their caregivers.

We provide ongoing opportunities for stakeholder input into the network. This includes advisory groups such as the Medical Advisory Committee and Fostering Healthy Lives Stakeholder Advisory Group as well as input from our internal staff, including the Community Engagement and Training team and Fostering Healthy Lives Concierge team. We continuously communicate across various levels and consider stakeholder input for our network. We share this information with providers and solicit their input as we work to meet the evolving needs of stakeholders.

We will continue to work closely with State partners, providers, communities, and other stakeholders to facilitate continuous communication. ***Our efforts will have the goal of delivering actionable information needed to allow PH and BH providers to engage members, work together for members with PH and BH conditions, improve member outcomes, and simplify practice management.*** We will continue to participate in forums and focus groups across our communities so we can connect our network providers with all the resources available to them.



Our listen-first approach ensures our solutions and programs meet the needs and expectations of our members and partners. UniCare has been actively talking with providers and community organizations to understand local resources and challenges faced by youth and families, how we can support and augment solutions that already exist, and where there are opportunities to build solutions. Apart from our West Virginia-based Fostering Healthy Lives Concierge and Provider Relations teams, we also deploy clinical and outreach personnel in the field to cultivate relationships across the state. For example:

- UniCare will meet with DHHR and industry-specific provider councils on a monthly basis during the first year of implementation and on a quarterly basis after the first year of implementation, as requested by DHHR.
- We will solicit parent and Caregiver Advisory Group input.
- Our Community Engagement and Training team's involvement in the community will also bring back information to the Network staff from their interactions in the community.
- Our Justice/Court liaison will provide information from interactions with the judiciary system.

Establishing a Statewide Provider Network with Capacity in Rural Areas (ND005)

UniCare has an established network with capacity to serve members in child welfare in rural areas of West Virginia. Our network meets geographic access and adequacy standards, and we currently contract with all West Virginia FQHCs and RHCs, some of which are in rural areas. Even so, we know there remain rural and remote areas of West Virginia where the availability of providers is limited.

Our strategies to address provider shortages in rural areas include:

- Leveraging physician extenders to expand capacity of providers — UniCare educates providers, including those in rural areas, on the use of physician extenders and incents providers to expand their use of physician extenders by paying an enhanced Medicaid fee schedule rate for services provided by PCP mid-level practitioners
- A comprehensive and multifaceted telemedicine approach focusing directly on expanding member access in rural and underserved geographic areas — collaborating with organizations, such as Stepping Stones and the West Virginia Primary Care Association, to expand access through telemedicine to children and youth to schools and residential settings through deployment of hardware and a HIPAA telehealth compliant platform solution. We provide detailed information about UniCare's telehealth program in our response to Attachment E.6, Provider Services
- Contracting additional providers when available, including out of network providers, to solicit participation
- Expanding capacity through financial and non-financial incentives such as providing enhanced reimbursement for after-hours and weekend appointments
- Facilitating member transportation to available providers and educating providers about non-emergency medical transportation

Our proven strategy has been successful. For example, we recently closed network gaps in certain rural areas where access to providers is limited by adding additional OB/GYN, Ear, Nose, Throat (ENT), and Home IV locations to increase access for our members. These additions allowed us to:

- Close gaps in both Jackson and Fayette Counties with the addition of participating OB/GYNs opening secondary locations in the underserved area
- Close a gap in Nicholas County with the addition of a participating ENT opening a secondary location
- Close gaps in Grant Hardy and Mineral Counties by contracting with a new Home IV provider (CAIS)

Establishing a Statewide Provider Network with Capacity Across Specialty Lines of Physical Health and Behavioral Health (ND006)

Our network supports co-location and integration of PH and BH services, with more than 85 provider groups providing both primary care and BH specialties. This is especially important in rural areas where integrated care providers help to meet the needs of members. Our network includes all West Virginia FQHCs and RHCs, and we are contracted with 12 West Virginia COMPs. We recently collaborated with three of our contracted COMPs to implement an integrated PH and BH approach to care delivery.

Offering Crisis Response Services (ND017)



UniCare has been responding to urgent, emergent, and life-threatening crisis situations for members in West Virginia who receive health care through government-sponsored medical and BH programs for more than 16 years. Our experience in West Virginia has informed the development of the Fostering Healthy Lives Concierge Line (Concierge Line) and BH hotline for members in the Program. Additionally, we will leverage the experience of our affiliates providing crisis response for more than 84,000 children and youth in child welfare in 13 markets across the nation.

We know from experience that while children in child welfare may experience medical emergencies, the majority of crises that occur with these children are related to BH. Our assessment and care planning process includes the establishment of an individualized crisis plan for complex members. Our crisis plan process can help prepare families to identify when a situation is escalating and to intervene quickly should a crisis occur.

We will provide interventions and supports for these members and their caregivers that will minimize crisis events, emergency room (ER) visits, and hospitalizations, promote member safety and well-being, help them realize resiliency and recovery, and preserve placements.

Our 24/7 BH hotline and 24/7 nurse advice line are extensions of our local Care Management team. Staffed by BH clinicians and Nurses, respectively, they are available to members around the clock to respond to a BH crisis or for assessment of physical symptoms, education, and referrals.

In the event our members experience crisis events, our experienced and trained health plan staff, coupled with our established policies, procedures, processes, and tools, will promote immediate screening and assessment of, response to, and follow-up in crisis situations. Upon notification or identification of a member experiencing a potentially life-threatening event, BH hotline staff will collect information by telephone to assess the status of the crisis and the services required. Depending on the member's acuity, our response will include contacting emergency services.

Our BH hotline staff will also contact the member's assigned Care Coordinator for involvement and follow-up with the member, caregiver, medical consenter, providers, and other involved parties. We will enter all crisis events into our care coordination system. The Care Coordinator will regroup with all members of the child's care team and the child to enhance the established Fostering Healthy Lives Care Plan, focused on prevention, de-escalation, and safety planning.

Members may also call the nurse advice line 24/7 to speak to a registered nurse. Nurses provide health information regarding illness and options for accessing care, including emergency services. Nurses will also warm transfer the caller to the BH hotline if necessary.

Provider Recruitment Strategies

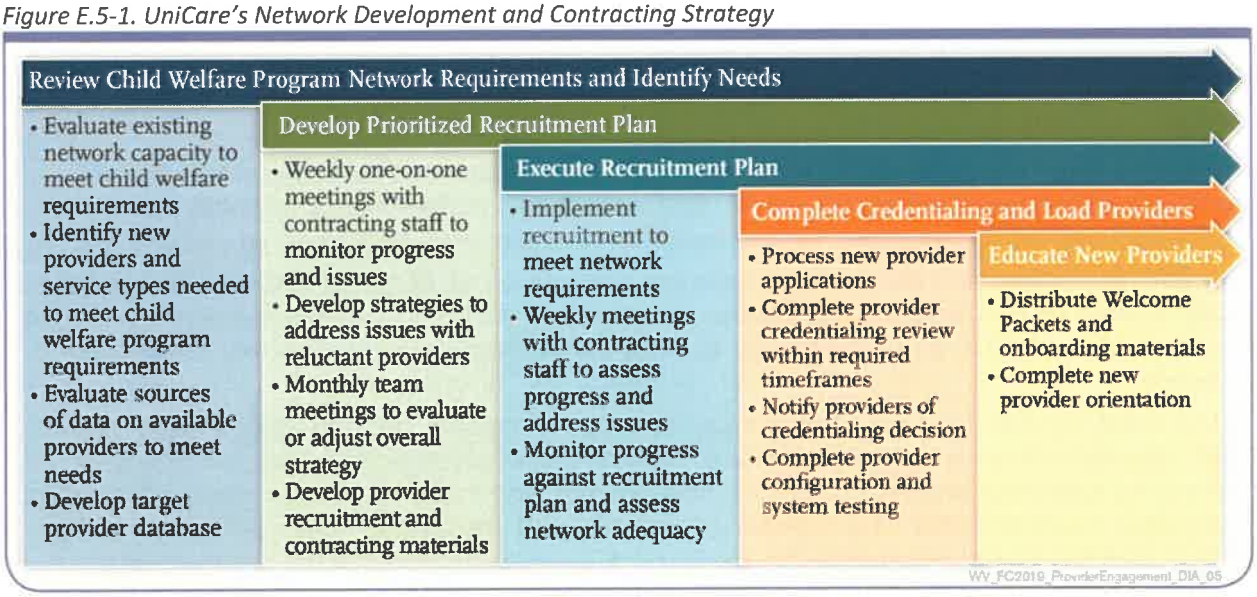
As evidenced by our existing comprehensive network of physical and BH providers currently serving the West Virginia Medicaid programs, UniCare knows how to recruit providers to meet the evolving needs of our West Virginia members. Our knowledgeable and expert staff and recruitment strategies have the ability to quickly and effectively mobilize to recruit and credential new providers of various types as necessary to ensure comprehensive accessible services for our Fostering Healthy Lives members.

We will deploy our proven recruitment strategy for the recruitment of all provider types, including FQHCs, RHCs, and publicly-supported providers, and any new or modified provider types that may require recruitment over time. Our Network Relations Consultants will design and implement a network development and recruitment work plan focused on providers already serving children, youth, and young adults in foster care, juvenile justice, and adoption assistance.

Recruiting New Providers Into the Network (ND010)

We will recruit new providers into our network to meet the specialized needs of our Fostering Healthy Lives members. Our Network Relations Consultants lead our development and recruitment efforts. Upon Contract award, we will be ready to move quickly to recruit identified providers, including new provider types and Medicaid-enrolled providers who only provide foster care services. We will use our proven recruitment strategy, summarized in Figure E.5-1, to expand our network and assure it is adequate to meet the needs of children in child welfare.

Figure E.5-1. UniCare's Network Development and Contracting Strategy



In recruiting and selecting providers, we consider:

- Anticipated enrollment and demographics of members
- Expected utilization of services based on the characteristics, health care, and long-term service needs of members
- The number and types (training, experience, and specialties) of providers required to furnish services for members—specifically, providers that deliver services in a culturally competent manner
- Providers that traditionally provide a high volume of services to children involved in the child welfare system
- The number and location of providers accepting new members
- The geographic location of providers and members, considering distance and travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities
- The number and counties served by providers that offer services in a member's home, such as home health, hospice, or attendant care agencies
- Home and community-based providers' capacity to ensure effective support of members receiving services
- Physician practice capacity to ensure that wait times and appointment availability do not exceed the requirements set forth by DHHR
- Compliance with UniCare's quality and utilization management (UM) programs
- Non-participating providers that may have established relationships with members

We review in-network as well as out-of-network utilization trends regularly to identify areas where additional contracting may be needed and to target providers for recruitment. Outreach may include mailings, phone calls, and in-person visits for the purposes of obtaining contracts with providers.

Recruiting Specialty Care Providers and Hospitals (ND016)

Our network currently meets current statewide access standards for both specialists and hospitals (except in certain limited cases where there are no providers available for contracting, as detailed in Table E.5-4. We offer a mix of specialists and hospitals so members' anticipated specialty and inpatient care needs can be substantially met within our network of providers. We also have a system to refer members to out-of-network providers if appropriate participating providers are not available.

We are contracted with all acute care and tertiary hospitals and are also contracted with all three West Virginia children's hospitals: West Virginia University (WVU) Medicine Children's Hospital, CAMC Women's and Children's Hospital, and Cabell Huntington Children's Hospital. We also contract with more than 3,200 specialty care providers, including more than 180 pediatric/child/adolescent specialists.

We make referrals available to members when it is medically appropriate. We maintain policies and written procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals.

Our network provides access to certified pediatric or family nurse practitioners and certified nurse midwives, even if such providers are not designated as PCPs.

Recruitment Strategy for FQHCs and RHCs (ND018, ND019, ND020)

UniCare currently contracts with all 75 West Virginia FQHCs and RHCs. We maintain an open network policy for FQHCs and RHCs. New FQHC and RHC sites have to be approved by the state and be assigned an established encounter rate. We work one-on-one with the State and the providers to facilitate this process. Once approved and the encounter rate is communicated

by the State, UniCare loads the provider and rate information in the system, enabling claims payment.

Ensuring Members Have Access to FQHCs and RHCs (ND021)

UniCare will continue to contract with West Virginia FQHCs and RHCs. In addition, we configure our systems to assure all members have direct access to FQHC and RHC services, regardless of whether the FQHC or RHC is participating in our network. For example, we have configured our claims payment system to reimburse FQHCs and RHCs for covered services, regardless of their participation status.

Recruitment Strategy for Publicly-supported Providers (ND022)

We describe UniCare's overarching recruitment strategy for all provider types in our response to ND010. We maintain contracts or will make good faith efforts to contract with all of the publicly-supported provider types identified in our responses to ND023 through ND029, as summarized in Table E.5-3. UniCare has reached out to all publicly-supported providers and has contracted with all those providers willing to contract with us. As new publicly-supported providers enter the market, we reach out to the provider and invite them to join our network.

Table E.5-3. UniCare Makes Good Faith Efforts to Assure Publicly-supported Providers Are Included in Our Network

Provider Type	Recruitment Status
Local Health Departments (ND023)	UniCare contracts with 28 local health departments. Some local health departments do not provide billable services and do not contract with MCOs. As more health departments provide additional services, they become interested in contracting with us. We will continue to outreach, educate, and recruit local health departments.
Critical Access Hospitals (ND024)	UniCare contracts with all hospitals in West Virginia, including all 22 West Virginia critical access hospitals.
Primary Care Centers (ND025)	UniCare contracts with 32 West Virginia primary care centers. In some cases, UniCare contracts with more than one primary care center per county. Twenty-five of the 55 West Virginia counties do not have a primary care center site. We will make good faith efforts to contract with additional primary care centers.
School-Based Health Centers (ND026)	We view School-Based Health Centers (SBHCs)as key partners and access points for expanding wellness and preventive care for our school-age members. All 160 SBHCs are participating in our network through our contracts with their sponsoring agencies (FQHCs and hospitals). UniCare further encourages SBHC participation and collaboration through our school-based incentive programs. UniCare began providing incentives for SBHCs for improvements in the provision of well-child exams beginning in 2015. The results of our initial school-based incentive program are detailed in our response to QU015. We have continued that practice through our School-based Well-visit Incentive Program (SBWIP) described in detail in our QU011 response. UniCare also understands not every school has an SBHC. To mitigate this gap and make sure services are available to youth in child welfare, our telemedicine strategy includes a focus on collaborating with the West Virginia Primary Care Association and schools to implement telemedicine presenter sites (via TytoCare). We provide additional information about our telemedicine strategy in our response to Attachment E.6, Provider Services.

Provider Type	Recruitment Status
Right From the Start Providers (ND027)	We will make good faith efforts to contract with Right From the Start providers. UniCare has an on-going relationship with Right From the Start. Right From the Start offers UniCare's Baby and Me Tobacco Free program which we fund in West Virginia. We have configured our claims payment system to reimburse Right From the Start providers for covered services regardless of their participation status.
Bureau for Public Health Laboratories (ND028)	UniCare has identified three Bureau for Public Health Laboratories in West Virginia and we will make good faith efforts to contract with them.
Children with Special Health Care Needs (CSHCN) Program (ND029)	UniCare has more than 400 CSHCN providers at more than 410 locations comprising more than 1,070 CSHCN access points.

Ensuring Members Have Access to Publicly-supported Providers (ND030)

Publically supported providers offer critical services to our members and recognizing this, we will continue to contract with them. Regardless of a provider's participation in our network, all of our members have direct access to publicly-supported services because our systems are configured to assure this. For example, we have configured our claims payment system to reimburse for covered services whether or not providers are participating in our network.

Recruitment Strategies for New or Modified Provider Types (ND031)

UniCare understands that that new or modified provider types, such as children's residential providers, may arise in response to the Family First Prevention Services Act (FFPSA) or the Children with Serious Emotional Disorder Waiver (CSEDW). As needs evolve and new or modified provider types are added to the program, UniCare will adjust our credentialing requirements and outreach efforts. If the provider type is one that has not previously required credentialing in a managed care environment, we will collaborate with DHHR to develop the appropriate credentialing standards. We will utilize DHHR data to identify those providers who may have provided services in the past. We will also deploy our proven recruiting process to assure that the network is adequate to meet services.

For example, we understand the State recently approved the first six qualified residential treatment program (QRTP) providers, including Cammack Children's Center and Pressley Ridge in Cabell County, that will provide licensed non-foster family home settings with a trauma-informed treatment model that aligns with the FFPSA. UniCare will comply with requirements for QRTP placements as described in the Service Provider Agreement (SPA), Section 13.2, including establishing contracts with these providers as applicable. We support and will collaborate with DHHR and Bureau for Children and Families (BCF) in their efforts to strengthen the continuum of care for children in the child welfare system in a setting that promotes permanency within their community.

We will continue to make good-/faith efforts to contract with any new provider types to assure all required covered services are available within our network to meet the needs of our members. Our experienced, knowledgeable Network team is poised and able to quickly initiate new recruitment efforts as needs arise. For example, in advance of the MHT program, our provider staff recruited nearly 400 BH providers prior to implementation by conducting more than 500 face-to-face BH provider visits. In addition, to support implementation of the SUD services carve-in to the MHT program in 2019, our Network team quickly evaluated our network

and secured contracts with five additional SUD providers to fill network needs. We expedited contracting and credentialing and completed these tasks prior to go-live on July 1, 2019. Our Network team collaborated and scheduled face-to-face meetings with providers and our BH Management team to build relationships, educate, and support the successful transition.

Often, new or modified provider types that have not previously provided service in a managed care environment may be required to serve our members. Our Network team will work with these providers to make sure they are understand the credentialing and contracting process and offer technical support and assistance as needed assuring an easy transition.

Credentialing and Recredentialing

Provider credentialing and recredentialing assures members have a selection of physicians and other PH and BH professionals who have demonstrated backgrounds consistent with the delivery of high-quality, cost-effective health care. UniCare will comply with all requirements in Sections 3.1.5 and 3.1.6 of the SPA.

Credentialing of New Providers (ND010)

UniCare maintains policies and procedures for selection and retention of PH and BH providers and Health Delivery Organizations (HDOs). In contracting with providers, we comply with all applicable federal regulations, including but not limited to, W. Va. CSR §114-53-6, 42 CFR 438.610, and 42 CFR 455, Subpart B. If credentilaing and recredentilaing functions are delegated, credentialing and recredentialing policies and procedures must meet UniCare's requirements. We know the West Virginia Medicaid provider community and have navigated industry changes (such as Council for Affordable Quality Healthcare [CAQH] and Medicaid enrollment changes) alongside our providers and State partners.

Our credentialing process involves verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims through the appropriate state licensing boards, such as the Board of Medicine, Chiropractic Board, Osteopathic Board, and Dental Board, and the National Practitioner Database.

Each practitioner or HDO must complete a standard, UniCare-approved, application form when applying for initial participation in UniCare's network. We have streamlined the credentialing process by teaming up with CAQH, nationally recognized for its thoroughness in collecting provider data.

In 2018, UniCare processed more than 400 initial credentialing applications for providers and HDOs with 99% completed within 90 days of receipt.
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UniCare verifies those elements related to an applicants' legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the Credentialing Committee making its credentialing recommendation or as otherwise required by applicable accreditation standards.

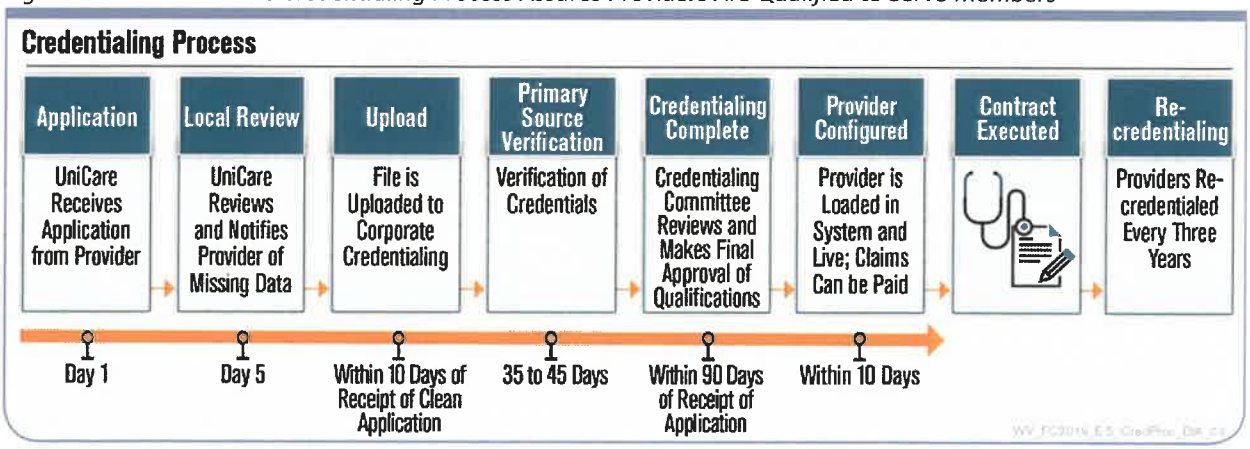
We meet or exceed all credentialing standards and protocols, including NCQA standards. Our current provider site visit process also meets NCQA standards and West Virginia standards. Our provider manual, available to all providers on our website, provides details on our eligibility standards and rules. In order for any provider to become a participating provider, they must meet all requirements, including eligibility, safety, medical record documentation, liability insurance, and all other standards, including handicap accessibility in accordance with the ADA. If we learn of any lapse or failures in any such eligibility standard or rule, UniCare will terminate the provider from participation.

Provider Pledge Our West Virginia-based Provider Relations team works to continually provide excellent service to our contracted providers. The team's overarching goal is to simplify health care so providers can focus on our members' health. We are dedicated to our providers and place great importance on serving their needs and interests.

Credentialing Process

Our credentialing process assures that the providers enrolled in our network deliver quality services. An overview of this process appears in Figure E.5-2.

Figure E.5-2. The UniCare Credentialing Process Assures Providers Are Qualified to Serve Members



Maximizing Provider Efficiency

Administrative Simplification
Provider Pledge

We have structured our credentialing process for efficiency. UniCare strongly encourages West Virginia providers to use CAQH's ProView for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation's leading health care plans and networks whose mission is to improve health care quality and access for more than 165 million Americans covered by these plans. The CAQH system collects data over 1.3 million providers and allows administrative requirements to be streamlined.

ProView is the industry standard for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia are able to enter information free of charge, reducing required paperwork for providers. ProView allows providers to fill out a single application to meet the credentialing data needs of multiple organizations. For both UniCare and providers, ProView is helpful because this process:

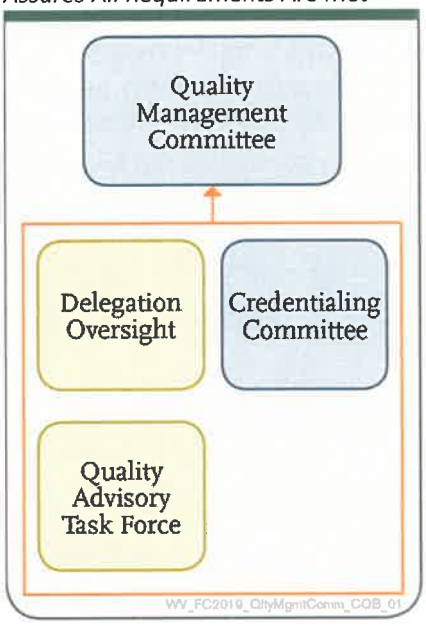
- Supports UniCare's administrative streamlining and paper reduction efforts
- Helps to ensure the accuracy and integrity of the provider database
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers
- Enables providers to utilize the ProView database at no cost

Oversight Structure

UniCare adheres to a formal structure, illustrated in Figure E.5-3, to monitor credentialing activities:

- The credentialing team uses the processes in the provider manual and credentialing policies to administer provider credentialing and recredentialing.
- The Credentialing Committee oversees the credentialing process. If a provider does not meet UniCare credentialing criteria (including clinical UniCare Network Participation Requirements and Quality of Care Standards), the credentialing team will bring the information to the Credentialing Committee to review.
- The Credentialing Committee will review the information and decide what action to take with the provider's participation in the UniCare network.
- A UniCare Medical Director leads the Credentialing Committee. The Medical Director is accountable for convening meetings, signing off on the providers that meet UniCare credentialing criteria, and reviewing and acting on practitioner credentialing files that have potentially significant issues.
- The Credentialing Committee reports periodically to the Quality Management Committee (QMC).

Figure E.5-3. Our Oversight Structure Assures All Requirements Are Met



The QMC has oversight and responsibility to review or make credentialing determinations regarding the following:

- Substantive changes to the credentialing policy manual
- Annual credentialing evaluations
- Semi-annual updates (high-level summary) of items reviewed by the Credentialing Committee
- Semi-annual updates (high-level summary) of delegates reviewed for compliance with company, regulatory, and accreditation standards at the Accreditation Delegation Oversight Committee

Minimum Credentialing and Licensing Requirements

Our written policies and procedures support the identification, recruitment, and retention of participating providers, and include a uniform credentialing and recredentialing policy for PH and BH providers. Our process includes a statement by the provider regarding:

- Any physical or mental health problems that may affect current ability to provide health care
- Any history of chemical dependency or SUD
- History of loss of license
- Felony convictions as required by West Virginia CSR §114-53-6.3 and other criminal convictions as required by 42 CFR 455.106
- History of loss or limitation of privileges or disciplinary activity
- History of debarment, suspension, or exclusion from any federal or State health care programs
- An attestation to correctness/completeness of the application

We regularly review and update our comprehensive credentialing policies and procedures when NCQA, the federal government, or the State, including DHHR, issue new standards and requirements. We monitor credentialing and recredentialing activities to assure a smooth onboarding process for providers. Primary source verification is completed by an NCQA vendor, certified in all current NCQA elements, or by UniCare, using the information and corresponding sources summarized in Figure E.5-4.

Figure E.5-4. Primary Source Verification Assures Providers Are Qualified to Serve Members

Primary Source Verification

Information Category	Source
License to practice	Appropriate licensing agency
Hospital privileges	Hospital or the completed hospital application item and a signed and dated attestation statement
DEA certificate	DEA online search via National Technical Information Service (NTIS)
Residency/education	Residency training program or state licensing agency
Board certification	American Board of Medical Specialties or acceptable specialty boards
Malpractice coverage	Copy of current malpractice coverage sheet or the completed malpractice coverage application item and a signed and dated attestation statement
Malpractice history	National Practitioners Data Bank (NPDB)
Sanction information (includes Medicare & Medicaid)	NPDB or state licensing boards
Work history	Application or curriculum vitae
Attestation to the correctness and completeness of information provided by the practitioner	Disclosure statement on the credentialing application attestation page
Reasons for inability to perform the essential functions of the position	Disclosure question #15 on the credentialing application
Lack of present illegal drug use	Disclosure question #17 on the credentialing application

Types of Providers Credentialed and Recredentialed

UniCare credentials and recredentials the provider and facility types as referenced in Figure E.5-5.

Figure E.5-5. UniCare Credentials and Recredentials the Full Spectrum of Providers

Medical Specialties That Require Credentialing:
- Physician (MD, DO)
- Podiatrist (DPM)
- Chiropractor (DC)
- Optometrist (OD)
- Oral and Maxillofacial Surgeon (DDS, DMD, MD)
- Certified Nurse Midwife (CNM)
- Traditional Midwife (LTM or LM)
- Registered Nurse Clinical Specialist (RNCS, CNS)
- Registered Nurse Practitioner (RNP)
- Physician Assistant (PA)
- Licensed Acupuncturist (LAC)
- Medical Therapists (for example, physical therapists, speech therapists, and occupational therapists)
- Genetic Counselors
- Audiologists
- Registered Dieticians

Behavioral Health Specialties That Require Credentialing:
- Psychologists who have doctoral or master's level training
- Clinical Social Workers who have master's level training
- Psychiatric or Behavioral Nurse Practitioners who have master's level training
- Other Behavioral Health Care Specialists/ Telemedicine Practitioners who provide treatment services under the health benefit plan

Facilities That Require Credentialing:
- Ambulatory Surgery Center (Free-standing Only)
- Birth Centers (Free-standing Only)
- Home Health Care Agency
- Hospital (All types, including Psychiatric)
- Skilled Nursing Facility/Nursing Home
- Sleep Center (Free-standing Only)
- Home Infusion Therapy when not associated with another currently credentialed HDO

Behavioral Health Facilities That Require Credentialing:
- Adult Family Care/Foster Care Homes
- Ambulatory Detox
- Community Mental Health Centers
- Crisis Stabilization Units
- Intensive Family Intervention Services
- Intensive Outpatient — mental health or substance use
- Methadone Maintenance Clinics
- Outpatient Mental Health Clinics
- Outpatient Substance Use Clinics
- Partial hospitalization — mental health or substance use
- Residential Treatment Centers — psychiatric or substance use

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The following BH practitioners are not subject to professional conduct and competence review under UniCare's credentialing program, but are subject to a certification requirement process, including verification of licensure by the applicable State licensing board to independently provide BH services or compliance with regulatory or State or federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

The following HDOs are not subject to professional conduct and competence review under UniCare's credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable State licensing agency or compliance with regulatory or State or federal contract requirements for the provision of services:

- Clinical laboratories (Clinical Laboratory Improvement Amendments [CLIA] Certification of Accreditation or CLIA Certificate of Compliance)
- End-stage renal disease (ESRD) service providers
- Dialysis facilities (CMS Certification)
- Portable X-ray suppliers (Food and Drug Administration [FDA] Certification)

- Home infusion therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- FQHCs (CMS Certification)
- RHCs (CMS Certification)

All participating providers must meet initial and ongoing UniCare credentialing standards and network participation criteria. Figure E.5-6 lists minimum credentialing requirements.

Figure E.5-6. UniCare Providers Undergo Rigorous Credentialing

Credentialing Requirements

Credentialing Requirements for Practitioners

- Graduation from medical school and completion of a residency, or other post-graduate training
- Board certification or eligibility, or specialized training as appropriate
- Current, unrestricted license to practice in West Virginia
- Valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate
- Hospital privileges, as applicable
- Current curriculum vitae or resume and work history (must show continuous five-year history)
- Current, adequate malpractice insurance with minimum coverage requirements of $1 million per individual episode and $1 million in the aggregate
- Signed attestation and release of information
- Absence of disciplinary action history, loss of clinical privileges, felony convictions, Medicare or Medicaid sanctions, exclusions, or debarments including the identity and the exclusion status of provider and any person with an ownership or control interest or who is an agent or managing employee of the provider through checks of federal databases as described in 42 CFR 455.436
- Curtailment or suspension of medical staff privileges (other than for incomplete records)
- Any revocation or suspension of a state license or DEA/Bureau of Narcotics and Dangerous Drugs (BNDD) number
- Any censure by the State or County Medical Association
- Enrollee complaints

Credentialing Requirements for Facilities and Organizational Providers

- Current and unrestricted licenses/accreditation for specified facility type
- Site Surveys for non-accredited providers (either State or CMS)
- Applicable general liability coverages
- Absence of Medicare, Medicaid, or Federal Employees Health Benefits Program sanctions, exclusions, or debarments
- Department of Health survey results, or recognized accrediting organization certification
- For inpatient BH facilities, verified professional liability history, designated Medical Director who is a board-certified psychiatrist
- For outpatient BH facilities, confirmation there is a board-certified Medical Director on staff

UniCare will comply with the additional credentialing and recredentialing requirements for dental providers and BH providers and agencies contained in Section 3.1.6 of the SPA.

SUD Providers

UniCare understands DHHR's Administrative Services Organization (ASO) contractor will complete the SUD provider certification process and provide a report to DHHR. Final certification letters will be sent by DHHR and we will be notified of the certified providers by DHHR. Contingent on the SUD providers receiving certification from the State, we will credential all SUD providers consistent with the key benchmarks from the ASAM Criteria as set forth in the Medicaid provider manual, Chapter 504. We will comply with the SUD provider network standards as outlined in Appendix K.

Site Visits

Additional credentialing criteria for PCPs, OB/GYNs, and other high-volume specialists include a visit to the provider's office, documenting a structured review of the site, and medical record-keeping practices to ensure conformance with our standards. We do not recognize site accreditation in lieu of an office site review. We maintain a recredentialing policy with all activities continuing to be conducted every three years.

Delegated Credentialing

In certain instances, UniCare may delegate credentialing and recredentialing functions to a third party (delegate). Delegated credentialing reduces the administrative burden for providers and, where feasible, is more efficient for all parties. Every delegate must perform credentialing and recredentialing functions according to our policies and procedures and the contract. UniCare retains final approval or denial for single provider participation within the delegated group. Our delegated credentialing and recredentialing processes meet or exceed NCQA accreditation requirements, as well as CMS and State guidelines. When considering potential credentialing and recredentialing delegates, we require the prospective delegate meet the following criteria:

- NCQA-accredited or certified or pursuing NCQA accreditation or certification
- Employ a minimum of 300 providers
- Meet or exceed all CMS regulations
- Comply with all applicable HIPAA requirements in accordance with business associate regulations
- Meet all UniCare credentialing requirements

Delegates may credential the following types of providers, including provider groups that meet specific eligibility requirements based on size, experience, infrastructure, and professional liability insurance: pharmacy providers, medical group practices, hospital-based physician groups, and physician and physician-hospital organizations.

Ongoing Provider Monitoring

UniCare credentialing staff review provider licensure and sanctions limitations monthly or within 30 days of a newly released provider sanction report. Our credentialing staff review provider-based sanctions and related reports from various sources such as: Office of Inspector General (OIG), OIG's List of Excluded Individuals/Entities, the General Services Administration's System for Award Management, applicable State and federal agencies, the Office of Personnel Management, State licensing boards and agencies, and our own internal data (for example, we review adverse incidents, member complaints, and satisfaction data). We also consider any other verified information received from other appropriate sources.

When a participating provider or facility has been identified by any of these sources, we use formal criteria to assess the appropriate response, which may include review by the Chair of the Credentialing Committee, review by the Medical Director, referral to the Credentialing Committee, or termination from the network. We also report these providers to the appropriate authorities as required by law.

If a provider's license is suspended or terminated, the provider is no longer eligible to participate in our network, and we terminate the provider agreement immediately. UniCare adds names of providers with terminated agreements due to sanctions and license issues to the Adverse Provider Action report; these providers may file an appeal within 30 calendar days of notification.

Our provider contracts require any individual employed by the provider and involved in providing services to the member must not be sanctioned. We also conduct monthly screening of any contracted individual identified as having 5% or greater ownership interest in a participating provider practice.

UniCare will continue to submit a monthly report to DHHR with the names, National Provider Identifiers (NPIs), and Employer Identification Number (EIN) or Medicaid ID of any health care professional, institutional provider, or supplier that has been the subject of program integrity actions. The report also includes the action taken by UniCare. We report this information using the appropriate DHHR template.

We will also continue to report any health care-related criminal convictions, when disclosed, to DHHR. We also notify appropriate licensing or disciplinary bodies and other appropriate authorities. Finally, we assure compliance with federal requirements prohibiting employment or contracts with individuals excluded from participation under Medicaid, Medicare, or CHIP, as required by 42 CFR 438.610. The MCO must provide written disclosure of any prohibited affiliation, as directed in 42 CFR 438.608 (c)(1).

Non-discrimination in Credentialing

UniCare conducts our provider credentialing and recredentialing processes in a non-discriminatory manner. Individual provider characteristics — such as race, color, creed, religion, gender, national origin, marital status, status with regard to public assistance, disability, age, sexual orientation, status as a disabled or Vietnam-era veteran, types of procedures performed, or types of patients for which the provider provides treatment — are not considered during the provider credentialing or recredentialing process. Our credentialing leadership team monitors credentialing files and provider complaints periodically to make sure we do not discriminate against providers. The Credentialing Committee also reviews aggregate provider credentialing and recredentialing data on a quarterly basis, which includes reasons for excluding providers or terminating provider agreements.

Recredentialing (ND044)

In 2018, UniCare recredentialed more than 930 providers and HDOs with 99.9% of providers recredentialed within 36 months of their last credentialing date.

All applicable PH and BH providers and HDOs in the network within the scope of the UniCare credentialing program are required to be recredentialed every three years unless otherwise required by contract or State regulations. The recredentialing process incorporates reverification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status, and/or performance information (including, but not limited to, malpractice experience, hospital privilege, or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. Recredentialing also considers performance indicators such as those collected through the quality assurance and performance improvement program, the UM system, the grievance system, member satisfaction surveys, member complaints, and other data tracked by UniCare.

We review this information to assess whether practitioners and HDOs continue to meet UniCare credentialing standards. Recredentialing is also essential to our members, who depend on the accuracy of the information in the online UniCare Provider Finder®.

Pharmacy Recredentialing. UniCare recredentials pharmacies every other year. Network pharmacies receive a survey questionnaire to verify the data on file for that pharmacy. A sample of data fields include, but are not limited to:

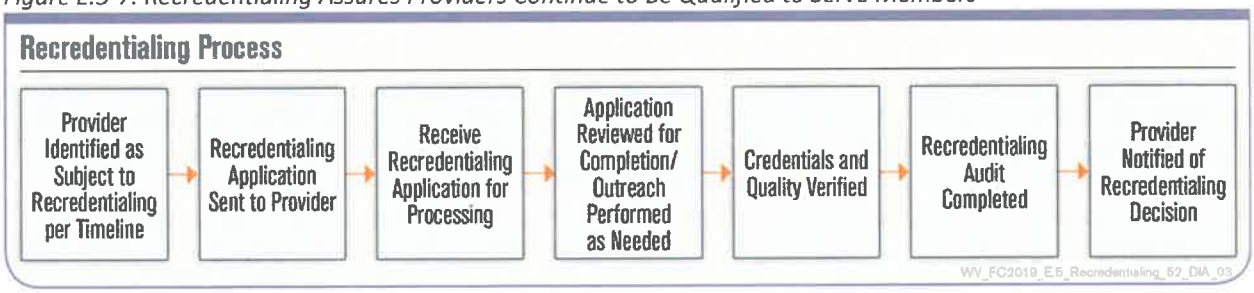
- Pharmacy name
- Address
- Telephone
- Fax
- E-Prescribing participation
- Additional services offered
- Licensure

We enter returned survey data into a database that compares the information to the current data on file. After completing the comparison, we make changes to the master pharmacy database.

Recredentialing Process

UniCare recredentials all practitioners and facilities contracted with UniCare within three years of the previous credentialing decision (Figure E.5-7). Our recredentialing requirements are the same as those used for initial credentialing. Recredentialing identifies any changes in providers' licensure, sanctions, board certification, clinical privileges, competence, or health status that may affect their ability to serve members. We track and monitor complaints made by members about providers and consider these complaints part of the recredentialing process.

Figure E.5-7. Recredentialing Assures Providers Continue to Be Qualified to Serve Members



During the recredentialing process, UniCare will review verification of the minimum credentialing requirements listed previously in Figure E.5-6, unless otherwise required by regulatory or accrediting bodies. In addition, UniCare will incorporate performance indicators into the recredentialing cycle. This includes any available information from internal sources such as satisfaction survey results, UM information, complaints or grievances, and other quality improvement activities.

Monitoring

We continually monitor our network for deficiencies in essential providers and specialty providers against DHHR access standards for travel times, distances, and member-to-provider ratios. We report deficiencies to DHHR annually and provide progress updates to DHHR quarterly or upon request. Where the deficiency is related to a lack of available providers, we continue to monitor for new providers entering the county and attempt to contract them to our network. To assure member access to the nearest available provider, we will authorize out-of-network services as necessary.

Addressing Network Gaps in Travel Times and Distances (ND007)

UniCare has no deficiency related to essential providers. We contract with all 75 FQHCs and RHCs, and we maintain an open network policy for these provider types. As new FQHCs and RHCs are established, we work one-on-one with the State and the providers to facilitate contracting. Once approved and the encounter rate is communicated by the State, UniCare loads the provider and rate information in the system, enabling claims payment.

Table E.5-4 provides a summary of current deficiencies and our actions to address these deficiencies.

Table E.5-4. Summary of Current Time and Distance Deficiencies

Specialty Type	Approach to Addressing Travel Times and Distances That May Be Experienced by a Member
OB/GYN	Deficient County: Roane We contract with a certified nurse midwife in Roane County. The average time to one provider is approximately five minutes, and time to two providers is 33 minutes. The two additional providers in Jackson County will enhance Roane County's member access. We are actively monitoring new providers in this area with the specialty, while at the same time authorizing non-participating provider services, if available, to help assure members have access to care.
ENT	Deficient Counties: Boone, Jackson, Mason, Nicholas, Preston, Tucker, Tyler, and Wetzel We have confirmed with the provider community there is a lack of this specialty in the area. The average time to one provider in these counties is less than 25 minutes and to two providers is less than 30 minutes. The provider community refers to contiguous counties. We are actively monitoring new ENT providers in this area, while at the same time authorizing non-participating provider services, if available, and encouraging telehealth services when available to help assure members have access to care.
General Surgery	Deficient Counties: Braxton, Calhoun, and Ritchie We have confirmed with the provider community there is a lack of this specialty in the area. The provider community refers to contiguous counties. We are actively monitoring new general surgery providers in this area, while at the same time authorizing non-participating provider services, if available, and encouraging telehealth services when available to help assure members have access to care.
Allergy	Deficient Counties: Pendleton and Pocahontas We have confirmed with the provider community there is a lack of this specialty in the area. The provider community refers to contiguous counties. We are actively monitoring new allergy specialists in this area, while at the same time authorizing non-participating provider services, if available, and encouraging telehealth services when available to help assure members have access to care.
Audiology	Deficient County: Wood We identified two providers and focused on their recruitment to our network. We have confirmed Marietta Memorial has an audiology department which enhances member access in Wood County. We will continue engagement with Audiology Services of West Virginia, LLC. We will continue to actively monitor new audiology providers in this area, while at the same time authorizing non-participating provider services, if available, to help assure members have access to care.
Free-standing Psych > 21	Deficient Counties: Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Mineral, Pendleton, Pocahontas, and Wood After further review of our provider network and outreach to area providers, there were no additional providers identified in these counties. We will continue to actively monitor new providers in this area with this specialty, while at the same time authorizing non-participating provider services, if available, and encouraging telehealth services when available to help assure members have access to care.
Home IV	Deficient Counties: Braxton, Grant, Hardy, Mineral, Pendleton, Pocahontas, and Wood After further review of our provider network and outreach to area providers, there were no additional providers identified in Pendleton County. We have added CAIS to our network, which will enhance access for our members. We will continue to outreach to hospitals to confirm home infusion is a service provided. We will continue to actively monitor new home infusion providers in this area, while at the same time authorizing non-participating provider services, if available, to help assure members have access to care.

Specialty Type	Approach to Addressing Travel Times and Distances That May Be Experienced by a Member
Orthotics/ Prosthetics	Deficient County: Braxton After further review of our provider network and outreach to area providers, there were no additional providers identified in Braxton County. We confirmed West Virginia Orthotics & Prosthetics have additional locations in Randolph, Greenbrier, Logan, and Nicholas Counties. We are working with the provider to update their profile to reflect the correct physical locations. We will continue to actively monitoring new orthotics and prosthetics providers in this area, while at the same time authorizing non-participating provider services, if available, to help assure members have access to care.
Psych Unit Adult	Deficient County: Webster After further review of our provider network and outreach to area providers, there were no additional providers identified in Webster County. We will continue to actively monitor new adult psychiatric providers in this area, while at the same time authorizing non-participating provider services, if available, to help assure members have access to care.
Dialysis	Deficient Counties: Brooke, Hancock, and Ohio We have confirmed with the provider community there is a lack of this specialty in the area. The provider community refers to contiguous counties. We are actively monitoring new dialysis providers in this area, while at the same time authorizing non-participating provider services, if available, and encouraging telehealth services when available to help assure members have access to care.
Durable Medical Equipment (DME)	Deficient Counties: Tyler and Wetzel After further review of our provider network and outreach to area providers, there are no providers located in Tyler County. We did confirm Wyoming Home Medical is no longer in business. We have confirmed Life Guard, an existing participating DME provider, has locations in Pleasants, Ritchie, Roane, Wetzel, and Preston Counties, which will enhance member access to care. We are working with the provider to update the provider profile to reflect all physical addresses. We will continue to actively monitor new DME providers in this area while, at the same time authorizing non-participating provider services, if available, to help assure members have access to care.

Measuring and Verifying Network Compliance Standards (ND008)



We know how important it is for our members to access care when and where they need it, and we will make sure our network is available to serve West Virginia's youth and families in compliance with DHHR access standards. We maintain a West Virginia network of appropriate, credentialed providers, supported by written arrangements, that is sufficient to provide adequate access (as defined by DHHR) to covered services (including the appropriate range of preventive, primary care, and specialty services) and to meet the needs of the population. To evaluate the current accessibility of our network and project future needs, we consider:

- The anticipated number of members
- The expected member utilization of services, taking into consideration the characteristics and health care needs of the population
- The multilingual, multicultural, and disability needs of members
- The numbers and types (in terms of training, experience, and specialization) of providers, and provider-to-member ratios
- Numbers of network providers who are not accepting new patients

- The geographic location of providers and members considering distance, travel time, the means of transportation ordinarily used by these members, and whether the location provides physical access for members with disabilities

We monitor our network to confirm compliance with contractual requirements and NCQA standards related to access to care and quality of services as summarized in Figure E.5-8.

Based on an analysis of current and future needs, we develop and maintain work plans that identify specific network development activities. Our network monitoring processes help us verify that our network includes enough practitioners with capacity to provide timely access to care.

As set forth in the contract, we will continue to submit to DHHR written documentation of the adequacy of our provider network at the following times:

- When the MCO enters into a Contract with DHHR
- On an annual basis
- When there has been a significant change in MCO operations
- When services, benefits, geographic service areas, or payments have been changed
- When there is enrollment of a new population in the MCO

Figure E.5-8. Comprehensive Network Monitoring Assures Compliance with Contractual Requirements

Measure	Measure Method of Monitoring	Frequency
Provider Level		
Appointment Availability and After-hours Access	Site visits	Ongoing
	Provider Access and Availability Survey	Annual
	CAHPS® Survey	Annual
	Member grievances	Ongoing
	Secret shopper calls	Ongoing
	Appointment availability audits	Annual
Office Waiting Time	Site visits	Ongoing
	Member input and feedback	Ongoing
	Employee feedback	Ongoing
	Administrative data	Ongoing
Patient Load	Site visits	Ongoing
	Member grievances	Ongoing
Network Level		
Travel Distance and Time	Network location mapping	Annual and as required
	Member grievances	Ongoing
	CAHPS Survey	Annual

Our local Provider Relations and QM departments work together to systematically review and analyze accessibility data, assure compliance with Program requirements, and assist with prioritization of opportunities to improve continuity and coordination of care. They measure and verify access to care through an ongoing assessment and review of network adequacy reports to determine network gaps, review of network requests to identify service gaps and target providers, and conduct ongoing monitoring of provider compliance with access standards through surveys and member complaints. UniCare monitors PCP panels for compliance with the Bureau for Medical Services limit of Medicaid members assigned per PCP, for applicable populations.

We hold providers accountable based on their contractual agreement with UniCare. ***If we identify deficiencies, we develop action plans*** for improving appointment availability, including:

- Sharing results with non-compliant providers and implementing corrective action plans
- Meeting with compliant providers to identify best practices
- Developing customer service seminars for physicians' office staff to discuss scheduling protocols and best practices to manage challenges and improve efficiency within the office

Actions Taken to Address Inappropriate Wait Times (ND009)

UniCare will comply with all DHHR standards for timeliness of access to care and services as defined in the SPA, Section 31.2.4, Timeliness of Access to Care, including:

- Emergency cases seen immediately or referred to an emergency facility
- Urgent cases seen within 48 hours
- Routine cases other than clinical preventive services, seen within 21 calendar days (exceptions are permitted at specific times when PCP capacity is temporarily limited)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services scheduled in accordance to EPSDT guidelines and the EPSDT Periodicity Schedule
- Initial prenatal care visits scheduled within 14 calendar days of the date on which the woman is found to be pregnant

We encourage members with Supplemental Security Income (SSI) to schedule an appointment with a PCP or specialist who manages the member's care within 45 calendar days of initial enrollment. We will schedule or facilitate an appointment with the member's PCP upon member or provider request.

We will continue to assure that the hours of operation of our providers are convenient, do not discriminate against members, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service (FFS). We will also continue to assure that waiting times at sites of care are kept to a minimum and that the waiting time standard for Medicaid members is the same standard used for commercial enrollees. Providers are not permitted to discriminate against Medicaid enrollees in the order that patients are seen or in the order that appointments are given. Providers are not permitted to schedule Medicaid-only days.

Our QMC reviews and analyzes data and assists with prioritization of opportunities to improve continuity and coordination of care. Our Provider Relations team also monitors and validates after-hours clinic and appointment availability during their in-person visits to provider offices.

If we learn a member is having difficulty obtaining an appointment with a specific provider, we immediately contact the provider to secure an appointment for the member. If the provider cannot see the member within a reasonable time period, we locate an appointment with another available provider within the area if the member is agreeable. A Network Relations Consultant contacts the provider to discuss the scheduling issue, remind the provider of appointment and access standards, and formulate an action plan to assure members are able to access care.

Provider Relations follows-up with the provider to make sure they are in compliance within 90 to 120 days. If we continue to see no improvement after repeated attempts to adjust the provider's performance, we may initiate steps to remove the provider from the network. These rare cases in which we terminate a provider are generally related to continued non-compliance with their contract, failure to meet recredentialing requirements, fraud or abuse, quality of care issues (as determined by our Quality Assurance and Performance Improvement [QAPI] team), or continued failure to adhere to authorization requirements. Over the past year, we have not had a network provider placed on a corrective action plan.

Reporting Underserved Areas and Need for Additional Socially Necessary Services Providers (ND011)

UniCare will provide monthly reports to DHHR on underserved areas of the State where the Vendor believes additional socially necessary services (SNS) providers should be permitted to enroll to address a gap in care. We will monitor input from a variety of sources to determine the need for additional SNS, including:

- Input from SNS focus groups
- Input from Advisory Groups
- Feedback from our SNS Liaison
- Input from provider rounds
- Data and analytics from our Health Insight system

UniCare will monitor the utilization of services and provide monthly reports that indicate geographic areas in which there is a high utilization of services required with low provider enrollment or the use of providers that are not most geographically appropriate in the requested service area.

Our Health Insight system has ability to keep an inventory of all SNS that are available by provider, by county, and by service. Utilizing the system's robust data analytics and our management of SNS services, we will have understanding of the SNS network capacity and access for services. The system can provide near real-time hot spot reports showing when and where capacity issues may exists. We can customize these reports and share data with the State.

Based on this data, we will offer recommendations to BCF on how to address such service gaps and misutilization of providers. In addition, we will collaborate with providers on a regular basis to understand challenges in the delivery of services and work on mitigating those issues while sharing quality and access results.

Using reports and analytics from our Health Insight system, we will be able to work with SNS providers to expand capacity and access for services. In addition to monitoring access through our Health Insight system, we will collaborate with providers on a regular basis to understand challenges in the delivery of services and work on mitigating those issues while sharing quality and access results.

Monitoring Ongoing Access to Services (ND012)

We review data from various sources (such as GeoAccess® reports, Concierge Representatives, satisfaction survey results, and provider feedback) and take action based on analysis of data as well as provider or membership changes. In addition, we use other data sources, including routine appointment wait times, quality of care and access concerns data, HEDIS® scores, CAHPS® results, administrative data review, annual comprehensive analysis of access and availability, and grievance and appeals data.

While comprehensive network data plays an important role in the ongoing management of our network, our hands-on collaborative approach to provider engagement is a critical source of information allowing us to best meet our member and provider needs. We also consider stakeholder feedback from members, caregivers, DHHR, and others to build our network.

2018 West Virginia CAHPS Child Survey Results

95.43% of respondents indicated that in the prior six months, when they made an appointment for a check-up or routine care for their child at a doctor's office or clinic, they got an appointment as soon as their child needed.

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On an ongoing basis, we assure network gaps are identified and resolved. For example, when we identify a network gap, our Network Relations Consultants immediately work to close that gap by identifying prospective providers in the geographic and specialty area affected, and negotiate a single-case agreement (SCA) to assure immediate

care for members. We then work to close the gap on a long-term basis by fully contracting and credentialing these providers.

Time/Distance Network Adequacy Analysis (ND013)

We continuously evaluate our network to identify deficiencies and enhance member access. Our locally based Provider Relations team members live and work in their local communities and build trusting and collaborative relationships with providers through a "boots on the ground" approach. We continuously monitor, maintain, and update our network to offer our West Virginia Medicaid members full access to core benefits and covered services within DHHR network standards for timely access to care and services and will extend this commitment to our members in child welfare.

UniCare continuously reviews the networks for any provider changes that would affect State and federal access requirements, and implements the necessary network changes to assure member access. To make sure that members have timely access to all covered health care services, the Provider Relations team performs network adequacy analysis.

On an annual basis, or more often in instances of the loss of a significant provider, using data analytic tools, we conduct a network assessment against DHHR time and distance standards to verify our network (including hospitals, groups, PCPs, specialty providers, and BH providers) meets adequacy and accessibility standards to deliver covered services to our members. We generate and review GeoAccess reports to determine network gaps based on where our members live. Based on our ongoing evaluation of our statewide network adequacy, we identify areas of focus for ongoing network development activities to further assure gaps are addressed proactively.

The network adequacy analysis affords us an opportunity to adjust our provider network strategy according to changing circumstances to maintain the stability and capacity of existing delivery systems. Our analysis includes geographic access mapping, gap analysis, review of potential providers for availability and type, and surveying and responding to member needs.

As previously described, UniCare's approach to conducting network adequacy compliance monitoring uses GeoAccess analysis. It combines dynamic time and distance access standards with minimum provider requirements for dozens of individual specialties and specific services performed at facilities to assess whether a network is meeting requirements to provide sufficient access to care. This analysis also identifies providers by allowing all network providers within the desired proximity of a beneficiary location to be considered in the analysis regardless of geographic boundaries.

Additional Sources of Data

We also review multiple sources of data to identify network gaps and enhancement opportunities based on patterns, trends, and service demands specific to the region. These data sources include:

- **Monthly Network Changes.** We review all network additions, deletions, and PCP capacity changes by provider type and location. We compare results to DHHR time and distance standards, and deploy targeted provider recruitment contracting strategies to address gaps and increase provider capacity.
- **Annual Member Satisfaction Surveys.** Our QM department engages a qualified vendor to administer the most current version of the CAHPS survey. We review results to identify areas where members indicate gaps may be preventing full satisfaction. ***During our most recent assessment of member satisfaction, we met our goals related to getting care quickly (95th Quality Compass Percentile) and getting needed care (90th Quality Compass Percentile).*** Based on results, we deploy targeted provider recruitment and

contracting strategies to mitigate gaps, and additional provider training through our Network Relations Consultants to improve service excellence.

- **Annual Provider Satisfaction Surveys.** We consider the findings from our provider satisfaction surveys to identify improvement opportunities. We place great emphasis on provider satisfaction to assure our members are being cared for by high-performing, engaged providers. ***According to the most recent measurement of provider satisfaction, 81% of providers say they are very or somewhat satisfied with UniCare overall.*** Based on survey results, we deploy strategies designed to increase retention and provider satisfaction.
- **Continuous Employee Feedback.** Our Network Relations Consultants, Care Coordinators, UM Clinicians, QM team, and Concierge Representatives provide feedback on the quality, access, and availability of our provider network to maximize success. They are in the field daily working with stakeholders — members, caregivers, providers, and community-based organizations. These stakeholders are best poised to provide feedback concerning needs and opportunities, help us solve challenges, and assure we are delivering the best possible array of services to meet member needs.
- **Member Grievance Information.** We review member grievances to monitor provider adherence to access standards. Our Concierge Representatives review, log, and categorize grievances by cause, disposition, and type. This includes grievances regarding access to care. We develop action plans and track results to closure.

Expanding Access

If we identify an area where access is limited, we will work with out-of-network providers to assure care for our members and work to recruit the providers to participate in our network. In areas where there are no providers available, we may also refer members to the nearest provider in another county or bordering state.

UniCare will implement a number of innovative approaches that expand access to essential and specialty providers for West Virginia's youth and families. These approaches include: expanding our telemedicine program to include BH and specialty consultations and school-based presentation sites; partnerships to expand specialist capacity in high-need specialties; leveraging contracts with border state affiliates for their providers within 25 miles of the border; and implementing UniCare's PCIT approach.

Verifying Appointment Timeliness by Provider Type (ND014)

Our provider agreements require network providers to abide by all appointment standards, including standards for appointment access and after-hours availability. To provide access to primary care services for routine, urgent, and emergency PH and BH needs, we require all PCPs be accessible 24/7, either personally or through covered arrangements with designated network PCPs. We communicate this expectation to providers via face-to-face meetings, provider training, policies and procedures, our provider agreement, and the provider manual. Should a network provider not be available to meet a member's needs, we refer that member to an out-of-network provider and execute a SCA. We then work to bring the provider into our network.

We inform and educate providers about compliance with appointment access and availability requirements through our face-to-face meetings with providers. We also confirm access and availability during our face-to-face and telephonic interactions with providers. We document provider responses, identify potential quality improvement opportunities, and make sure we maintain accurate access information in our system and the provider directory. Our Academy, provider newsletters, provider manual, and provider agreements also specify provider access requirements.

Monitoring Appointment Accessibility, After-hours Accessibility, and Telephone Accessibility

UniCare monitors practitioner appointment accessibility, after-hour accessibility, and telephone accessibility annually to ensure members have timely access to their medical health care practitioners and prompt response to telephonic inquiries. The plan uses the following data sources to formally assess its performance against its own standards for accessibility:

- Accessibility of Services surveys conducted by North American Testing Organization, an NCQA-certified survey vendor
- CAHPS Survey (Adult and Child, as appropriate)
- Complaints/grievances related to appointment access

The 2018 appointment accessibility survey results showed PCP appointment access was **82% for routine appointments** and **91% for urgent care appointments.** For high-impact specialists, **routine appointment access was 100%.**

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The QAPI Committee reviews and analyzes the data and assists with prioritization of opportunities to improve continuity and coordination of care. This committee includes stakeholders and UniCare staff from the following areas: Provider Relations, UM, and QM. We monitor appointment access and availability of our provider network according to State requirements, federal regulations, and NCQA access standards. Assuring and improving compliance with appointment timeliness standards is an ongoing process in our current contract, and interventions have led to a steady increase in compliance. In Table E.5-5, we summarize the various ways we gather data to assess provider compliance with access and availability standards.

Table E.5-5. Additional Mechanisms to Monitor Compliance with Availability and Appointment Standards

Source	Activities
Provider Interactions	We check network PCPs to confirm they are maintaining an open panel and can schedule member appointments within established access standards. We do this during face-to-face visits and telephone calls.
Concierge Services Data	We analyze call center data to identify potential compliance issues. For example, if we receive feedback regarding a provider's inaccessibility, we contact the provider, determine the cause, and work with the provider to correct the situation.
Complaint and Appeals Data	We analyze complaint and appeals data to monitor provider adherence to access standards at an individual provider level.
Secret Shopper Phone Calls	We use Secret Shopper calls to confirm compliance with appointment availability and access to care, including hours of operation and after-hours availability, for those providers who perform poorly on the annual After-hours and Appointment Availability Survey. We do this to assure performance has improved after our Network Relations Consultants meet with these providers to discuss their performance and develop a plan to mitigate issues. We also use Secret Shopper calls to follow up on complaints we receive from members or stakeholders.
Provider Survey	We survey providers annually to monitor access asking them to respond to a series of related questions. We outreach to non-compliant providers by phone or in person to provide re-education. We develop corrective action plan for deficiencies, which ultimately may lead to committee review for possible termination if the issue is not corrected.
Member Satisfaction Surveys	Each year, our QM department engages an NCQA-approved organization to administer the most current version of the CAHPS survey that queries members on access to care, among other key questions.
Focus Groups	We conduct focus groups to solicit feedback from our members and providers on UniCare's services and the adequacy and availability of our provider network. For example, we will conduct SNS focus groups.

To measure and verify compliance with appointment access standards, we conduct an annual After-hours and Appointment Availability Survey of a random, statistically valid sample of PCPs and BH providers to assess appointment availability and after-hours coverage.

Encouraging Providers to Expand Services and Hours

We also use incentives to drive access and availability compliance. For example, our After-hours Primary Care program provides additional reimbursement to providers for extended evening hours and weekend appointments. This increases member access to care and helps avoid unnecessary ER use. We are collaborating with PCPs affiliated with hospitals, outpatient clinics, and RHCs, and enhancing after-hours reimbursement to incent them to expand office hours. In addition, our APMs include measures to incent providers to improve quality and accessibility and help foster provider collaboration and access for our members. For example, our Foster Care Access Incentive Program offers providers an opportunity to earn an enhanced payment rate for each eligible encounter for completion of comprehensive EPSDT exams, including dental, hearing, developmental, and trauma screenings within 30 days of placement in foster care. We will pay earned incentives quarterly at enhanced fee for eligible claims for specified CPT® and diagnosis codes. As part of the criteria for participation in many of our APMs, PCPs must have open panel status and other provider types must be willing to accept all UniCare members.

Subcontractor Oversight

Our Subcontractor Oversight Program includes activities and infrastructure that enable us to closely and continuously monitor the performance of our subcontractors. We monitor their compliance with contractual and other requirements, including access to services, to confirm that our members are receiving the highest quality services. This program's flexible approach is tailored to the functions and services each subcontractor provides, and the scope and frequency of oversight activities reflects the nature of the role, responsibilities, and service nuances. Similar to our approach to monitoring our own levels of access to services for members, we monitor the same for our subcontractors through our Subcontractor Oversight Program. We require that our subcontractors provide us with reports on a regular basis to enable us to monitor performance and access levels; for example, among other reports, our Vision Benefits Manager VSP provides us with GeoAccess reports on a quarterly basis to demonstrate member access to vision providers is meeting standards required by the contract. They also provide us with Provider Satisfaction Survey results on an annual basis to give us additional insight into member access and satisfaction.

Our Subcontractor Oversight Program combines the local health plan team with centralized national resources. UniCare maintains full responsibility for the services subcontractors deliver to our members. Certain subcontractors also provide services to our affiliates; the resulting oversight and monitoring at both the local and national level offers a number of key benefits, including:

- Accountability to State-specific requirements
- Consistency in management, expectations, and remediation or corrective actions, as well as a high-level review of performance across all markets to better identify trends
- Identification of best practices and innovations in one market to be shared with others
- Proactive identification and mitigation of performance variance in a single state, often avoiding impact on other markets

Clearly defined expectations are a key component of our subcontractor Oversight Program. UniCare executes written agreements with each Subcontractor that detail the specific scope of services required, performance standards, reporting responsibilities, and actions to address

inadequate or substandard performance, such as development of a corrective action plan, use of sanctions, and termination. If at any time performance does not meet requirements, we take action and work with the subcontractor to correct the deficiency.

Adequate Access to Specialists in the Absence of a Defined Standard (ND0015)

We monitor our network to assure adequate access to all specialists. We maintain our own internal access standards and monitor access against these in the absence of DHHR access standards. To make sure members have access to specialists, we also rely on data from a number of other sources, including:

- Input from UM and care management to monitor requests for out-of-network services
- Ongoing monitoring of feedback from Advisory Groups
- Ongoing monitoring of member grievances
- Ongoing monitoring and analysis of provider feedback regarding referral patterns

We also develop tools to make sure members have access to services. For example, we created a tracking mechanism to monitor all home health services available by county. This allows us to monitor the availability of these providers and assure member access in the absence of a defined standard.

Specialists Serving as PCPs

Guidelines for Which Specialists Can Serve as PCPs (ND032)

UniCare recognizes that primary care services for members with complex, underlying health conditions may best be managed by having an appropriate specialist serve as the member's PCP.

Under our current guidelines, UniCare will allow the following types of providers to be deemed a member's PCP: pediatricians, family and general practitioners, nurse practitioners or physician assistants, and internists. A female member may select an OB/GYN or a participating advanced registered nurse practitioner as their PCP. Individuals who have chronic, disabling, or life-threatening conditions may also choose an appropriate specialist to serve as the PCP.

For our Fostering Healthy Lives members, we will take a person-centered approach to assuring that the right care for our members is provided by the right providers. Our guidelines for which specialists can serve as PCPs will reflect the unique needs and circumstances of each member. For example, in some instances where appropriate, we may allow a BH provider, such as a psychiatrist or psychiatric nurse practitioner, to serve as a PCP for members with complex BH conditions.

Circumstances and Process for Members Selecting a Specialist as Their PCP (ND033)

In general, UniCare will allow a specialist to serve as a member's PCP in circumstances where the member has underlying health conditions that would be best managed by the specialist. For example, the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists
- The majority of care needs to be given by a specialist
- The administrative requirements arranging for care exceed the capacity of the PCP; this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, SMI, serious emotional disturbance (SED), etc.

Our Care Coordinator will work directly with our members and their caregivers to determine which provider can best serve as their PCP. In addition to the role our Care Coordinators will

play in coordinating care, a member or the specialist may initiate a request to serve as the member's PCP. To request a specialist to serve as a member's PCP, the member or specialist may contact the Care Coordinator directly, or contact our dedicated Fostering Healthy Lives Concierge Line for members, their caregivers, and providers.

We evaluate each request on a case-by-case basis to determine the best provider to meet the member's primary care needs. In all cases, the specialist must agree to assume all PCP responsibilities, including providing EPSDT services, and have admitting privileges at a participating hospital. The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24/7, and coordinate the member's health care, including preventive care.

Our Care Coordinator will collaborate with our Network Relations Consultant to assure the specialist understands what is required to serve as a member's PCP, and if required, provide specialized training (for example, trauma-informed care and ACEs) related to children and youth in the child welfare system.

Required Approvals (ND034)

A Care Coordinator will review each request for a specialist to serve as a Fostering Healthy Lives member's PCP and submit the request to the UniCare Medical Director for review. UniCare will notify the member and the specialist of our determination in writing within 30 days of receiving the request. Should we deny the request, we will provide written notification to the member with the reason for denial within one day.

Additional Restrictions on the Types of Specialists That Can Serve as PCPs for Foster Care or Other Members with Complex Needs (ND035)

UniCare will take a person-centered approach to determining which providers can best serve as PCPs for our Fostering Healthy Lives members. Taking a person-centered approach is essential due to the complex and variable needs of our Fostering Healthy Lives members. As such, we will evaluate each member's circumstances on a case-by-case basis to determine the best provider to meet the member's primary care needs. We do not foresee placing additional restrictions on the types of specialists that can serve as a PCP for our Fostering Healthy Lives members or other members with complex needs.

Pharmacy Services

Per the Vendor Response Guidance on the Detailed Specifications from Addendum 3, we are providing a general description of the strategies we would use to meet these specifications if pharmacy benefits are carved-in at a future date.

Contracted Network Will Provide a Range of Pharmaceutical Needs (ND036, ND037, ND038)

If the pharmacy benefit is carved in, we will set-up a pharmacy network compliant with all access requirements issued by the State which will include 24/7, compound, and specialty drug pharmacies. We will partner with our affiliate pharmacy benefit manager (PBM), IngenioRx, which has experience successfully setting up new pharmacy networks in the 17 Medicaid markets where they manage pharmacy benefits today. IngenioRx will also be able to leverage their national network to build our pharmacy network thereby reducing the amount of time needed to set up a compliant network. Our Concierge Representatives will be available to link providers, members, and community agencies to our pharmaceutical resources.

Credentialing and Recredentialing of Network Pharmacies

Should additional pharmacies be needed to meet access requirements, outside of those available under the national network and to maintain the highest retail pharmacy network standards, IngenioRx will implement their rigorous protocol for reviewing and enrolling pharmacies in our retail network. Each pharmacy network applicant must have specific credentials and meet specific contractual standards, including, but not limited to:

- Active membership in NCPDP and compliance with HIPAA regulations
- Appropriate State licensure
- A valid DEA number at time of enrollment
- ACA compliance
- Evidence that all prescriptions will be dispensed as dictated by applicable State laws
- Ability to meet all contractual and professional obligations of network participation, including:
  - Mandatory requirements for electronic transmission of claims
  - Submission of usual and customary (U&C) charges
  - Submission of accurate claims data
  - Evaluation of concurrent drug utilization review (DUR) alerts, along with other online claims processing messaging
  - Compliance with contract and maximum allowable cost (MAC) pricing
  - Valid tax ID number
- Proof of insurance and compliance with malpractice liability requirements
- Submission of the pharmacy's customary service levels, such as delivery services, language accommodations, and emergency hours

Independent retail pharmacies must complete a membership enrollment form and comply with data and licensing requirements. This form includes the pharmacy's demographic and ownership information. In addition, the pharmacy must return the following documentation:

- A signed provider contract
- A completed Provider Service Levels form
- A copy of the State Provider License and DEA certificate
- A copy of the Liability Insurance Policy

Chain pharmacies do not need to provide hard copies of insurance policy and State license certificates upon enrollment. The chain headquarters is responsible for assuring that each store has this information.

During the pre-enrollment process, and on a monthly basis, IngenioRx performs all required 42 CFR § 455.436 federal database and certain State reviews for excluded providers. If IngenioRx learns that a participating retail network pharmacy is not in good standing with the OIG, IngenioRx will terminate that pharmacy's network participation. In addition, IngenioRx frequently

verifies a pharmacy's status with state board of pharmacy websites and personnel when it appears that a pharmacy may be under regulatory review.

Recredentialing occurs every other year. Network pharmacies receive a survey questionnaire to verify the data on file for that pharmacy. Data fields include, but are not limited to:

- Pharmacy name
- Address
- Telephone
- Fax
- E-Prescribing participation
- Additional services offered
- Licensure

IngenioRx will enter returned survey data into a database that compares the information to the current data on file. After completing the comparison, IngenioRx makes changes to the master pharmacy database.

UniCare will work with IngenioRx to monitor the pharmacy network against access requirements and to assure that it provides a suitable range of pharmaceutical therapies.

Bridging Gaps in Pharmaceutical Care

Our Network team will work closely with our Fostering Healthy Lives Care Coordination and Concierge teams to bridge any care gaps a member may be experiencing including needed pharmaceutical therapies. For example, if a member is unable to access a specialty pharmacy for a pharmaceutical need, our Care Coordinator will contact our Provider Relations team. If a specialty pharmacy is not available in our network in the member's area, we will negotiate an SCA to meet the needs of the member.

Managing Compound and Specialty Pharmacies (ND037, ND038)

Our contracted pharmacy network will have availability of compounds and specialty drug pharmacies. Because of the exponential rise in costs associated with compound and specialty drugs, IngenioRx has developed management strategies to mitigate the rapidly increasing prices of these drugs. IngenioRx has a comprehensive compounding and specialty pharmacy strategy in place that includes pharmacy and medical management initiatives and activities.

Compounds

If the State chooses to carve-in pharmacy benefits, in collaboration with IngenioRx, we will take a proactive approach to manage the costs and safety issues of compound drugs. This strategy encourages physicians to consider products that have been evaluated for safety and effectiveness and approved by the FDA. We must continually and quickly evolve to stay ahead of new approaches and campaigns by compounding pharmacies (and others) directed at prescribers, members, and their caregivers. To manage compounds, we will offer the dual strategy of exclusion and prior authorization with a dollar amount threshold. The program is designed to manage high-cost individual ingredients within compounds as well as high-cost compound prescriptions while continuing to provide access for members when commercially available products are either not available at all or not available in a dosage form that meets the member's needs.

Specialty

IngenioRx's specialty drug program will provide injectable and biotech drugs efficiently and cost-effectively through one full-service source, offer member support and education, integrate drug utilization and compliance programs, and offer PBM-based electronic claims processing. IngenioRx's specialty management capabilities will address drug spending under both the pharmacy and medical benefits. ***IngenioRx's specialty pharmacy is the only one that integrates rare disease management*** — critical in controlling overall costs related to this small but high-cost population. IngenioRx also provides specialty pharmacy access through retail

stores, within state restrictions, allowing seamless access. Once the prescription is ready, the member's caregiver is alerted that a disease-specific Specialty Care team will call them, generally within a few hours. The Specialty Care team includes pharmacy coordinators who deal with much of the administrative requirements for filling the prescription. The Specialty Care team also includes pharmacists to manage the medication-specific discussions including side effect management, injection training, and options for delivery. The clinicians on the Specialty Care team include disease management nurses and Coram® nurses who support patients on infused medications.

Pharmacy Outreach Efforts (ND039) to High Volume (ND040) and Rural (ND041) Pharmacies

UniCare will work with DHHR to identify high-volume and rural pharmacies. In collaboration with IngenioRx, we will review these identified pharmacies to make sure they are included in the network. In addition, we will monitor our network coverage and demographic data to identify areas in which additional pharmacies are needed. In areas identified as having inadequate pharmacy access levels, we will work with IngenioRx to recruit additional pharmacies for participation in our network by phone, fax, or direct mail solicitation. In addition, DHHR, members, or their caregivers can request that non-participating pharmacies be solicited to join our network.

Initially, a solicitation packet, containing a contract and a full description of network requirements, will be mailed or faxed to targeted independent pharmacies. IngenioRx will contact chain pharmacy executives who operate stores in desired locations by phone, then either mail or fax a contract with a full description of network requirements for their consideration. IngenioRx's network enrollment staff will also follow up with solicited pharmacies by phone to discuss unresolved issues and answer questions. When IngenioRx has the signed agreement in-house, the pharmacy effectively becomes part of the network within three to five business days.

We will work with IngenioRx to help assure our network complies with any willing provider and freedom of choice legislation, if applicable, and will monitor changes in legislation so that recruitment activities stand in full accord with the most current requirements in the market.

Outreach Efforts to Public Health Entities Administering the Vaccines for Children Program (ND042)

We are familiar with the public health entities administering the Vaccines for Children (VFC) program. Currently, we outreach to these entities to provide education to our network providers on the VFC program. When a new PCP or pediatrician is contracted as a network provider, we refer them to the VFC online program manual.

Through our Youth Records Access Portal (YouthRAP), we will be able to better coordinate member vaccination information so that children are not over-vaccinated due to gaps in information and transitions. YouthRAP is a standalone portal that will be used by our child and family-centered Fostering Healthy Lives interdisciplinary care team (ICT) and Intensive Care Management (ICM) team to support members. Department caseworkers, caregivers, child placement agencies, and other authorized users will be able to access information needed to effectively coordinate care, including electronic health records and vaccination information. This will enable better coordination with public health entities administering the VFC program.

Timely Pharmacy Service Availability (ND043)

Today, UniCare's Care Coordination team coordinates with contracted providers, members, and the State's pharmacy network to ensure access to needed pharmaceutical therapies. Our

Concierge team will be the West Virginia-based entry point for members and their caregivers. Concierge Representatives are highly skilled case specialists with specialty training who support and coordinate activities with the Care Coordination team and our external partners. We also provide care coordination to members 24/7, including nights and weekends, through our enhancement of an on-call Care Coordinator after normal business hours.

If the State carves in the pharmacy benefit, we will provide multiple pharmacy benefit information resources, such as the member handbook and website. Members and their caregivers will be able to search for and find participating retail pharmacies in their area, including 24/7 pharmacies, through the Locate a Pharmacy web tool. The tool will allow members to search for network pharmacies by ZIP code or city and state, and print a map with directions to the selected pharmacy. Members can also view pharmacy addresses and contact information. However, the pharmacy locator tool does not include compounding pharmacies. If members need information about a compound pharmacy, they can contact the Concierge team.

In addition, as stated earlier, IngenioRx also provides specialty pharmacy access through retail stores, within State restrictions, allowing seamless and timely access.

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6. PROVIDER SERVICES

The Vendor should refer to the relevant specifications located in Appendix 1: Detailed Specifications (based on the categorization within Column E: Subject Matter Area) and pertinent narrative' in Section 4: Project Specifications in this RFP, and then describe its approach to Provider Services below. The Vendor's narrative response should not exceed 30 pages.

PS001	The Vendor should provide initial (during implementation) and ongoing training for existing providers.	1) The Vendor should explain the proposed process, and content for providing ongoing training to existing providers. 2) The Vendor should provide an overall summary of training topics for existing providers.
PS002	The Vendor should provide initial and ongoing training targeted to new providers.	1) The Vendor should explain the proposed ongoing training to new providers. 2) The Vendor should provide an overall summary of training topics for new providers.
PS003	The Vendor should provide training on mandated reporters to support applicable State Code, as defined by the Department.	The Vendor should describe how it will meet this specification.
PS004	The Vendor should coordinate with the member's primary care provider (PCP) and behavioral health provider, for applicable populations, to ensure each provider has access to the most up-to-date medical records.	The Vendor should describe how it will meet this specification.
PS005	The Vendor should establish a quality rating system for its contracted providers and disseminate this information to help members make informed choices about their care.	The Vendor should describe how it will meet this specification, including an approach to establishing quality ratings and how the Vendor will disseminate the information.
PS006	The Vendor should distribute provider manuals according to set timeframes and methods of delivery.	The Vendor should describe how it will meet this specification, including proposed timeframes and methods of delivery.
PS007	The Vendor should accept and pay claims on time for physical and behavioral health services, as defined by the Service Provider Agreement (SPA).	The Vendor should describe how it will meet this specification. The response should include, but is not limited to: •A breakdown of turnaround times for paper vs. electronic data interchange (EDI) claims •Claim turnaround report for each of the past 12 months, indicating the percentage of total claims that are clean, and the percentage of clean claims processed within 30 days, and within 90 days

PS008	The Vendor should establish and implement guidelines to approve out-of-network provider claims for physical health and behavioral health services--including, but not limited to, hospitals-on an ongoing basis (after the 90-day exemption timeframe)	1) The Vendor should describe how it will meet this specification. 2) The Vendor should state whether it will reimburse these providers using the Medicaid fee schedule(s) or an alternate fee schedule.
PS009	The Vendor should establish and implement a review process for payments for emergency services for applicable populations, including, but not limited to, the following:	1) The Vendor should describe how it will meet this specification. 2) If algorithms are used to evaluate pended claims, the Vendor should describe how it will ensure that the "prudent layperson" standard is upheld.
PS010	Which types of claims are automatically paid	See the parent specification.
PS011	Which types of claims are automatically pended	See the parent specification.
PS012	Evaluation of pended claims for payment, upholding the ""prudent layperson" standard	See the parent specification.
PS013	The Vendor should educate primary care providers (PCPs) on their responsibility to coordinate a member's overall health, for applicable populations.	The Vendor should describe how it will meet this specification.
PS014	The Vendor should conduct outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services, for applicable populations.	The Vendor should describe how it will meet this specification.
PS015	The Vendor should educate and provide guidance to primary care providers (PCPs) on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health and/or socially necessary services (SNS),for applicable populations.	The Vendor should describe how it will meet this specification.
PS016	The Vendor should educate primary care providers (PCPs) about the Importance of dental screenings to ensure appropriate referrals to dental providers, including, but not limited to, training PCPs to verify that beginning at six (6) months after the first tooth erupts or by 12 months of age (as part of the Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] process),	The Vendor should describe how it will meet this specification.

	the member should be referred to dental providers, for applicable populations.	
PS017	The Vendor should educate and monitor primary care providers (PCPs) regarding administration of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, for applicable populations.	The Vendor should describe how it will meet this specification.
PS018	The Vendor should educate providers about the ability to request out-of-network referrals.	The Vendor should describe how it will meet this specification.
PS019	The Vendor should support e-Prescribing functions.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.
PS020	The Vendor should educate primary and specialty care physicians about foster care members and members with complex needs, including, but not limited to, the following:	The Vendor should provide a detailed description of how it will meet this specification.
PS021	Opportunities for standing referrals	See the parent specification.
PS022	Opportunities for specialists to serve as primary care providers (PCPs)	See the parent specification.
PS023	Availability of disease management	See the parent specification.
PS024	The Vendor should provide a publicly accessible, secure website with information targeted to providers.	The Vendor should describe how it will leverage its website to help meet the needs of providers.
PS025	The Vendor should provide a secure portal-accessible by providers, Department caseworkers, and other stakeholders as permitted by the Department--that allows these stakeholders to log in and access information as permitted by the Department, including, but not limited to, the following:	The Vendor should describe how it will leverage its website to help meet the needs of providers, Department caseworkers, and other stakeholders as permitted by the Department. *Note: The Medicaid fiscal agent will provide member eligibility information.*
PS026	Medical records	See the parent specification.
PS027	Authorization status	See the parent specification.
PS028	Confirmation of services previously provided to avoid duplication	See the parent specification.

The UniCare Health Plan of West Virginia, Inc. (UniCare) approach to provider services is founded on the principles of our ***Provider Pledge: to deliver a best-in-class experience by simplifying health care so our providers can focus on member health.*** Our approach supports the Specialized Managed Care for Children and Youth Program (the Program) providers so they can focus on delivering trauma-informed, evidence-based quality services to children in West Virginia's child welfare system and their caregivers.

Our Provider Pledge aligns our suite of provider programs and solutions as follows:



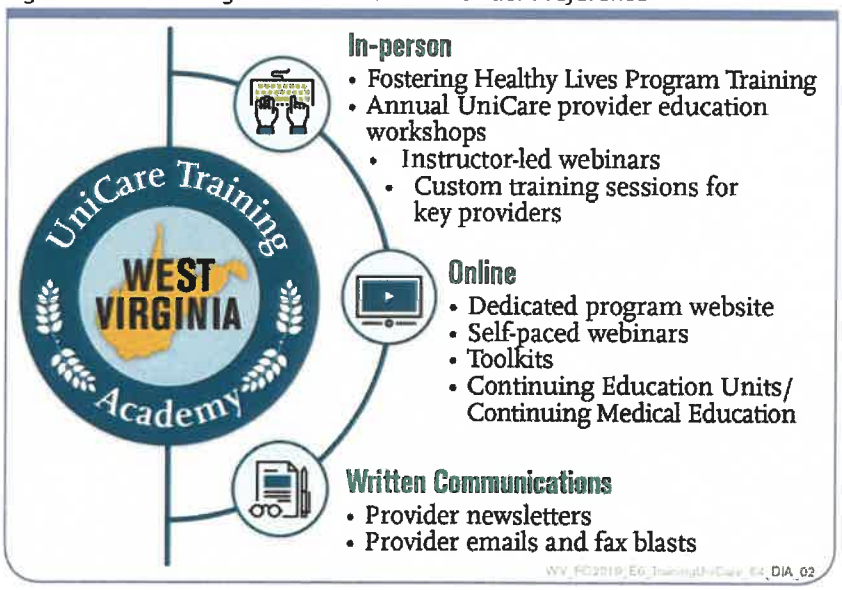
- **Capacity for Efficient Care.** UniCare assures cost-effective provider capacity by compiling the appropriate mix of network providers and resources capable of delivering a culturally sensitive, effective model of care. For example, in West Virginia, our network includes more than 14,000 providers serving all 55 counties in the State at more than 30,000 locations. We comply with all current access standards. We also expand access by enhancing provider capabilities to meet the needs of specialized populations through our UniCare Training Academy (the Academy).
- **Accountable Reimbursement.** UniCare enhances providers' fiscal ability to transform their practices' care delivery to a model based on population health principles that emphasizes high quality and improved efficiency outcomes. We do this through our performance-based alternative payment model (APM) strategies that focus on expanding access to preventive care; improving population health management; integrating physical health (PH), behavioral health (BH), and specialized services; and supporting the social needs of our members.
- **Administrative Simplification.** UniCare makes it easier for providers to efficiently and effectively care for their patients through administrative simplification, specialized service models, and technical supports that reduce administrative burden and increase provider and patient satisfaction. For example, our comprehensive Academy platform provides access to specialized training that eases provider administrative burden by offering training through multiple modalities, including in-person practice sessions, webinars and online training, free Continuing Medical Education credits, and digital offerings for provider convenience or to address time-sensitive training needs.
- **Health Advocacy.** UniCare connects members to high-performing providers with the expertise and experience to optimize member health outcomes and assure effective management of their PH, BH, and social health.

UniCare's Provider Training Model

UniCare's approach to comprehensive provider training is through the Academy. The Academy encompasses all provider trainings, including initial onboarding for new providers and ongoing training for all. It incorporates convenient, on-demand access and multi-modality delivery channels to maximize provider participation, increase efficiency, reduce administrative burden, and promote enhanced member service quality as summarized in Figure E.6-1.

The Academy is also our approach to population-specific provider training related to the specialized needs of our member populations, including that related to trauma and trauma-informed care, Adverse Childhood Experiences (ACEs), and other topics pertinent to the unique needs of our Program members.

Figure E.6-1. Training Modalities to Suit Provider Preference

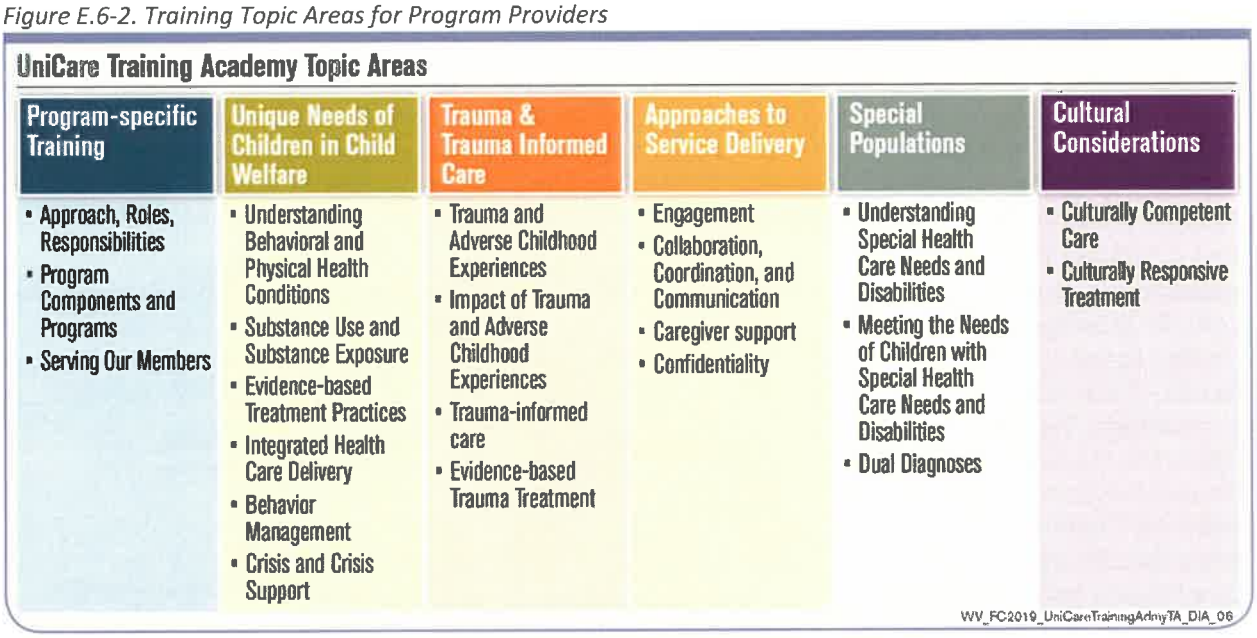


Based on our affiliates' experience serving more than 84,000 members in child welfare programs across 13 markets nationally, we know that youth in child welfare programs have high rates of trauma exposure, and the foundation of our provider training philosophy must be built on the principles of trauma-informed and -responsive care.

Research shows trauma has long-term, negative effects on a child's well-being, body, brain, and behavior, and is associated with increased risks of obesity, alcoholism, and depression. Therefore, our Academy training will seek to enhance providers' ability to identify and build resiliency, with the goal of reducing the consequences of trauma, and addressing the challenges that children face as a result of traumatic events.

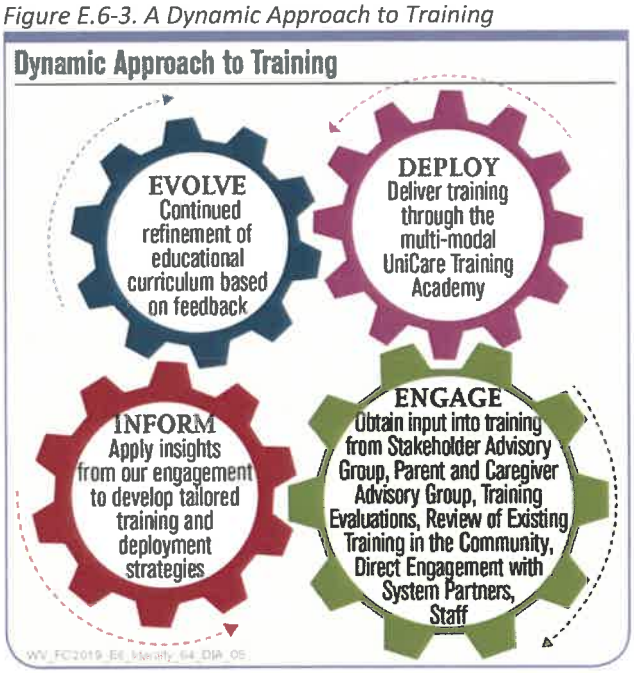
Our Academy will include relevant and timely Program-specific training and will highlight the unique needs of this population (Figure E.6-2). It will be open to providers and their office staffs, caregivers, and other health professionals, and will offer customized trainings and resources that are clinically appropriate, population-specific, culturally competent, and tailored to our members. Our Academy will support providers throughout their tenure, and assure focus on evidence-based best practices and support for all stakeholders in all members' lives.

Figure E.6-2. Training Topic Areas for Program Providers



Our Academy will be dynamic. Based on input from our West Virginia State partners, members and their caregivers, providers, and other stakeholders, we will continuously develop and refine its offerings using our dynamic Evolve, Deploy, Engage, and Inform approach, as illustrated in Figure E.6-3.

Figure E.6-3. A Dynamic Approach to Training



We have assembled a dedicated Community Engagement and Training team that will develop our Program education, training, and outreach strategy, including the development and delivery of customized training to various audiences in different formats. This dedicated team will be led by our Community Engagement Director. Our Community Engagement and Training team will include a Justice/Court Liaison, a Career Development Specialist, and five regionally focused Engagement and Training Representatives strategically positioned throughout West Virginia to identify local training needs, collaborate with local subject matter experts, and provide trainings in local forums. Our team will also communicate regularly with staff responsible for other UniCare functions — provider services, quality, and clinical services — to assure alignment of messaging and educational programming in the community.

In accordance with the Contract, we will submit our comprehensive provider education and training approach to DHHR within 150 calendar days of the Program's Operational Start Date. We will allow at least 10 calendar days for DHHR to review the materials, and following the

review, we will submit the finalized UniCare provider education approach to DHHR within five calendar days.

Providing Initial and Ongoing Training for New and Existing Providers (PS001, PS002)

Initial Provider Training

As an existing Medicaid health plan in West Virginia, UniCare already has a r Authorized Representatives ust network of providers that have previously received our initial training, which includes the topics outlined in Table E.6-1. We will continue to conduct this training for new providers at least monthly, and will also encourage existing providers to take it as a refresher course or as they hire new staff.

Table E.6-1. Standard UniCare Network Provider Training Topics at a Glance

Initial and Ongoing Provider Training	
• Introduction to UniCare, our Network Management department, and working with an MCO	• UniCare's Quality Management Program, HEDIS®, and the Provider's Role in the Program
• DHHR Policies, Priorities, and Processes	• Reporting Requirements, including Communicable Disease Reporting; Mandated Reporter's Training; and Fraud, Waste, and Abuse
• Enrollment and Credentialing Processes	• Privacy and Confidentiality of Protected Health Information
• Provider Roles and Responsibilities	• Use of Evidence-based and Clinical Practice Guidelines
• Verifying Eligibility, Pre-authorization, Referral and Authorization of Services	• Value-Added Services and Social Supports
• Person-centered Care Planning	• Social Determinants of Health (SDOH)
• Early Childhood Intervention (ECI)	• BH and Substance Use Disorder (SUD) Protocols and Resources
• Appointment Access Standards and Time Frames	• Alternative Payment Model (APM) training, including enabling provider readiness for value-based reimbursement
• Billing Procedures, Claims Submission, Processing, Required Documentation, and Payment	• Member and Provider Satisfaction Surveys
• Provider Manual, website, and Resources	• The Importance of Encounter Data
• Provider Grievances and Appeals, Dispute Resolution Processes, Helping Members File Grievances and Appeals	• Uses of Telemedicine, Telehealth, and Telemonitoring
• Integrating PH and BH	
• Preventive Health Care Guidelines	
• Medical Necessity Criteria	
Cultural Competency Training	
• The UniCare Cultural Competency Plan	• Understanding SDOH Expectations for providers and staffs (including mandate to continually expand cultural competency knowledge and skills)
• Cultural Competency Assessment Tools	• Compliance with physical access requirements and Americans with Disabilities Act (ADA) accessibility standards for members, including those with physical or cognitive disabilities
• Understanding and increasing awareness of the multi-lingual, multi-cultural, and disability needs of the individuals and families in West Virginia communities	• Examples of Best Practices
• National Standards for Culturally and Linguistically Appropriate Services (CLAS)	
• Culture and the impact on Health Care	
Behavioral Health Disorders Training	
• Screening for, Identifying, and Coordinating BH Disorders (including screening tools)	• Collaborating with Other Providers Involved in Member Care
• Responding to members with Co-occurring Mental Health and SUD	• BH and SUD training, including provider skills trainings
• Referring Members to a BH Specialist	• Supporting integrated care at the pediatric practice level

Cultural Competency Training and Resources

We are committed to making sure our providers are fully trained in the delivery of culturally appropriate services for our members, their families, and their communities. All providers receive cultural competency training during initial onboarding, educational outreach from our Network Relations Consultant, and annual training thereafter. Our cultural competency training helps make certain our providers understand that delivering services to people of all cultures, races, ethnic backgrounds, sexual orientations, abilities, and beliefs must occur in a manner that recognizes, values, affirms, and respects the worth and dignity of all members. Our provider website includes a robust array of resources for providers, including Cultural Competency Assessment Tools and My Diverse Patient Trainings.

Behavioral Health and Integrated Care Training

Our provider network will also be optimally trained to use evidence-based treatment practices for both PH and BH conditions. We recognize that primary care providers (PCPs) are often the primary resources and early interveners in West Virginia and that they are positioned to identify BH conditions sooner through integrated assessments. We leverage our Academy to offer comprehensive training to both PH and BH providers on clinical practice guidelines and evidence-based practices related to integrating physical, behavioral, and social needs. We provide training for PCPs on screening, treating, and referring members with BH disorders. Our Academy curriculum includes modules on Screening, Brief Intervention, and Referral to Treatment (SBIRT), trauma-informed care, care coordination, quality of care, and new models of BH interventions.

Fostering Healthy Lives Training

We understand that all UniCare providers, whether existing or new, will be new to serving children and youth in the child welfare program under managed care rather than fee-for-service. As such, ***every network provider*** will be required to take our Fostering Healthy Lives Training. It will orient providers and their staff to the Program and its unique features and requirements, as shown in Figure E.6-4. We will work with DHHR to make sure any additional topics of importance are incorporated into that training.

Our Community Engagement and Training team will offer Fostering Healthy Lives training in-person at central locations throughout the state, as well as through virtual, instructor-led webinars for provider convenience. Our affiliates' experience managing child welfare programs in other markets has shown us that timing provider training appropriately is key to a successful implementation. With DHHR approval, we will begin scheduling training for providers 60 days prior to the Program effective date. This time frame will help make sure providers are adequately prepared for the transition and with the material still fresh in their minds as they begin serving members. We will continue to offer this training, in-person or through virtual instructor led trainings, at least monthly for the first 12 months of the Program to accommodate new providers or those that may need refresher training.

Figure E.6-4. UniCare's Fostering Healthy Lives Provider Training Topics

West Virginia Fostering Healthy Lives Training Topics for Providers

Approach, Roles, and Responsibilities	• Program goals • System-based approach, collaborating and coordinating with system partners	• Roles and responsibilities of each system partner, including the MCO, State Agencies, judiciary, community child welfare agencies, placement agencies, providers, caregivers, and others
Provider Information and Responsibilities	• Requesting out-of-network referrals • Mandated reporting requirements • Specialists: encouraging members with complex needs to seek primary care services • Members with complex needs: standing referrals, specialists as PCPs, and availability of disease management • Participation in care planning	• Access to care standards, required time frames for assessments, and EPSDT • PCP responsibility to coordinate a member's overall health • PCP coordination of physical health services, coordinating with behavioral health services and SNS as applicable • Importance of dental screenings and referrals to dental services in accordance with EPSDT process
MCO Components and Processes	• Organization and staffing • Utilization management and authorizations • Socially Necessary Services and processes • Complaints, grievances, and appeals	• Performance measures and health outcomes • Quality, performance improvement, and compliance • Member benefits and Value-Added Services • Access to care and transition of care
Serving Our Members	• Care coordination and management, including chronic condition management • Intake, screening, and care planning • Children with Special Health Care Needs: outreach at enrollment, care management, and resources	• How to provide services to members with disabilities • Transition-aged youth • Out-of-network referrals
Supporting Network Providers	• Providing trauma-informed care, the AAP model, and recognizing ACEs • Special provider programs (Alternative Payment Models, Foster Care Patient Centered Medical Homes, and Improving Trauma-informed Care)	• Training, engagement, and advisory groups • Website, handbook, FAQs, and contact information

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We describe in depth some key topics to be included in our Fostering Healthy Lives Training below in our responses to PS003, PS013, PS015 – PS018, and PS020 – PS023. Training on many of these topics will also be reinforced through standard provider outreach and educational materials, which include our provider manual, alerts posted on the provider website, fax blasts, and face-to-face interaction between PCPs and our Provider Services team and Network Relations Consultant.

Ongoing Provider Training

First, We Listen

In addition to the Fostering Healthy Lives Training, UniCare will continue to monitor feedback from our providers and develop training based on identified needs. As a current West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid programs) MCO, we have experience listening to our providers and incorporating their feedback into our ongoing training strategy. Our Community Engagement and Training team will continue this best practice of developing training based on provider feedback. Ongoing training will be delivered to providers and their staff through:

- Live, in-person training at central locations throughout the State
- Virtual, instructor-led provider orientation webinars delivered at least monthly
- Virtual, instructor-led educational webinars on topics such as utilization management, delivered at least quarterly

When UniCare Mountain Health Trust network providers expressed unfamiliarity with our online authorization tool, we quickly developed training and made it available to providers via webinar. Providers have since shared how much they appreciated the training because the tool significantly reduced administrative burden.

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- Self-guided training modules in the Academy platform available on our provider website
- Face-to-face targeted training sessions in provider offices, as requested
- Annual provider education workshops at central locations throughout the State
- Mentoring via ACEs Provider Champions

We will monitor our training effectiveness by conducting post-training provider surveys to determine whether our training objectives were met or training module adjustments are necessary.

Provider Toolkits

Toolkits, available to providers and stakeholders on demand, are supplemental resources that reinforce learning objectives and facilitate adoption and application of principles and best practices presented during formal training. Our Academy will host an array of Provider Toolkits on various topics critical to caring for Program members, including:

- Screening and Identifying BH Disorders
- The Prevalence of BH Conditions in Children in the Child Welfare System on Psychiatric Medications
- Neonatal Abstinence Syndrome (NAS)
- ACEs
- Children and Adolescents Needs and Strengths (CANS)
- Families First Preservation Act (FFPA)
- Parent-child interactive therapy (PCIT)
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Multi-systemic Therapy
- Functional Family Therapy
- Motivational Interviewing Techniques
- Families Facing the Future

Mandated Reporters Training (PS003)

All Fostering Healthy Lives network providers, along with staff from their offices, will be required to complete Mandated Reporters Training. Subjects covered will include how to respond when physical abuse, sexual abuse, or sexual assault is disclosed or suspected. Training will also cover responsibilities, time frames, and how to contact the State Police and any law-enforcement agency having investigative jurisdiction. Contact information will also be available on our provider website.

Educating PCPs on Their Responsibility to Coordinate Member Care (PS013)

All UniCare network providers who serve as PCPs will be trained on the importance of, and their responsibility for, coordinating members' health care services. Training will emphasize the nuances of coordinating care for members in the child welfare system, HIPAA restrictions, and appropriately sharing information with the Care Coordination team, members' caregivers, other providers, Department caseworkers, and other stakeholders. Since information sharing is central to the coordination of care, we will also emphasize the importance of sharing accurate and timely information, including Care Plan updates, changes in medications, and hospitalizations.

We will emphasize some of the challenges of coordinating care when there may be limited information about prior care and health histories, and ways providers can address those challenges.

Educating PCPs on Coordinating Physical Health, Behavioral Health, and Socially Necessary Services (PS015)

We currently provide PCPs training on screening, treating, and referring members with BH disorders. Our Academy curriculum includes modules on SBIRT, trauma-informed care, coordination and quality of care, and new models of BH interventions. In addition, we will train all Fostering Healthy Lives network providers on the importance of coordinating PH, BH, and socially necessary services (SNS). Topics will include the roles and responsibilities of our Care Coordinators and how they assist with coordinating a member's medical health services. All providers, including PCPs, who engage with members in the child welfare system, will be trained in the fundamental tenets of our care coordination model, including initial outreach, health risk screening and information gathering, Care Coordinator assignment, care coordination stratification, collaborative trauma-informed care plans, ongoing outreach and engagement, and reassessment. We will also provide training on availability of our telemedicine, telehealth, and other video-conferencing and web-based solutions (described in detail in our response to CM019–CM021) as a means of expanding access for members and facilitating integration of physical and behavioral health.

Educating PCPs on Dental Screenings (PS016)

We will make sure Fostering Healthy Lives network providers serving as PCPs are educated about the importance of dental screenings and how and when to make appropriate referrals to dental providers. We will see that PCPs understand their responsibilities — for example, beginning at six months after the first tooth erupts or by 12 months of age (as part of the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) process), the member should be referred to dental providers — and that fluoride varnish is a covered service that can be applied by a PCP.

Our provider website will include a link to in-network dental providers and offer information on oral health, pediatric oral health, oral health and diabetes, and the importance of dental screenings and their relationship to overall health and disease management (Healthy Mouth = Healthy Body).

Educating and Monitoring PCPs on EPSDT Services (PS017)

Initial and ongoing training via our Academy will include periodicity requirements for EPSDT screenings, the required components of initial and periodic health assessments, and EPSDT coverage even when a recommended service may not be covered under the Program. We will also include periodicity information targeted to specialists serving as members' PCPs in our EPSDT toolkit as part of our Academy and online resources. We will advise providers that no service for a child in the West Virginia child welfare system will be denied, reduced, or terminated before it is reviewed in accordance with our EPSDT policy. This policy will be available in our provider manual and on our provider website.

Ongoing training and monitoring provision of EPSDT services will be the shared responsibility of our Quality Management (QM) Practice Consultants, our Network Relations Consultant, and Care Coordinators. Our QM department will run monthly reports on EPSDT gaps in care and share them with other members of the team. Our Care Coordinator and Concierge teams will be able to contact members, their caregivers, and providers to remind them of the importance of getting timely EPSDT services and facilitate appointment scheduling. Our QM Practice Consultants and Network Relations Consultant will enhance these education efforts during office visits and other interactions to foster awareness of EPSDT requirements and how the office staffs can effectively use our gaps in care reports to outreach to members for appointments.

Our QM Practice Consultants will also audit the charts of members under the age of 21 for timely periodicity screenings. They will conduct focused PCP feedback and education when audit findings disclose average screening rates below 80% to improve performance with EPSDT screening outcomes. If they identify members who have not received required EPSDT services, they will reach out providers to identify any barriers and attempt to remediate them via education. They will inform PCPs about our EPSDT coordination services that are available at no cost. They will also continue to follow up with providers to assess whether performance has improved or if additional actions are required.

Educating Providers on Requesting Out-of-Network Referrals (PS018)

We currently educate our network providers about their ability to request out-of-network referrals and have existing policies and procedures for them to follow. We will modify these, as appropriate, for use by our Fostering Healthy Lives network providers. Additionally, our Network Relations Consultants and Concierge Representatives will be available to assist providers with requesting out-of-network referrals, if needed.

Educating Providers About Foster Care Members and Members with Special Needs (PS020, PS021, PS022, PS023)

UniCare understands that foster care children and those with complex needs will require additional provider support, and that it is our responsibility to see that providers are appropriately prepared to provide it. We will educate primary and specialty care providers, on the unique needs of this population. In addition, through our Academy training, our provider manual, and provider website, we will educate providers on the available tools and resources to help them most effectively serve these members, as described below.

Opportunities for Standing Referrals

Children with complex needs often require ongoing specialist services. UniCare does not require referrals to in-network specialists. Our provider manual contains instructions for providers to obtain authorizations for specialist services. Our Provider Services or Care Coordination departments are available to assist providers in identifying an in-network specialist or arranging specialty care. Authorization is not required to refer a member to an in-network specialist for consultation or a nonsurgical course of treatment. Authorization is required to refer a member to an out-of-network specialist when an in-network specialist is not available in the geographical area.

Opportunities for Specialists to Serve as PCPs

We recognize that it is sometimes in a member's best interest to have a specialist serve as their PCP. We will train providers on the administrative, contractual, and credentialing requirements for a specialist willing to serve as a member's PCP, how to obtain UniCare approval for a specialist to be a member's PCP, and the role of the Fostering Healthy Lives Care Coordinator in assisting with naming a specialist to serve as a member's PCP. During this training, we will also outline the types of specialists that may be allowed to serve as PCPs, including psychiatrists or psychiatric nurse practitioners for members with complex BH conditions. Please refer to our response to ND032–ND035 for a detailed description of our processes and requirements for a specialist to serve as a member's PCP.

Availability of Disease Management

Our Disease Management program plays a significant role in helping our members with chronic conditions meet their health care goals. During training, we educate providers on:

- The overall Disease Management program, including how UniCare works with enrolled members
- How to enroll a member in the program
- Reciprocal referral and sharing of information policies and procedures related to disease management
- The role of UniCare's Centralized Disease Management Care Unit, its telephonic care planning, and education related to the seven categories of conditions
- Value-Added Services (VAS) that UniCare offers related to common conditions (for example, scholarships to Camp Catch Your Breath focused on teaching members with asthma self-management skills; scholarships to Camp Kno-Koma where members learn about diabetes self-management skills; and our Online Well-being program to help members manage stress, anxiety, depression, substance use, and other challenges)
- How to provide feedback on the Disease Management program



Establishing a Provider Quality Rating System and Disseminating Information to Members (PS005)

UniCare will leverage our extensive experience using quality performance data to establish a provider rating system for the Program. We will work with DHHR, our Provider and Parent and Caregiver Advisory Groups, and other stakeholder forums to obtain input on the quality-related information our members would find most beneficial in making informed decisions about their health care. We will then work to establish quality measures, as well as reporting to form the basis of a provider quality rating system, with results that can be disseminated to members to assist them in making informed choices.

We will leverage data obtained through our provider profiling strategy, described in detail in QU038–QU042. We know that not all providers will meet all of the necessary criteria for accurate measurement and profiling. Our experience tells us that measuring quality at a provider-specific level requires a combination of member attributability to a specific provider, actionable quality indicators that are measurable, and sufficient volume of members associated with each quality measure to be able to ascertain provider performance with reasonable accuracy and fairness. Therefore, we will also rely on objective quality-based designations that indicate providers' relevant expertise and experience in serving our Fostering Healthy Lives members, such as ACEs Provider Champions, Gold Star Providers, Foster Care Patient Centered Medical Home designations, and provider participation in our APM programs, as potential quality rating indicators in addition to measures-based ratings.

We will explore the most appropriate ways to make provider quality rating information available to our members. For example, a provider may earn a quality stamp by meeting specified goals or targets. We believe a person-centered approach to disseminating quality rating information to members based on their needs is most appropriate. For example, our Care Coordinators and Concierge Representatives will use quality rating information when coordinating care to connect members with the most appropriate providers; members and their caregivers will then be able to make informed decisions on where to go to receive the highest level of care based on quality rating information. In addition, we will explore including a quality designation on our online provider directory.

Timely Distribution of the Provider Manual (PS006)

UniCare educates providers on the availability of our provider manual at the time of contracting, during orientation, and during Fostering Healthy Lives training.

Our experience has shown our network providers prefer to have access to an online version of the manual. Therefore, during provider training, we give them the website link and carefully detail how they can access the provider manual through our public website. The benefits of having an electronic version of our provider manual include on-demand access and the ability to search for specific topics; however, we will give providers a hard copy of the manual upon request — either at the time of training, or as soon as possible after their request.

Our provider manual is updated at least annually. Notification of updates are posted on our provider website, through fax blasts as appropriate, and during interactions with our Concierge Representatives and Network Relations Consultants.

Our provider manual reinforces learning objectives and facilitates adoption and application of the principles and best practices presented during formal training.

Conducting Outreach to Specialists Regarding Encouraging Members to Seek Primary Care Services (PS014)

Understanding that children and youth in the child welfare system often have complex needs that result in increased medical costs, a higher number of preventable complications, and higher rates of avoidable hospitalizations, we know the importance of stressing that they receive not only the services of specific specialists, but also routine and ongoing primary care services.



In line with the State's goal of enhancing the coordination of care and access to services, including PH, BH, and SNS, we will conduct focused outreach to specialists to stress the importance of encouraging members with complex needs (two or more chronic conditions) to seek primary care services. Our outreach will primarily be conducted by our Care Coordination team. Each Program member will be assigned to a Care Coordinator who will be responsible for making sure the member receives primary care services. The Care Coordinator will reinforce with specialists the importance of encouraging members to seek primary care services, and will also work with members and their caregivers to emphasize the importance of primary care services.

As we educate specialists on the importance of encouraging members with complex needs to seek primary care services, we will also inform them that they can provide those services themselves if they are willing. In addition, we will detail the benefits of patient centered medical homes (PCMHs) in caring for members with complex needs. Our foster care PCMH model is discussed in CM006, CM007, CM008, CM009, and CM010.

Access to Current Medical Records for Member PCPs and Behavioral Health Providers (PS004)

Children and youth often enter the child welfare system with undiagnosed or under-treated health issues and gaps in care. We prioritize sharing comprehensive and up-to-date information with a members' PCPs and BH Providers because it is central to the coordination of care and improving outcomes.

We will leverage our existing information technology capabilities and protocols to make sure each provider has fast access to the most up-to-date information. This includes medical records, information collected by the Concierge team during the intake process, and the Care Plan for West Virginia's children and youth in child welfare.

Information Technology to Facilitate Medical Record Sharing

Capacity for Efficient Care
Provider Pledge

Providers currently access members' health records through our Health Insight platform. Health Insight aggregates and shares actionable data across systems and organizations. Most data is updated in real time (as it is received) or within 24 hours for information that requires manual uploading.

The Health Insight platform includes available data from UniCare's care coordination, utilization management, and claims processing systems. The platform is fully capable of integrating with available Health Information Exchanges (HIEs). Health Insight also aggregates member data from available sources and presents a single health record that provides a complete picture of the member's medical history. Health Insight is fully compliant with all applicable State and federal laws, and supports role-based access to essential information and functionality. Health Insight includes a HIPAA-compliant website that facilitates provider access to a single view of member data in an easy-to-navigate dashboard that includes HEDIS care alerts, authorizations, prescriptions, and claims. It enables sharing of member care coordination information, including screenings, assessments, and the Care Plan.

Through Health Insight, providers can readily access the member's complete health information, which is especially vital during placement transitions and when coordinating care across different disciplines. A longitudinal health and service record that travels with children over time and across placements can improve communication, avoid redundant assessment processes, and reduce service duplication and fragmentation.

Timely Claims Payment (PS007, PS008, PS009, PS010, PS011, PS012)

> On average, we are processing and paying clean claims in 2.31 days.
> WV_FC2019_ProPayClaims_COB01

UniCare has a history of working closely with providers in all regions of the state, identifying and addressing their questions and concerns. One theme that has emerged — particularly from our smaller and rurally based participating providers — is the need for timely claims payment. Many of our providers rely on timely claims payments to pay their staff on time. We understand the need and have worked closely with providers to facilitate timely claims processing and payment times, processing more than 99% of claims within 30 days — many within just a few days. ***In 2019, 99.61% of UniCare provider claims were processed and paid in 30 days. Electronic and paper claims were processed well within the 30-day timeline, with an average turnaround time (from the date of receipt to the date of payment) for both types of claims of only 2.31 days.*** Figure E.6-5 provides a monthly look at the turnaround time for processing claims based on whether they were submitted electronically or by paper.

Figure E.6-5. Average Time to Process and Pay Claims by Method of Claims Submission, in Days

Average Turnaround Time, Days:

	2018 Jun	Jul	Aug	Sep	Oct	Nov	Dec	2019 Jan	Feb	Mar	Apr	May	Jun	Jul	14-Month Average
Electronic	1.99	1.81	1.67	1.50	1.60	1.51	1.54	1.53	1.65	1.71	2.05	2.26	2.31	1.72	1.89
Paper	6.92	7.80	5.87	4.78	8.59	6.69	4.87	4.99	5.90	7.42	6.79	7.17	6.94	8.79	6.86

WV_FC2019_PS007_AvgTurnaroundTime_COB_01

Accepting and Paying Claims On Time for Health Services

In 2019, 99.61% of provider claims were processed and paid in 30 days.
WV_FC2019_PercentClaims_COB_01

Whenever possible, we make health care easier for providers, including reducing administrative burden and processing and paying claims promptly. With more than 16 years of experience serving West Virginia's Medicaid population, we have a strong record of paying claims efficiently and on time. Within the past 14 months, an average of 83.8% of the claims we received from providers were clean claims, or claims that could be automatically adjudicated without being denied or sent back to a provider or third party for additional information. Of those clean claims, we successfully processed and paid most within 30 days; and virtually all within 90 days, as shown in Figure E.6-6. We will continue to meet our contractual requirements to pay clean claims, including PH and BH services claims, within 30 calendar days of receipt, and always strive to pay claims more quickly, if possible.

Figure E.6-6. Percentage of Clean Claims and Processing Time, by Month

	Month End Date 6/30/18	7/31/18	8/31/18	09/30/18	10/31/18	11/30/18	12/31/18	01/31/19	02/28/19	03/31/19	04/30/19	05/31/19	06/30/19	07/31/19
Clean Claims (CC), Percent of Total Claims	82.1%	83.2%	83.6%	84.5%	84.2%	84.9%	85.0%	85.8%	83.4%	83.7%	84.2%	81.9%	82.5%	83.0%
CC Processed in 30 Days Percentage	99.6%	99.6%	99.9%	99.9%	99.8%	99.8%	100.0%	99.9%	100.0%	99.7%	99.9%	99.9%	99.9%	99.9%
CC Processed in 90 Days Percentage	100.0%	100.0%	100.0%	100.0%	99.8%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

WV_FC2019_PercentTotalClaims_COB_01

We encourage our current providers to submit clean claims by offering them resources such as orientation and follow-up training (discussed in greater detail in the Provider Services introduction), an online provider manual that includes our Concierge Line contact information and instructions on how to submit clean claims with links to key resources, and an online provider portal to submit and check claims status (discussed in greater detail at PS024 and PS025). We will offer these same resources to our new Program providers. We will also continue to accept both paper and electronic claims to accommodate different provider technologies and preferences, but do encourage electronic submission when possible to facilitate faster claims processing and payment.

We also plan to provide new Program providers with new resources to afford them additional, dedicated support. They will have access to the locally based Concierge Representatives to help address additional questions and concerns they have related to their Fostering Healthy Lives patients, including claims questions. If the Concierge Representatives cannot address the provider's issue, the call will be transferred directly to someone who can help, further facilitating timely claims submission, processing, and payment.

Establishing and Implementing Guidelines to Approve Out-of-Network Provider Claims for Physical Health and Behavioral Health Services (PS008)

Members will be permitted to retain their current provider for 90 calendar days, even if that provider is not in our network. Following this 90-day timeframe, we have guidelines in place to approve out-of-network (OON) provider claims for PH and BH services, including those for hospitals. We will continue to adhere to State and federal policies, and will make any necessary adjustments to our guidelines to address the unique needs of the child welfare population.

We encourage providers to join our network by offering them higher levels of reimbursement than we offer OON providers. This strategy has been effective; we are currently contracted with over 14,000 providers, including all acute care and tertiary hospitals and all three West Virginia children's hospitals. If a provider does not join our network, their claims are typically reimbursed at 80% of the Medicaid Fee Schedule, with the exception of emergent and family planning services, which will be reimbursed at 100% unless otherwise negotiated, and will not require prior authorization. Depending on the needs of our members, we may also choose to execute a single case agreement (SCA) to pay OON providers up to 100% of the Medicaid Fee Schedule for a defined period of time. In these instances, our claims system is configured to process these claims based on the negotiated SCA rate.

For services that do require prior authorization, a nurse will review all requests to determine if they meet criteria and will enter the authorization into our system if deemed appropriate. Our claims processing system is configured to automatically check for these authorizations when OON provider claims are received, and will pay 80% of the Medicaid Fee Schedule or the negotiated SCA rate. If providers do not obtain prior authorization, we will still pay their claims if they (1) submit clinical information with the claims, (2) the post-service review teams determine the service was medical necessary, and (3) they accept the reason given for not obtaining prior authorization.

Our Review Process for Emergency Services Payments

We automatically process and pay all clean emergent claims for in- and out-of-network providers, except for certain claims designated as emergency room (ER) Triage. ER Triage claims will be "pended" and routed for review and determination of the appropriate level of care for payment if they are:

- Billed with ER Triage levels 3-5 with attached medical records
- Have codes that may not meet the prudent layperson standard for emergent services

UniCare does not use algorithms to process pending claims; instead, we have each pending claim reviewed by a qualified analyst. We follow the State's definition of "prudent layperson" when reviewing pending claims payments. If a person with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of an individual or unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part, the condition could be considered an emergency medical condition.

We facilitate 24-hour access to all needed emergency services and cover the cost of services necessary to screen and stabilize members without pre-authorization.

After the service has been rendered without a prior authorization, we perform post-service reviews. A qualified (licensed clinical or highly skilled, non-clinical) Registered Nurse (RN) assesses the medical necessity or level of care for emergency services rendered without prior authorization, regardless of whether the provider is in- or out-of-network, in- or out-of-state. The assessment will be based on factors such as diagnosis, medical treatment, timeliness of services rendered, and factors that impact the decision to use emergency services. Services will be covered if staff determines the services were medically necessary, met the prudent layperson standard, or if the member was referred to the services by an authorized representative, such as an in-network PCP or nurse advice line Nurse.

UniCare's Support of e-Prescribing Functions (PS019)

Per the Vendor Response Guidance on the Detailed Specifications from Addendum 3, we are providing a general description of the strategies we would use to meet these specifications if pharmacy benefits are carved in at a future date.

UniCare believes strongly that e-Prescribing will continue to play a vital role in health care. As electronic health records (EHR) become standard, converting physicians to electronic prescribing (e-Prescribing) becomes increasingly more important in creating a more efficient and better informed health care system. E-Prescribing results in measurable waste reduction through improved generic utilization and formulary compliance, as well as reduction in adverse drug events, while improving therapy adherence. In partnership with our affiliate pharmacy benefit manager (PBM), IngenioRx, UniCare providers will be able to leverage real time e-Prescribing through their EHR and have access to formulary information. The e-Prescribing tool is integrated into the EHR and provides details on formulary options for members.

E-Prescribing will enable eligibility confirmation, preferred drug list (PDL) benefit confirmation, identification of "alternative" (as in preferred) drugs that can be used instead of non-preferred drugs, medication history, and prescription routing. In addition, we will have customized e-Prescribing messages for certain preferred products that alert providers if they choose a non-preferred drug.

We will provide an e-Prescribing capability called Real-Time Benefit Check (RTBC). Providers can access real-time, ***member-specific*** prescription drug benefit information at the point-of-care. It is part of the e-Prescribing process, and is located within a provider's EHR system.

This functionality helps providers determine prescription coverage more quickly by sharing information about patient drug cost, formulary, and coverage alerts such as prior authorization (PA) before sending a prescription to the pharmacy. This information can help providers proactively identify barriers to medication compliance. For example, if a medication requires a PA, alternatives can be discussed before the patient leaves the provider's office.

Providers can find the following patient-specific prescription benefit information with their EHR:

- Formulary status of selected medication
- Pricing of medication at a retail and mail order pharmacy
- Formulary alternatives
- Coverage alerts, including PA and step therapy

Providers will have the ability to electronically prescribe medication while having access to a wealth of relevant, real-time member information. This tool promotes greater efficiency and member safety through real-time delivery of clinical and economic decision support at the point-of-care. It also provides the following services:

- **Member Information Sharing.** Supplies provider EHR systems information about member eligibility and history.
- **Prescription Benefit.** Delivers member-specific benefit and formulary information that enables physicians to write compliant prescriptions the first time.
- **Prescription Routing Services.** Provides direct electronic delivery of a new prescription from a physician to an in-network pharmacy of the member's choice.
- **Prescription History.** Delivers prescription history information across providers during a member's office visit. This service can also facilitate reconciliation support for those in an inpatient setting, and promotes safety by avoiding drug-drug interactions.

The e-Prescribing framework promotes increased safety and convenience for members and increased efficiency in the prescription creation and delivery process.

We will also offer e-PA through the provider's e-Prescribing tool, if available, which enables providers to submit their PA requests electronically and securely. The e-PA capability enables providers to submit required clinical documentation, answer PA criteria questions, and receive the status of the PA request. The e-PA programming logic identifies the member, determines if the prescriptions require a PA, and presents the criteria to the prescriber in real-time. The PA

criteria question set has decision-tree logic to present only the questions required to determine medication necessity. After answering all required questions, the prescriber will submit the responses for medical necessity determination. When appropriate, the prescriber will receive automatic approval. The ability to receive automatic approvals with e-PA expedites the process, reduces the administrative burden of submitting a traditional PA request, and fosters a positive member and provider experience.

We will work with IngenioRx to assess prescribers' current level of e-Prescribing utilization and identify opportunities to encourage further adoption. We will educate prescribers about the availability and use of e-Prescribing through training and communications to support continued growth in the utilization of this valuable service.

Easy to Use Public Provider Website (PS024)

We maintain a comprehensive provider website that maximizes usability and administrative simplicity. Our provider website features both public and secure sides, offering a variety of tools and resources for stakeholders, including an online copy of our provider manual. The website includes a variety of training and educational resources from the latest provider communications to toolkits, such as our EPSDT Toolkit — all designed to make the provider's job easier. In addition, we display basic information and tools, such as PA procedures, formularies, and reimbursement policies. We use the website to deliver information to providers and other stakeholders, including announcements, alerts, and forms. Providers can also contact our Concierge Representatives who can help with site registration and queries about website content.

Secure Provider Portal Provides Access to Key Information and Tools (PS025, PS026, PS027, PS028)

Registered providers have access to additional tools and functions via our secure portal, including our Health Insight platform. To simplify access and use, we deploy our provider portal through Availity. Availity is a multi-payer portal that gives providers no-cost access to multiple payers' information with a single secure log-on. Within Availity, providers use the UniCare Payer Space. Our integration with Availity through this Payer Space provides a UniCare-branded experience for our providers.

Our provider portal opens the door to a secure, 24/7/365, mobile-compatible environment with information and transactions that providers rely on for partnering with UniCare. Providers and their staff have access to information resources and self-service tools that enable them to complete business transactions with UniCare, including requests for service authorizations, authorization status verification, access to medical records, and utilization history, when it is convenient for them and without spending time calling the Fostering Healthy Lives Concierge team.



Portal Functionality (PS026, PS027, PS028)

Our provider portal complies with HIPAA, State and federal Medicaid managed care requirements. The portal does not store health information; it only exchanges information in strict compliance with security and privacy requirements. UniCare manages Protected Health Information (PHI) consistent with HIPAA guidelines and uses encryption when transmitting sensitive information. Providers and their authorized users log-in to UniCare's provider portal by registering with Availity and creating user accounts with defined roles and permissions. To register for Availity, the designated administrator for the provider organization visits Availity.com to create and maintain organization information and additional system users. Administrators set up roles and permissions, controlling who has access to sensitive health and financial data. Every organization must have at least one administrator. The provider's administrator establishes role-based access for the functionality defined in Table E.6-2.

Table E.6-2. UniCare Provider Portal Functions

Portal Function	Description
Prior Authorizations (PS027)	The portal's Interactive Care Reviewer (ICR) gives providers easy access to submit a service authorization request and associated documentation. The ICR includes a search feature and supports sorting on status, service dates, requesting National Provider Identifier (NPI), and patient name.
Medical Records and Patient Health and Treatment History (PS026, PS028)	Through our Health Insight platform, providers have access to a real-time dashboard that gives them a picture of their patients' health and treatment histories, including the ability to drill down to specific items in a record to get demographic information, care summaries, claims details, PA details, pharmacy information, and care management activities.
Verification of Client Eligibility and Benefits	Providers can check eligibility of one member, or use online batch management to check eligibility for multiple members. Users must identify members by a unique ID and either their date of birth or their name. The unique ID can be either their UniCare ID or their West Virginia Medicaid ID. Providers may also choose to register as a Trading Partner with UniCare to send and receive 270/271 EDI transactions, real-time or batch, through a clearinghouse.
Claims Submission and Status Inquiry	Providers can submit individual claims using direct data entry, and complete batch submission through upload of HIPAA EDI-compliant files. They can also submit clinical data for medical claims via HIPAA-compliant 275 transactions on the provider portal, or as a Trading Partner through EDI. Providers can submit professional and institutional claims through the provider portal. If using direct data entry, the portal offers "express entry," a feature that eases entry by auto-populating certain fields once an NPI or Tax Identification Number (TIN) is entered. Providers may complete a claim status inquiry in the portal. The response returns claims matching inquiry criteria. Users select from the result set to view the details of the selected claim. Providers may also choose to register as a Trading Partner to send and receive EDI transactions through a clearinghouse. In the case of claims submission, this includes the 837P and 837I; in the case of claim status inquiry and response, this includes the 276/277.
Prior Authorization Appeals	Providers will be able to submit prior authorization medical appeals using the ICR, and will also be able to check the status of appeals.
Claims Appeals	Providers can upload relevant supporting documentation for a payment appeal to the provider portal, including the original Explanation of Payment, corrected claim, invoices, medical records, and reference materials.
Submission of Clinical Data	Providers can submit unsolicited and solicited medical attachments via the portal associated with claims. Providers can also submit clinical data with authorization requests.
Remittance Advice and Explanation of Payment	Providers will be able to access an image of the paper remittance advice and can search by check number, electronic funds transfer (EFT), or by remittance date ranges. Providers may also receive their 835 remittance advice via EDI.

Portal Function	Description
Handling Appeals and Recoupments Due to DHHR Retrospective Eligibility Changes	The portal hosts information on handling appeals for recoupments due to DHHR retro-eligibility changes. Providers may submit a claims dispute or an appeal for recoupment on the provider portal.
PCP Panel Listing	PCPs can research and download a complete list of their past and current assigned members through the portal's Online Reporting tool.
Precertification Lookup Tool	Providers can search by member's plan and CPT® code to determine if a service requires precertification.

Portal Access for Department Caseworkers and Other Stakeholders (PS025)

UniCare will be using the YouthRAP portal to provide Department caseworkers, caregivers, and other authorized stakeholders with role-based access to medical records, authorization details, Care Plans, and other patient data. This solution will link caregivers to their assigned members and will provide designated stakeholders role- and assignment-based access to Care Plan and medical record data, including notifications and alerts. YouthRAP also provides access to members and their Authorized Representatives. The patient health record information in YouthRAP will be the same data that is available to providers via the secure provider portal. Additional details on the YouthRAP portal are provided in our response to MS048, MS049, MS050, and MS051.

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7. QUALITY

The Vendor should refer to the relevant specifications located in **Appendix 1: Detailed Specifications** (based on the categorization within Column E: Subject Matter Area) and pertinent narrative in **Section 4: Project Specifications** in this RFP, and then describe its approach to Network Development below. The Vendor's narrative response should not exceed 60 pages.

QU001	The Vendor should reward physical and behavioral health providers that adhere to the quality or performance standards of the Department.	The Vendor should describe how it will meet this specification, as well as any other ways they would actively work with network providers to ensure accountability and improvement in the quality of care provided.
QU002	The Vendor should share best practice methods or programs with physical and behavioral health providers, and should provide identified best practice methods or programs to the Department for consideration in sharing with socially necessary services (SNS) providers.	The Vendor should describe how it will meet this specification, as well as any other ways it would actively work with network providers to ensure accountability and improvement in the quality of care provided. The Vendor should describe which best practice methods it employs to its provider network.
QU003	The Vendor should take action against physical and behavioral health providers that demonstrate unacceptable performance and should share identified socially necessary services (SNS) provider performance deficiencies with the Department.	1) The Vendor should describe the standards it uses to assess provider performance. 2) The Vendor should describe how it will meet this specification, as well as any other ways they would actively work with network providers to ensure accountability and improvement in the quality of care provided.
QU004	The Vendor should adopt strategies to simplify administrative procedures.	The Vendor should describe how it will meet this specification.
QU005	The Vendor should administer a Quality Assurance and Performance improvement (QAPI) Program.	The Vendor should describe how it will meet this specification.
QU006	The Vendor should use Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	The Vendor should describe in detail how it will meet this specification.
QU007	The Vendor should use measures beyond Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	The Vendor should describe proposed measures beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS).
QU008	The Vendor should report measures to the Department according to the requirements	The Vendor should describe how it will meet this specification.

	in the Service Provider Agreement (SPA), including, but not limited to, the following:	
QU009	Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.
QU010	Measures that go beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.
QU011	The Vendor should use alternative payment structures for those providers over which the Vendor has direct contract oversight--including, but not limited to, provider incentives and/or overcoming limitations of diagnosis-driven eligibility--for the percentage of provider contracts identified in the Service Provider Agreement (SPA) to increase healthcare quality and efficiency through collaboration and innovation to improve access to comprehensive healthcare.	The Vendor should describe: 1) A plan for alternative payment structures 2) Mechanics by which incentive payments to providers to improve quality of care would be made 3) Quality metrics that would be required for provider incentives and shared savings
QU012	For those providers over which the Vendor has direct contract oversight, the Vendor should identify and incorporate into alternative payment structures opportunities including, but not limited to the following:	The Vendor should describe how it will meet this specification.
QU013	Cost savings	See the parent specification.
QU014	Reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions	See the parent specification.
QU015	The Vendor should design and implement payment models with network providers (over which the Vendor has direct contract oversight) that tie reimbursement to measurable outcomes and ensure appropriate care is delivered in the most appropriate place and time.	The Vendor should describe how it will meet this specification.
QU016	The Vendor should report annually to the Department on its activities related to alternative payment structures for those providers over which the Vendor has direct	The Vendor should describe how it will meet this specification.

	contract oversight, according to the Service Provider Agreement (SPA).	
QU017	The Vendor should monitor quality Improvement strategies with measurements including, but not limited to, the following:	The Vendor should describe in detail how it will meet this specification.
QU018	Access to care	See the parent specification.
QU019	Demand for services	See the parent specification.
QU020	Quality of care	See the parent specification.
QU021	Health outcomes	See the parent specification.
QU022	Member satisfaction	See the parent specification.
QU023	The Vendor should analyze utilization data to monitor quality improvement strategies.	The Vendor should describe in detail how it will meet this specification.
QU024	The Vendor should collect and analyze quality measures at a set frequency.	The Vendor should describe in detail how it will meet this specification.
QU025	The Vendor should report annually to the Department on its activities related to access to care, according to the Service Provider Agreement (SPA).	The Vendor should describe in detail how it will meet this specification.
QU026	The Vendor should use data to identify barriers to care for individuals with special healthcare needs, including, but not limited to, the following data collection methods:	The Vendor should describe in detail how it will meet this specification.
QU027	Focus groups	See the parent specification.
QU028	Surveys	See the parent specification.

QU029	"Secret shopper calls"	See the parent specification.
QU030	Aggregate utilization monitoring	See the parent specification.
QU031	The Vendor should develop, update, and disseminate clinical guidelines to participating providers.	The Vendor should describe how it will meet this specification.
QU032	The Vendor should follow a process to address quality issues, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.
QU033	What steps will be taken	See the parent specification.
QU034	Who is responsible for addressing issues	See the parent specification.
QU035	Timeframes for resolution	See the parent specification.
QU036	The Vendor should initiate data-driven clinical initiatives that yield improvements in clinical care for applicable populations.	The Vendor should describe: 1) Data-driven clinical initiatives that the Vendor initiated within the past 24 months that have yielded improvement in clinical care. 2) Statistically significant improvements generated by these clinical initiatives.
QU037	The Vendor should establish and collect member satisfaction measures following the implementation date.	1) The Vendor should provide proposed member satisfaction measures. 2) The Vendor should describe past Vendor efforts to assess member satisfaction.
QU038	The Vendor should profile the quality of care delivered by network providers, including, but not limited to, the following:	1) The Vendor should describe its practice of profiling the quality of care delivered by network providers. 2) The Vendor should provide the methodology for determining which and how many providers will be profiled.
QU039	Primary care providers (PCPs)	See the parent specification.
QU040	High-volume specialists	See the parent specification.

QU041	Hospitals	See the parent specification.
QU042	Other acute care providers	See the parent specification.
QU043	The Vendor should monitor and reinforce primary care provider (PCP) compliance with program requirements for applicable populations.	1) The Vendor should describe how it will meet this specification, in general. 2) The Vendor should describe specifically how it will meet this specification for program requirements including, but not limited to, 24-hour coverage, appointment scheduling, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity standards.
QU044	The Vendor should use data to identify access barriers for members with special needs, including, but not limited to, the following data:	The Vendor should describe in detail how it will meet this specification.
QU045	Complaints and grievances	See the parent specification.
QU046	Primary care provider (PCP) change requests	See the parent specification.
QU047	Out-of-network referrals	See the parent specification.
QU048	Emergency room (ER) usage	See the parent specification.
QU049	The Vendor should use reports/data from subcontractor(s),as applicable, to ensure appropriate subcontractor oversight and the following member-related outcomes:	The Vendor should describe how it will meet this specification.
QU050	Access to care	See the parent specification.
QU051	Member satisfaction	See the parent specification.
QU052	Continuity of care	See the parent specification.

QU053	The Vendor should run data at a set frequency to identify which members in applicable populations have not received primary care services.	The Vendor should describe: 1) Types of data the Vendor will use to determine which members have/have not received primary care services 2) Any other mechanisms the Vendor will use to determine which members have/have not received primary care services 3) Who is responsible for tracking this data 4) How frequently the Vendor will run this data
QU054	The Vendor should contact members within a set timeframe after identifying which members in applicable populations have not received primary care services.	The Vendor should describe in detail how it will meet this specification.
QU055	The Vendor should contact the member's primary care provider (PCP) within a set timeframe after identifying that a member has not received primary care services, for applicable populations.	See the parent specification.
QU056	The Vendor should analyze and synthesize reports on data about members In applicable populations who have not received primary care services.	The Vendor should describe in detail how it will meet this specification.
QU057	The Vendor should establish and implement ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	The Vendor should describe how it will meet this specification.
QU058	The Vendor should periodically enhance ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	1) The Vendor should describe how it will meet this specification. 2) The Vendor should describe when it will perform quality initiative monitoring activities.

PROVIDER INCENTIVES AND VALUE-BASED ALTERNATIVE PAYMENT MODELS (APMS)

Using Alternative Payment Structures to Increase Quality and Efficiency to Comprehensive Health Care (QU011)



Using alternative payment structures to increase quality and efficiency through ***accountable reimbursement*** is a key pillar of our ***Provider Pledge***. Together with our affiliated health plans, we are a leader in the use of alternative payment models (APMs) that result in improvements to quality, access, and evidence-based clinical performance while containing costs.

In West Virginia, UniCare Health Plan of West Virginia, Inc. (UniCare) has used provider incentives and rewards to drive improvements in quality and access since 2015. ***Currently, 40% of our members and 40% of our medical spending in West Virginia is with providers who participate in our Provider Quality Incentive Program (PQIP):***

- In 2015, UniCare began providing incentives for school-based health clinics for improvements in the provision of well-child exams.
- In 2017, UniCare implemented our PQIP for high-volume primary care providers (PCPs). In West Virginia, 23 PCP groups with more than 49,800 assigned members participate in our PQIP.
- In 2019, UniCare further expanded the scope of our APMs to include behavioral health (BH) services through implementation of our Behavioral Health Quality Incentive Program (BHQIP).
- We will continue to expand our array of APMs in West Virginia to include a larger segment of our PCP network. We will do this through implementation of our PQIP Essentials (PQIPE) and Pay for Quality (P4Q) programs, which will make participation in APMs available to smaller volume and rural PCPs across West Virginia.
- We will further expand our array of APMs focused on specialized services through implementation of our Obstetrical Care Quality Incentive Program (OBQIP) and Behavioral Health Facility Incentive Program (BHFIP), and BH/physical health (PH) integration through our Integrated Care Quality Incentive Program (ICQIP).
- We will implement additional APMs focused on services that are particularly relevant to the needs of our Specialized Managed Care for Children and Youth Program (the Program) members, specifically our Foster Care Access Incentive Program (FCAIP), Pediatric Residential Treatment Facility Quality Incentive Program (PRTQIP), and our Social Determinants of Health Provider Incentive Program (SDOHPIP).

In addition, we are currently in discussions with West Virginia Health Network (WVHN), a newly formed accountable care organization (ACO) that is currently comprised of 12 primary care practices, to implement our first negotiated risk shared savings (NRSS) program in West Virginia. Both parties are eager to have an agreement in place for 2020.

We will continue to leverage the extensive experience of our affiliates in the broad-based adoption of value-based programs and APMs in West Virginia to drive improvements in evidence-based, clinical performance. Our expanded array of current and proposed APMs is detailed in Figure E.7-1. By deploying innovative APMs, we help to drive locally provided care coordination with a focus on improving health outcomes and eliminating gaps in care, reducing low value care, and supporting the care delivery system by providing participants with actionable, real time data and analytics.

Our APM Strategic Focus

Our APM strategy for the Program is designed to advance DHHR's goals and objectives for improved coordination and access, improved health outcomes, and increasing family-centered care through provider collaboration and innovation to increase quality, efficiency, and access to comprehensive health care services. We will do this by implementing an expanded array of APMs and supports for providers centered around the following strategic focus areas (Figure E.7-1):

- Expanding access to preventive care and wellness
- Enhancing quality, efficiency, and cost of care savings
- Incenting integration of PH and BH and specialty services
- Enhancing focus on social determinants of health (SDOH) and support for socially necessary services (SNS)
- Recognizing and rewarding providers for innovation and use of best practices

Figure E.7-1. UniCare's APM Strategic Focus

UniCare APM/Provider Incentive Strategy Focus Areas

Access and Wellness	Population Health	Specialized Services	Social Determinants and Supports	Provider Recognition Incentives
Focus on enhancing access, preventive care, and wellness • School-based Well-visit Incentive Program (SBWIP) • *Foster Care Access Incentive Program (FCAIP)** • *Pay for Quality (P4Q)**	**Focus on enhancing quality, efficiency, and total cost of care savings** • Provider Quality Incentive Program (PQIP) • *PQIP Essentials (PQIPE)** • *Negotiated Risk/ Shared Savings (NRSS)**	**Focus on specialized services and BH/PH integration** • Behavioral Health Quality Incentive Program (BHQIP) • *Obstetrical Care Quality Incentive Program (OBQIP)** • *Integrated Care Quality Incentive Program (ICQIP)** • *Behavioral Health Facility Incentive Program (BHFIP)** • *Pediatric Residential Treatment Facility Quality Incentive Program (PRTQIP)**	**Focus on social determinants of health and socially necessary services and supports** • *Social Determinants of Health Provider Incentive Program (SDOHQIP)**	**Focus on recognition of providers who demonstrate innovation and best practices** • *Adverse Childhood Events (ACE) Provider Champion** • *Physician Innovation Champion Award** • *Trauma-informed Care Blue Ribbon Providers (Blue Ribbon Providers)** • *Foster Care Patient Centered Medical Home Recognition (FC-PCMH)**

**Indicates proposed program*

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Provider collaboration and promoting accountability for value through provider partnership and engagement is part of our strategy to help assure access to high quality and cost-effective health care. Our care delivery transformation and APM strategies help make sure the majority of our members receive care from high-performing, engaged providers that collaborate with us because of our competitive value proposition. Through our provider engagement model, we provide extensive support to our APM providers to optimize results through data sharing and performance reporting, expert consultation, and ongoing support to help providers meet quality and performance targets and implement targeted interventions.

Our APM Framework

UniCare's APMs increase the level of reward providers can earn based on improvements in quality and member outcomes. Our APMs align with the Health Care Payment Learning and Action Network (HCP-LAN) APM categorization and framework (Figure E.7-2). Our APM continuum is designed to incent, encourage, and support provider movement along the continuum, and increase the level of rewards for providers with the organizational and technical ability to assume greater

responsibility and financial risk. To support a population health focus, our APMs encompass all members attributed to the APM provider so as not to limit program participation based on diagnosis-driven eligibility. To ease provider administrative burden, we leverage industry-standard measure sets such as HEDIS®, which can be assessed based on claims data (versus medical record audits) to measure quality performance in our APMs. As such, only members who meet the criteria for each specific measure (for example, age, gender, diagnosis, or other qualifying criteria) will be counted toward performance assessment of that measure.

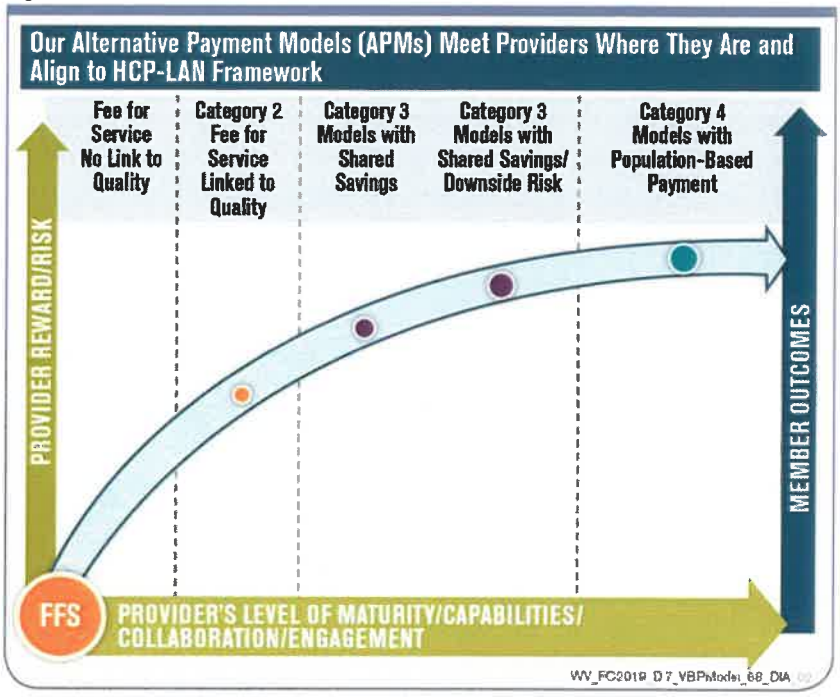
Our continuum of APMs includes HCP-LAN Category 2 programs in which providers receive incentives for meeting specified quality, cost, or efficiency targets. In addition, we are able to offer Category 3 as well as Category 4 APMs in which providers can share in savings derived from improvements in quality and medical cost management (such as PQIP), or programs in which providers assume financial risk for effective population health management.

Our risk-based APMs require providers to meet specific financial solvency requirements in order to participate in our downside risk arrangements.

When developing and implementing APM models we consider various factors:

- Provider interest and capability to assume risk and level of sophistication in the provider community
- Current reimbursement structures
- Contractual requirements
- Geography (such as the urban and rural geography)

Figure E.7-2. UniCare's APM Continuum



Following program implementation, we monitor APM outcomes to determine the effectiveness of each of our APMs and any future adjustments that may be needed to meet the needs of the Program. Through our Care Delivery Transformation program, we encourage innovation and provider collaboration to increase quality and drive improvements in member outcomes. We work with providers to assess their comfort levels with APMs and their readiness to progress to higher levels within the value-based continuum.

Strategies for Rural and Small Volume Providers

Smaller volume and rural area providers who may lack sufficient panel size are often not eligible for participation in APM programs. However, UniCare's array of APMs encompasses programs for providers of all sizes in both urban and rural settings. For example, our FCAIP and P4Q programs are available to all PCPs regardless of panel size. Our PQIPE program is available to PCPs with as few as 250 assigned members. In addition, we have the ability to offer participation in shared savings arrangements through collaborative multi-provider agreements for provider entities who separately may not have the minimum membership or administrative capacity needed for participation in these models.

Strategies for Enhancing Access and Wellness for Children in the Child Welfare System

To further assure access for our Program members, we will offer FCAIP, a provider incentive program to make sure that members newly enrolled and re-enrolled in the child welfare system receive initial health assessments, comprehensive Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) exams, and medical, dental, and trauma assessments within the timeframes prescribed by DHHR. This additional payment is designed to recognize the immediate need for these services and the additional time and complexity of performing these services for children in the Fostering Healthy Lives model, and to offset financial barriers related to access due to historically low Medicaid reimbursement for these services.

Our Current and Proposed APMs

Table E.7-1 lists each of the current and proposed APMs within our strategic focus areas that we are prepared to offer to network providers and includes descriptions of the incentive payment mechanism of each program.

Table E.7-1. UniCare's Array of APMs for Our Members in the Child Welfare System in West Virginia

APM	Description	HCP/LAN APM Category	Provider Types	Implementation Timeframe
Access and Wellness				
Foster Care Access Incentive Program (FCAIP)	Under FCAIP, providers will have the opportunity to earn an enhanced payment rate for each eligible encounter for completion of comprehensive EPSDT exams, including dental, hearing, developmental, and trauma screenings within 30 days of placement in foster care. Earned incentives will be paid quarterly at enhanced fee for eligible claims for specified CPT® and Dx codes.	2C	PCPs	Proposed for implementation in 2020 upon award
School-based Well-visit Incentive Program (SBWIP)	Developed in collaboration with the West Virginia School-based Health Assembly, SBWIP incentivizes school-based health centers for completion of well child and well adolescent exams, nutritional and physical activity assessment and counseling. SBHCs receive a $25 incentive payment following timely submission for each completed medical record reflecting a well visit for children in targeted age categories.	2C	School-based health centers (SBHCs)	Active since 2015
Pay for Quality (P4Q)	P4Q incents providers for closing HEDIS care gaps. Providers receive monthly care gap reports that identify members needing specified preventive or chronic condition interventions. Related education encourages participation in improving quality metrics and health outcomes.	2C	PCPs and other rendering providers	Proposed for implementation in 2021

APM	Description	HCP/LAN APM Category	Provider Types	Implementation Timeframe
Total Population Health Focus/Shared Savings				
Provider Quality Incentive Program (PQIP)	PQIP incents select PCP practices to undertake systematic improvements that affect health care outcomes and cost trends. Practices must participate with us for at least one year and have at least 1,000 assigned members to participate.	3A	PCPs, Hospitals with PCPs, ACOs, Independent Practice Associations (IPAs)	Active since 2017
PQIP Essentials (PQIPE)	PQIPE incents smaller practices, focusing on PCPs with at least 250 attributed members. Providers receive quarterly and year-end scorecard reports. Earned incentive payments are made annually.	3A	PCPs	Proposed for implementation in 2020
Negotiated Risk/Shared Savings (NRSS)	NRSS uses quality metrics as a gateway to shared savings eligibility to encourage efficient, preventive, and cost-effective health care practices. Providers with 500 or more attributed members can accept upside-only risk or both upside and downside exposure.	3A/3B	PCPs, Hospitals with PCPs, ACOs, IPAs	Proposed for implementation in 2020
Specialized Services Focus				
Behavioral Health Quality Incentive Program (BHQIP)	Our BHQIP incents Comprehensive Behavioral Health Centers (COMPs) and Licensed Behavioral Health Centers (LBHCs) to improve coordination of members' PH and BH needs and the quality of care provided to those with BH conditions. Providers receive incentive payments for achieving performance targets on specific measures important to members' health (for example, reduction in BH inpatient readmission rates, decrease in emergency room [ER] visits, increased PCP visits, and follow-up after discharge for treatment of a mental health disorder). We make earned payments annually.	2C	COMPs, LBHCs	Implemented in 2019
Integrated Care Quality Incentive Program (ICQIP)	Under ICQIP, BH providers will be incented to enter into Care Compacts with PCPs who participate in PQIP or other incentive programs. BH providers will have an increased ability to earn an incentive the more integrated they become with PH providers, as the incentive measures are focused on both BH and PH. PH providers will have an increased ability to earn increased incremental incentives in their existing arrangements.	2C	COMPs, LBHCs PQIP/ PQIPE/ NRSS PCPs	Proposed for implementation in 2020

APM	Description	HCP/LAN APM Category	Provider Types	Implementation Timeframe
Behavioral Health Facility Incentive Program (BHFIP)	Our BHFIP incents BH inpatient facilities for providing quality care and service to our members with long-term service and support needs. Facilities participating in the program that meet quality, service, and utilization goals will be eligible to receive incentive payments for improvements in indicators related to clinical quality, patient outcomes, patient satisfaction, cost management, and integration with PH (such as 30-day readmission rates, seven-day follow-up rates, and admission screening for violence, substance use disorder, and psychological trauma risk).	2C	BH Facilities	Proposed for implementation in 2020
Obstetrical Quality Incentive Program (OBQIP)	OBQIP incents OB providers with at least 10 attributed members for improving access, quality of care, and outcomes for members with OB needs throughout all phases of their pregnancy. OBQIP providers receive periodic reports indicating interim performance throughout the year, and an annual performance scorecard. We make earned incentive payments annually.	2C	OB Providers	Proposed for implementation in 2020
Pediatric Residential Treatment Facility Quality Incentive Program (PRTQIP)	PRTQIP incents eligible PRTFs to provide quality care and service to our pediatric members, and for collaborating to support effective discharge and post-discharge management of both BH and PH services. PRTQIP providers that meet specified quality and utilization performance targets receive incentive payments twice annually. In addition, PRTFs receive a bonus for each occurrence of a successful transition of a member from the PRTF to the in-state community setting when the member remains in the setting for at least six months following the PRTF discharge.	2C	PRT Facilities	Proposed for implementation in 2020
Social Determinants of Health and Social Supports Focus				
Social Determinants of Health Provider Incentive Program (SDOHPIP)	SDOHPIP offers incentives to PCPs and other eligible providers for completion of SDOH assessments using an SDOH screening tool and referral of member to community resources.	2C	PCPs	Proposed for implementation in 2021

Including SDOH in Provider Value-based Payment Programs

UniCare currently offers an SDOH incentive program to Preferred Community Health Partners (PCHPs) for completion of SDOH assessments for members in case management using a 10-question SDOH screening tool. For 2021, we will expand our SDOH incentive program to additional PCPs participating in PQIP or PQIPE to include an incentive tied to a provider's assessment of their patient's SDOH and connection to community resources.

Incorporating Opportunities for Cost Savings (QU012, QU013)

Enabling provision of the right care at the right time and the right place through collaboration and incentives is at the core of our APM and provider collaboration strategy. We use our incentive programs to engage providers and encourage them to collaborate with us to improve member outcomes. We believe opportunities exist for cost savings through reductions in unnecessary services, such as potentially avoidable emergency department utilization, potentially avoidable readmissions, provider preventable conditions, as well as improvements in care coordination and integration of PH and BH services and social factors that adversely affect health.

All our APMs drive cost savings through incenting providers to improve access and quality and reduce inefficiencies in utilization; however, our population health-focused programs, which include shared savings arrangements, are particularly effective in driving cost savings. ***For example, for the 2017 and 2018 performance years, our PQIP participating providers achieved costs savings from reductions in medical loss ratio (MLR) by more than 6% annually compared to target MLR, and as a result earned more than $2.0 million in incentives derived from shared savings and quality performance.***

Incorporating Opportunities for Reductions in Inappropriate Utilization (QU012, QU014)

Our APMs include measures and goals that incent reductions in inappropriate and unnecessary utilization of services, as detailed in Table E.7-2.

Table E.7-2. UniCare APMs Incent Reduction in Unnecessary Services

Service	APMs
Reduction in avoidable inpatient and ER use	PQIP, PQIPE, NRSS, BHQIP, ICQIP
Reduction in BH inpatient readmissions	BHQIP, ICQIP
Reduction in 30-day BH inpatient readmission rates	BHQIP, ICQIP, BHFIP
7-day and 30-day post-discharge follow-up rates	BHQIP, BHFIP, ICQIP
Decrease in overall C-section rates	OBQIP

Supporting Providers Participating in Our APMs

We have learned that to effectively drive quality and reduce cost, we must design provider incentives and APM models that meet providers where they are. We offer enhanced support and collaboration to APM providers aligned with their level of collaboration and engagement with us with the goal of jointly improving outcomes. Providers require access to actionable data, delivered in a timely and accessible manner, to perform well in APM programs. UniCare is committed to collaborating with and providing technical assistance to our APM participating providers for achieving improved outcomes, reductions in inappropriate utilization, and overall costs.

We use a multi-layered approach to providing technical assistance and developing readiness for providers participating in our APM arrangements. Through our UniCare Training Academy (Academy), we provide comprehensive training to all providers on APM reimbursement principles and our APM programs. Our locally based Network

Relations Consultants are in the field meeting face-to-face with providers and offering ongoing services and support, training and education, and information sharing.

Our Care Delivery Transformation (CDT) Consultants manage the technical assistance program for our total population health-focused, shared savings APM providers. CDT Consultants lead a team that includes Network Relations Consultants, Patient Centered Care Consultants (PC3s), Quality Management (QM) Practice Consultants, Medical Directors, and staff on our national CDT team. For specialized services-focused APM programs, our PC3s work to identify, educate, and enroll providers in APM programs that are suitable for them and to assist with the onboarding. Everyone on the team has in-depth knowledge of our APM programs and will receive training on the Program.

Our experience as a current West Virginia Health Bridge and Mountain Health Trust (West Virginia Medicaid Programs) MCO has shown us that West Virginia's providers have historically been reluctant to enter shared savings or risk-based APM arrangements due to lack of experience and concerns about technical support. Our CDT Consultants' technical support for providers includes practice consultation, coaching, and assistance with using and interpreting our reporting tools, as well as guiding providers in the development of performance improvement action plans (PIAPs) to improve cost, quality, and member experience. Our PIAPs include goals associated with quality and cost performance. CDT Consultants monitor and report provider performance against the PIAP goals monthly.



The data we offer our participating providers includes custom data analytics through our reporting platforms, performance scorecards, and dashboard reports. CDT Consultants serve as the navigator and performance coach. With the support of our Quality and HEDIS teams, CDT Consultants analyze provider performance based on quality metrics, utilization trends, and provider profile tools to help our APM providers identify practice-centric solutions and improvement opportunities. Through consultation and coaching, they encourage adoption of practice management strategies to improve our members' experience based on best practices and strategies used by top-performing peers. For example, they may assist a provider's director of quality in developing solutions to address below par performance on quality measures. If a provider has their own health coaches, our CDT Consultants collaborate with those coaches to help extend and optimize the provider's resources in meeting APM performance objectives. CDT Consultants are dedicated to reducing administrative burdens on APM providers by training them how to efficiently and effectively use our data analytic tools.

We continually gather feedback from our APM providers on how we can improve our portals, data visualization, content organization, and embedded reports, and we frequently enhance our reports based on that feedback.

We continuously monitor data and evaluate how our APMs influence improvements in outcomes, cost, and avoidable utilization including potentially avoidable admissions, readmissions, and ER utilization. We also use what we learn to inform our APM program design, performance improvement support, and APM expansion strategies.

Tying Reimbursement to Outcomes and the Most Appropriate Place and Time (QU015)

For the 2018 performance period, UniCare providers that participated in our PQIP performed better than non-PQIP providers in 8 of 12 quality measures. PQIP providers also showed year over year improvement versus 2017 in 10 of 12 quality measures, three measures of which increased by more than 7.5%.
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Our methodology for developing quality targets can vary by APM and is specified in each APM Program Description document. Our APMs use a variety of HEDIS-like quality measures aligned with State program goals and related member incentives to maximize their effectiveness. To the greatest extent possible, we leverage measures that can be assessed using claims-based data to minimize provider administrative burden in the absence of medical record or robust electronic health record or other health information network sources. We develop provider incentive performance targets based on relevant health plan, regional, and/or peer performance aligned with the goals of the State program as well as prior year performance and Provider feedback through our Provider Advisory Committee. At the beginning of each performance period, we notify all APM-participating providers of the quality measures and controls we will use to evaluate their performance.

Our APMs Result in Improved Outcomes

Our experience in West Virginia shows our APMs drive improvements in quality, produce savings, and reduce avoidable emergency room visits. ***For the 2018 performance period, West Virginia PQIP providers performed better than non-PQIP providers in 66% of PQIP quality measures***, most notably the measures shown in Table E.7-3.

Table E.7-3. 2018 Results Indicate that PQIP Providers Performance Exceeds Non-PQIP Providers

Measure	PQIP vs. Non-PQIP
Adolescent well-care visits (AWC)	5.4%
Breast cancer screening (BCS)	1.4%
Medication Management for People with Asthma (MMA)	4.5%
Well-Child Age 0–15 Months (W15)	4.6%
Well-Child Age 3–6 Years (W34)	3.4%

Results of School-based Health Center Well-child Incentive

Our School-Based Health Center (SBHC) Check-up Contest, originally developed in 2015 in collaboration with the West Virginia School-based Health Assembly, was designed with the goal of increasing completion of well-child and well-adolescent exams, nutritional and physical activity assessments, and counseling by leveraging SBHC providers to improve statewide use of preventive care.

In the first year, a total of 4,522 UniCare child and adolescent members were eligible for the program because they had not had a qualifying well visit. Fifteen providers participated and, of the 15 who participated, 73% met the quality threshold and were entered in the drawing for the bonus incentive. The winning SBHC provider was Family Care Health Center, which was awarded $5,000. The winning school was Summersville Middle School in Nicholas County, which was awarded $2,500.

UniCare also paid SBHCs a $25 incentive for each completed medical record, reflecting a well-visit for children in the targeted age categories. A total of 1,264 exams had been completed and the corresponding medical records were returned to UniCare. Of those, 1,047 (83%) met the Bright Futures/EPSDT criteria and qualified for a $25 incentive per record. 575 adolescent members were able to be counted towards the HEDIS AWC measure; 398 young children were able to be counted toward the W34 measure.

Based on the success of this program, we decided to continue and expand it. We just completed our fourth year and are proud to report that over 8,000 exams have been completed through this program. Providers have earned almost $250,000 and schools have earned almost $15,000 in these four years.

APM Alignment to the Program

Our APMs use a variety of HEDIS-like quality measures aligned with the needs of our Program members to maximize their effectiveness, as shown in the Table E.7-4.

Table E.7-4. APM Quality Measures for West Virginia Foster Care Members

Specialized Managed Care for Children and Youth Program-related Quality Measures	UniCare APMs
HEDIS Measures Applicable to All Members in Each APM, Including Program Members	
Follow-Up After Hospitalization for Mental Illness (FUH)	PQIP, PQIPE, BHQIP, BHFIP, ICQIP
Follow-Up After ER Visit for Mental Illness (FUM)	BHQIP, ICQIP
Follow-Up After ER Visit for Alcohol or Other Drug Abuse (FUA)	BHQIP, ICQIP
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	ICQIP
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	ICQIP
ADHD medications (initiation, continuation and maintenance phases)	PQIP, PQIPE, ICQIP
Asthma (AMR)	PQIP, PQIPE
Diabetes	PQIP, PQIPE, ICQIP
Well-Child Visits	PQIP, PQIPE, School-based Well-visit Incentive Program (SBWIP)
Other Measures Specifically Related to Children and Youth in Child Welfare	
Percentage of members who are readmitted to BH Inpatient Facilities	BHQIP, BHFIP, PRTQIP
Percentage of youth readmitted to a residential care facility or PRTF	PRTQIP
Successful and stable placement of members in the community	PRTQIP
Percentage of children successfully transitioned to in-state care	PRTQIP
Initial health assessments, comprehensive EPSDT exams, medical, dental and trauma assessments completed within prescribed timeframes	FCAIP

Reporting Annually to DHHR on Alternative Payment Structures (QU016)

UniCare will provide reports to DHHR on our APMs and activities annually and/or as required in accordance with the Service Provider Agreement (SPA). UniCare currently provides annual reporting to DHHR on our APMs in compliance with current West Virginia Medicaid Program requirements.

Rewarding Providers that Adhere to Quality and Performance Standards (QU001)

Our APM strategy detailed earlier in our response to QU011–QU016 is our main approach to rewarding PH and BH providers for adhering to DHHR and UniCare quality and performance standards; however, in addition to our APMs, UniCare offers additional opportunities for providers to earn recognition for their expertise in areas of importance to our Program members and adherence to Program requirements, including:

- **Adverse Childhood Experiences (ACEs) Provider Champion.** UniCare will partner with leading West Virginia providers to implement our ACEs Provider Champion program. The goal is to identify and work with designated organizations in West Virginia to implement innovative programming to increase the resiliency of our communities, address ACEs, and serve as role models and mentors for other providers. Each provider champion partner will receive funding to accelerate and expand the reach/impact of their innovative programming. The amount of funding will be determined based on the anticipated scale of the project, is intended to expand the scale and reach of innovative strategies, and are not meant to replace existing Medicaid-reimbursable services or activities.
- **Physician Champion Award.** UniCare will launch an annual Physician Champion Award to recognize providers who demonstrate innovations or significant improvements in quality and service to our members. In addition to making a donation in the provider's name to a charity of their choice, we will present our Physician Champions with a plaque to celebrate their contributions to a healthier West Virginia. We will communicate information about the Physician Champion Award in advance to providers in our network via newsletters and bulletins on our provider website. Criteria for the award may include effective use of electronic health records (EHR), smoking cessation and reduction in tobacco use, and other topics aligned with West Virginia foster care program goals and objectives.
- **Gold Star Provider Recognition.** UniCare's Trauma-responsive Care Provider Recognition Program identifies providers who complete a specified series of Academy Trauma-informed Care/System of Care trainings by placing them in a "Gold Star" status and on a "trained provider list" for reference by staff, stakeholders, and families. Additionally, we will provide a small financial incentive upon completion of training. By obtaining Gold Star status, providers demonstrate a greater comprehension of the effects of trauma and approaches for treatment and services and meeting the complex needs of our vulnerable children and families who have experienced a traumatic event. Our affiliate in Georgia developed this incentive and recognition and we are excited to strengthen our community-based services and supports for our members with this initiative.



- **Foster Care Patient Centered Medical Home (FC-PCMH) Recognition.** UniCare will establish a FC-PCMH program to distinguish primary care practices who have met FC-PCMH program criteria and demonstrated experience and expertise in providing comprehensive patient-centered care for children and youth in our Fostering Healthy Lives model. As part of the implementation of the FC-PCMH program, UniCare will create a designation on our online provider directory recognizing that the practice has met UniCare's criteria and standards aligned with American Academy of Pediatrics (AAP) guidelines as a provider of distinction and expertise in the comprehensive treatment of foster care members. We provide full details related to our FC-PCMH model in our response to CM006-CM010.

PROVIDER EDUCATION AND QUALITY MONITORING

Sharing Best Practices with Physical and Behavioral Health Providers and with DHHR for Socially Necessary Services (SNS) Providers (QU002)

UniCare believes that sharing best practices with and among providers is crucial to enhancing the quality of care delivered to members. We will leverage our 16 years of experience in West Virginia to enhance the coordination and quality of care for children and youth in West Virginia's child welfare system by sharing best practices, as they are identified, that reflect optimal treatment protocols for Program members and their caregivers.

Sharing Best Practices Employed with Physical and BH Providers

We will share best practice methods and programs with PH and BH providers through our Academy. The Academy is our multi-modal approach to provider training and education. We will evolve our training offerings in collaboration with DHHR, members and their caregivers, and other stakeholders. We review best practices in regularly scheduled staff meetings and annual clinical leadership meetings, and maintain playbooks that will provide access to best practices across our organization. We will continuously develop new training and refine current training based on continuous input and feedback from training participants, lessons learned, and best practices. We will monitor emerging industry best practices and incorporate them into our Academy and provider website for sharing with providers.

We use our provider website, bulletins/fax blasts, newsletters, email blasts, and conference calls to present best practice methods and programs, and offer additional information related to upcoming training sessions to assure full provider accountability and improved quality of care.

We will also share best practices through our Community Engagement and Training team who will oversee development of our Fostering Healthy Lives education, training, and outreach strategy, including development and delivery of customized training to various audiences and in different formats. Community Engagement and Training Representatives will be strategically positioned throughout West Virginia to identify local training needs, collaborate with local subject matter experts, and provide trainings in local forums. This team will be communicating regularly with UniCare staff including Provider Services, QM, and Clinical Services to assure alignment of messaging related to best practices.

Best Practice Methods We Employ

We develop new best practices and programs based on evidence-based practices and emerging evidence, and encourage adoption through collaboration, monitoring, and education. For example:

- We monitor federal Family First Prevention Services Act (FFPSA) guidance, Administration of Children and Families notices, and the California Evidence-Based Clearinghouse on Child Welfare for methods they have determined to be promising, supported, well-supported, or best practices.
- We have also been approved to use relevant documents and videos from Harvard's Center on the Developing Child and will include this information in our provider training and toolkits, including the Impact of Early Adversity on a Child's Development and The Science of Resilience; Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Working Paper No. 9.

In addition, we will educate network providers on best practices identified by the AAP including *The Guide for Implementing Trauma Informed Care for Providers of Children in Child Welfare,* which uses assessments and a Trauma Toolbox to increase a provider's ability to effectively provide trauma-informed care.

Promoting Expansion of Parent-child Interaction Therapy (PCIT)

PCIT is a recognized best practice for working with children and their families and caregivers. UniCare currently contracts with 14 PCIT-certified therapists in West Virginia. PCIT is typically offered on a weekly basis, over a number of months, to an individual parent-child dyad (including foster parent-child dyads). While proven effective, this delivery mode can present a number of logistical challenges for parents and caregivers, such as lack of transportation, needing to take time off work, or securing childcare during the weekly sessions. These issues can contribute to a high PCIT attrition rate and undermine the program's effectiveness.

To improve access and delivery, and lessen program costs while maintaining effectiveness, through collaboration with Dr. Cheryl McNeil of West Virginia University and FMRS Health Systems Inc., UniCare has adapted the typical PCIT program delivery model for Fostering Healthy Lives, as follows:

- UniCare will provide one initial 8-hour in-person session, followed by four weekly phone consultations (generally in the evening hours when caregivers are available). A second 8-hour in-person session will then be conducted with four additional weekly phone consultations.
- Further, our in-person PCIT sessions will be delivered to up to 10 families concurrently, because group sessions are more cost effective than working individually with each foster family. During these sessions, we will provide additional services including childcare for biological or other foster children in the care of participants, and snacks and meals as appropriate.
- UniCare is collaborating with Dr. McNeil to develop training materials and methods to expand delivery of the program through a "train-the-trainer" model. Initial PCIT train-the-trainer materials will be given to PCIT-certified therapists in person during the first 8-hour PCIT session. These therapists will then work with other therapists to develop their PCIT expertise and replicate the model across multiple West Virginia sites.
- UniCare will also work to expand awareness of PCIT and its benefits within our provider network by offering providers access to online PCIT training, including continuing education courses through our Academy, such as those offered through PCIT International.

Providing Identified Best Practices with DHHR for Sharing with SNS Providers

UniCare will identify and share best practices with DHHR that are applicable to SNS providers. For example, we will review the best practices we have already identified such as trauma-informed care, PCIT, and motivational interviewing to determine which are applicable to SNS providers. As we identify those that are applicable, we will work with DHHR to share them with the SNS provider community.

Other Ways of Assuring Accountability and Improvements in Quality of Care

We actively educate, counsel, and hold providers accountable for driving positive change. Our QM Consultants, in collaboration with our Network Relations Consultant and PC3s, will share quality performance information, such as Gaps in Care (GIC) reports and other profiling reports, and work one-to-one with providers to address deficiencies, and identify and implement strategies and action plans to improve performance.

Taking Action Against Physical and Behavioral Health Providers that Demonstrate Unacceptable Performance and Sharing SNS Provider Deficiencies with DHHR (QU003)

UniCare uses a variety of methods to assess the performance of providers. These include:

- Annual HEDIS measures
- Member experience surveys
- Member complaints, grievances, and appeals
- Child CAHPS® member satisfaction surveys
- Provider access and availability

We continually monitor member experience to identify evolving access issues or trends. Additionally, we monitor our network to verify continued compliance with DHHR's access standards, including annual appointment access audits for a random sample of providers. If we identify a provider that demonstrates unacceptable performance, or that does not meet DHHR's

access standards as specified in the provider agreement, we will first connect any affected members with the health service they need. Then we will address the provider's non-compliance.

Our Provider Services team, working with QM, will investigate and resolve issues accordingly. If we confirm that the provider is not meeting access standards, Provider Services will:

- Request that the provider submit a Provider Outcomes Improvement Plan, which specifies the actions the provider will take to correct the problem
- Conduct follow-up checks by phone or onsite to review the draft plan, re-educate the provider about DHHR access standards, formalize the plan, and obtain an agreement for another follow-up reassessment
- Monitor progress with respect to the Provider Outcomes Improvement Plan each quarter to confirm that critical tasks are being completed according to the schedule outlined in the Plan
- Report progress to the QM department

Our Medical Director, Network Relations Consultant, and QM team will collaborate with providers whose performance is below target thresholds to encourage them to adopt practice management protocols that are effective for their peers. We will work diligently with providers to identify and implement individual improvement plans, and maintain incentives to align provider goals with those of DHHR. However, we will not take punitive action solely based on provider profile results. If we see no improvement after repeated attempts to adjust the provider's performance, we may initiate steps to remove the provider from the network. These rare cases in which we terminate a provider are generally related to continued non-compliance with their contract, failure to meet re-credentialing requirements, fraud or abuse, quality of care issues (as determined by our QM team), or continued failure to adhere to authorization requirements.

Sharing SNS Provider Performance Deficiencies with DHHR

Collaboratively with DHHR, we will develop a routine process for sharing SNS provider performance deficiencies. Our SNS Liaison will be responsible for obtaining feedback related to SNS providers' performance by participating in our Stakeholder Advisory Group and Parent Caregiver Advisory Group, querying Fostering Healthy Lives Care Coordinators (Care Coordinators) about SNS provider performance, and attending SNS Focus Groups.

Developing, Updating, and Disseminating Clinical Guidelines (QU031)

Our Academy structure as well as our provider website are our main methods for dissemination of clinical practice guidelines (CPGs) to our provider network. UniCare currently provides listings of our CPGs to providers through the Provider Resources section of our provider website. Our CPGs are based on guidelines developed by nationally recognized sources such as the American Diabetes Association, American Congress of Obstetricians and Gynecologists, National Heart Lung and Blood Institute, and others.

UniCare will develop, update, and disseminate CPGs related to the Program to participating providers. Our CPGs for the Program will be developed and reviewed through a partnership between our national Medical Advisory Committee and our local West Virginia-based Medical Advisory Committee. They will reflect conditions prevalent to the children in West Virginia's child welfare system (for example, asthma, upper respiratory infections in children, bipolar disorder in adolescents, and ADHD).

Providers will be directed to these as part of our Fostering Healthy Lives provider training and provider toolkits (discussed in detail in the Network Development section) disseminated through subsequent face-to-face interaction between providers and our QM Practice Consultants.

Monitoring and Reinforcing PCP Compliance with Program Requirements (QU043)

We will use our Academy and provider website as our principle means of communicating Program requirements and updates to our participating PCPs and other providers. PCPs will initially be trained on program requirements for applicable populations during our Fostering Healthy Lives provider training. As changes to the program occur, PCPs will be updated via periodic training through our Academy, through our provider website, via periodic webinars, and through our standard provider outreach and educational materials (provider manual, alerts and bulletins posted on the provider website, fax blasts as appropriate, and face-to-face interaction between PCPs and our Provider Services team).

We will use various methods and indicators to monitor PCP compliance with Program requirements, including, but not limited to 24-hour coverage, appointment scheduling, and EPSDT periodicity standards as shown in Table E.7-5.

Table E.7-5. Mechanisms for Monitoring Provider Compliance with Program Requirements

Mechanism	Description
Audits of Appointment Availability	Annual audits of a random, statistically valid sampling of PCPs, designated specialists (including OB/GYN), BH providers, dental providers, and vision providers to assess appointment availability and after-hours coverage.
Review of Member Grievances	Member grievances are routed to our Network Management team for review, investigation, and follow-up.
Member Satisfaction Surveys	Each year, our QM department engages a qualified vendor to administer the most current version of the CAHPS survey to query members on access to care and other key questions.
On-site Visits to Provider Offices	Our Network Relations Consultant conducts site visits to network providers based on established visit frequencies.
Review of Panel (Roster) Reports	We review provider panel status to confirm that an adequate number of practices are open to new members. Network Relations Consultants monitor practices with closed panels to identify opportunities for re-opening.

We will monitor provider appointment wait times, after-hours accessibility, and telephone accessibility to assure members have timely access to their PH and BH providers and prompt response to telephonic inquiries. In accordance with our QM policies and procedures, we will conduct quarterly provider audits to measure appointment wait times for specific types of visits and provider types. Annually, we will contract with an external vendor who performs independent appointment access and after-hours surveys. Access and availability will be monitored on an annual basis via the member satisfaction survey. We will use the NCQA-required data sources detailed to formally assess our performance against our standards for appointment wait times.

Our Network Relations Consultant will also monitor and validate after-hours clinic and appointment availability during in-person visits to provider offices. When we identify a provider who is not complying with after-hours coverage, we will investigate the issue and take corrective action.

We will continually evaluate the efficacy, capacity, and geographic placement of our providers and seek to maximize member interaction with providers who consistently deliver high-quality care. When we determine a provider is not advancing toward suitable standards or higher performance levels consistent with program requirements, we will employ various interventions, such as member reassignment or restricted member assignment to optimize our network composition and minimize the use of lower performing providers.

Simplifying Administrative Procedures (QU004)

Our Network Management strategy complements DHHR's goal to deliver needed supports and services in the most integrated, appropriate, and cost-effective way possible by assuring members are cared for by high performing, engaged providers that collaborate with us in a consistent and on-going basis. Our network providers are the most critical component of care delivery. As such, in line with our Provider Promise of Administrative Simplification, we will adopt strategies so our network providers are able to spend most of their time delivering care, instead of on administrative tasks.



Our commitment to administrative simplification and provider support guides our processes for effectively managing provider relations and communications, as well as our development and implementation of specialized service models and technical supports that promote accuracy, reduce administrative burden, and increase provider and patient satisfaction. For example, UniCare has extensive experience working with the different provider types in West Virginia and blends best practices and innovative solutions to assure our network providers receive timely payment. We offer multiple billing methods, including both paper and electronic, with the flexibility to support non-standard billing processes for non-traditional services that are not easily supported using standard claim forms. We adjudicate claims daily, run payment cycles nightly, Monday through Saturday, and make claims payments twice weekly.

UniCare also simplifies provider administration by offering support tools that are easy to access and use. Our Academy offers multiple modalities including access through our website, provider portal, and in-person, as requested. Our provider manual, as well as other materials such as our Quick Reference Guides and provider newsletters, is available online and in print. We created our provider manual in a clear format for providers to easily find the support they need.

UniCare's provider website offers the latest provider communication, toolkits designed to make the provider's job easier, formularies, reimbursement policies, and a link to our prior authorization (PA) lookup tool. The website delivers timely and relevant information, announcements, alerts, forms, and a contact information for our Network Relations Consultant for providers, their staff, and other stakeholders. Our provider website includes a public section, as well as a secure, login-only provider portal deployed through Availity. It features tools that promote convenience and transparency while simplifying practice management.

Our Network Development Consultants support administrative simplification by assisting providers with claims, billing, and other administrative processes. Through consultation, coaching, and working closely with a PCP's staff, our PC3s, in collaboration with our CDT Consultants, encourage and support our APM participating providers in the adoption of practice management strategies based on best practices and strategies used by top-performing peers. For example, a CDT Consultant may assist a provider's director of quality with developing solutions to address sub-par performance related to quality measures. If a provider has their own health coach, a CDT Consultant will collaborate with that individual to help extend and optimize their resources in meeting APM program performance objectives. The CDT Consultant is dedicated to reducing administrative burden on APM providers by training them to efficiently and effectively use our data analytic tools.

Profiling Provider Quality of Care (QU038)

UniCare and its affiliates have tools for providing extensive data sharing and performance reporting to providers to support providers' ability to monitor and improve their performance. In profiling provider quality of care, our multifaceted approach recognizes the different roles that different types of providers serve and the different needs they have for profiling information. Our strategy is designed to provide relevant, actionable information that can be used effectively to improve performance. For example, providers who participate in our APMs receive an enhanced array of performance reporting, including APM scorecards, action plans, and interactive management tools to drive performance improvement.

We will develop new provider profile reports for PCPs and hospitals. Our PCP and hospital provider profile reports will include relevant indicators drawn from data sources such as HEDIS results, CAHPS surveys, appointment availability and after-hours surveys, member grievance and complaints data, claims and utilization data such as prior authorizations, APM performance data, and other clinical quality sources. UniCare will submit a sample copy of our provider profile report template to DHHR prior to distribution to the provider network.

We will work with providers and other stakeholders through our Provider Advisory Group (PAG) and Stakeholder Advisory Group (SAG) to incorporate foster care-related measures that are reliable, measureable, and actionable by our providers. We will select measures that are aligned with DHHR and HEDIS priorities and reflect the health care needs of our member populations. We strive to select quality indicators that can be measured using claims to minimize administrative burden on providers and staff.

Profiling PCPs, Specialists, Hospitals, and Other Acute Care Providers (QU039, QU040, QU041, QU042)

Our array of profile reports and performance improvement tools available to profile quality of care delivered by PCPs, specialists, hospitals, and other acute care providers are shown in Table E.7-6.

Table E.7-6. UniCare Provider Profiling to Promote Performance Improvement

Profiling Approach	Status	Frequency and Distribution	Recipients
PCPs			
PCP Quality Profile. Provides PCPs with a profile of their performance against key HEDIS measures, such as diabetes HbA1c testing.	Proposed	• Updated and distributed semi-annually by email and reviewed during face-to-face meetings with our Network Relations Consultant and Care Coordinators	PCPs with at least 100 members
Gap In Care List. Provides a list of assigned members with gaps in recommended care, such as missed preventive health services. Includes member contact information and a calculation of potential P4Q HEDIS incentive bonus payments.	Currently available	• Updated monthly and distributed by email. Reviewed during face-to-face meetings with Network Relations Consultants and QM Practice Consultants	PCPs that have members with GIC
Population Health-focused APM Performance Scorecards and Reconciliations. APM-participating PCPs receive performance scorecards and/or reconciliation reports showing their performance against defined measures and targets.	Currently available	• Updated quarterly and annually • Available through our provider website • Distributed and reviewed during face-to-face meetings with our Network Relations Consultants and Care Coordinators	PCPs that participate in our PQIP, PQIPE, and R/SS Category 3 APM programs
Performance Improvement Action Plan (PIAP). Developed by our Care Coordinators in collaboration with providers participating in our PQIP and PQIPE and R/SS APMs, PIAPs outline the specific goals and steps the provider will undertake to achieve specified goals.	Currently Available	• Updated twice yearly • Produced as needed and distributed by our Care Coordinators in face-to-face performance improvement meetings	PCPs that participate in our PQIP, PQIPE, and R/SS Category 3 APM programs
Provider Care Management Solution (PCMS). Our population health-focused APM-participating PCPs can view actionable, specific information to identify members for outreach and engagement. It is filterable by key conditions, risk factors, GIC, and visits.	Currently available	• Updated daily and available 24/7 on our provider portal	PCPs that participate in our PQIP, PQIPE, and R/SS Category 3 APM programs
Opioid Prescribing Summary (available under the pharmacy carve-in scenario). Providers will receive a report detailing their opioid prescribing patterns against evidence-based quality standards and peer comparisons. Providers can use this data to target opportunities to improve their prescribing practices.	Currently available (under the pharmacy carve-in scenario)	• Updated and distributed monthly	PCPs and other prescribing Providers

Profiling Approach	Status	Frequency and Distribution	Recipients
Specialists			
Performance Efficiency Reports (PERs). PERs support delivery of efficient, quality care by sharing objective data on practice patterns with providers. PERs include a provider-to-peer comparison, using an Episode Treatment Groups® methodology.	Currently available	• Updated annually and distributed face to face in meetings with our Network Relations Consultants	PCPs and specialists with at least 20 qualifying attributed episodes
OB Profile Reports. Compares performance on key clinical metrics to benchmarks and performance of peers in West Virginia and nationally. Metrics are calculated for members who had a delivery during the measurement period.	Currently available	• Updated annually, distributed during face-to-face meetings with our Network Relations Consultants and OB Practice Consultants	OB groups with at least 10 attributed members during the measurement period
Specialized Services-focused APM Performance Scorecards. OB and BH providers who participate in our OBQIP and BHQIP APMs receive scorecards and reconciliation reports showing performance against defined measures and targets.	Currently available	• Updated quarterly and annually • Distributed during face-to-face meetings with our BH Network Relations Consultants and OB Practice Consultants	OB and BH providers who participate in our OBQIP and BHQIP APMs
Hospitals			
Hospital Profile. Provides a profile of performance against key quality measures, such as potentially avoidable readmissions and ER visits, member satisfaction and complaints, and utilization.	Proposed	• Updated and distributed twice yearly	Acute care hospitals that meet minimum volume thresholds
Other Acute Care Providers			
Service Coordination Platform. Our integrated platform supports our profiling and reporting strategy, and provides access to a single view of member-specific data in an easy-to-navigate dashboard. It is our primary vehicle for sharing service coordination information.	Currently available	• Updated daily • Available 24/7 through our provider website	Available to all participating providers

Table E.7-7 summarizes our process and timeline for development of our proposed PCP and hospital provider profile reports.

Table E.7-7. Proposed Process for PCP Profiling

Process and Timeframe	Scope and Activities
Development of Provider Profile Template	
Award through Contract Implementation Date	• Identify specific indicators that are clinically relevant, quantitatively measurable, and appropriate to the provider's member population • Obtain stakeholder input through PAG, Medical Advisory Committee (MAC), and SAG • Develop mock profile template • Submit copy of profile templates to DHHR for prior approval
Establish Baselines, Implement Provider Profile Reports	
Within 12 months of Contract Implementation	• Complete development of reports, baseline data sets, and comparative benchmarks • Collaborate, educate, and prepare providers for new profile reports • Develop internal processes for distribution and review with providers • Distribute reports to providers
Deploy, Monitor, Maintain	
Ongoing	• Continue to educate and inform providers on provider-specific-profile reports • Evaluate initial results and identify adjustments • Obtain DHHR approval and implement any necessary program adjustments

QUALITY PROGRAM INFRASTRUCTURE AND IMPROVEMENT METHODS

UniCare's quality assurance and improvement focus permeates every department and guides our day-to-day business. ***Quality goes beyond HEDIS and CAHPS scores; it is how we work every day, with the goal of improving the health care, service quality, and stability for our members.*** UniCare's robust QM Program includes numerous quality-related committees with responsibility for program oversight and improvement. We structure our quality committees to serve as working groups to be sure all health plan decisions consider whole-person, integrated care. UniCare has continuously maintained NCQA accreditation for more than a decade, validating our commitment to, and compliance with established quality standards. We will be good stewards of the state's financial investment in the child welfare system and hold ourselves accountable to the success of the Fostering Healthy Lives model.

Administering a Quality Assurance and Performance Improvement Program (QAPI) (QU005, MR021)

Committed to enhancing well-being, permanency, and safety for children and youth in child welfare, UniCare will capitalize on our strong QM infrastructure. As a current West Virginia Medicaid MCO, collaborative state partner, and thought leader in the Medicaid space, we are focused on helping West Virginia care for children, youth, and families in foster care or who are receiving adoption assistance. Our Quality Assessment and Performance Improvement (QAPI) program, led by an experienced local team, analyzes data across the health plan. It includes measures related to access to care, demand for services, quality of care, utilization, health outcomes, and client satisfaction to drive quality improvement strategies. As a current West Virginia Medicaid Program MCO, ***our QM structure meets all DHHR requirements and we stand prepared to expand our scope to meet the demands of this Contract***. We maintain



UniCare shared the top ranking in West Virginia in the NCQA Medicaid Health Insurance Plan Ratings for the past two years.

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a QAPI program structure that supports a culture of continuous quality improvement and reinforces clear accountability through written policies. We blend local and national resources that align with the State's goals and objectives, strategically designing our program to have inclusive participation by a wide range of constituents, including providers and members. Further, we have a commitment to cultural competency and have received NCQA Multicultural Health Care Distinction.

Our QAPI program encompasses the full spectrum of PH, BH, and social supports available to our members. For the Program, we will expand it to include relevant services, such as SNS. The QAPI program involves extensive collaboration with providers, our State partners, and the External Quality Review Organization (EQRO) — all with the goal of improving members' well-being. Our QAPI program includes clinical and non-clinical services and addresses issues related to quality; care, disease, and utilization management; care coordination; customer service; provider credentialing and re-credentialing; and risk management.

Augmenting this experience, we will expand our West Virginia QAPI program to incorporate innovations and programs that have demonstrated success with children and youth in child welfare in other states. This includes adopting best practices from our Georgia affiliate and adapting them to the unique landscape and needs of West Virginia's children and youth in child welfare. Our Georgia affiliate is the sole MCO for the Georgia Families 360°$_{SM}$ program, serving youth and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system. In Georgia, we are proud to have achieved superior quality results, including numerous 2018 HEDIS measures scoring over the 90th percentile in NCQA's Quality Compass, including Childhood Immunization Status, Annual Dental Visits, and Follow-Up After Hospitalization for Mental Illness (7 Days).

UniCare QAPI Strategies

UniCare's QAPI program maintains the resources, structure, and processes to support our commitment to high-quality care and services for all members. Our QAPI Program Description includes distinct goals and strategies that are aligned to contract requirements, as described in Table E.7-8.

Table E.7-8. UniCare QAPI Goals Align with DHHR Requirements

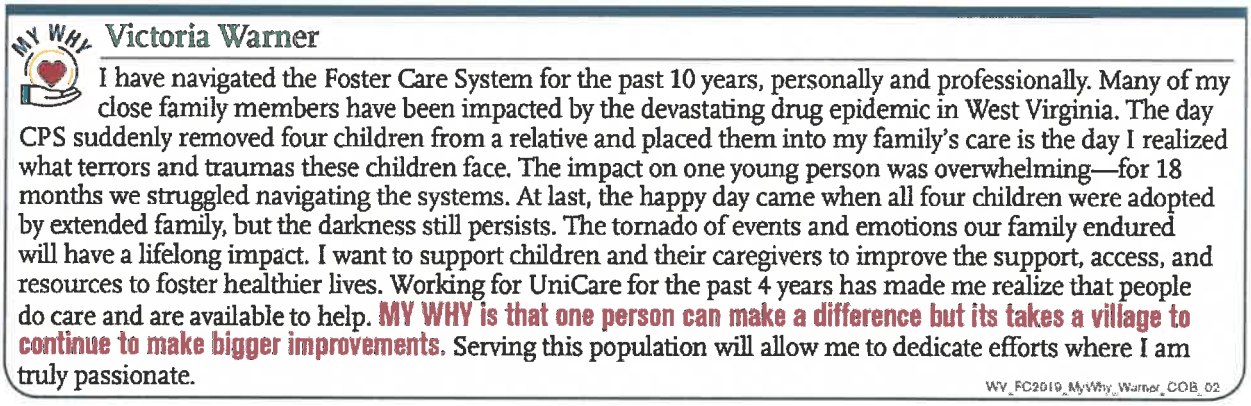
DHHR QAPI Requirements	UniCare QAPI Program Goals and Strategies
Annual measurement of performance in specified areas and achievement of performance targets	• Develop effective methods for measuring the outcomes of care and services provided to members; intervene to achieve continuous measurable improvements using a Continuous Quality Improvement (CQI) approach • Coordinate, monitor, and report QM activities • Monitor and improve accessibility to care and services • Monitor and improve receipt of seamless, continuous, and appropriate care throughout the continuum of care • Conduct and publish annual QAPI evaluation with measures of performance against targets
Multi-year performance improvement projects addressing clinical and non-clinical areas	• Operate multi-year Performance Improvement Projects (PIPs) • Improve members' outcomes through education regarding appropriate preventive services and healthy lifestyles • Measure member satisfaction and implement effective interventions to address areas of dissatisfaction

DHHR QAPI Requirements	UniCare QAPI Program Goals and Strategies
Approach for addressing systematic problems and critical incidents	• Ensure that critical incidents are identified, investigated, tracked and reported • Increase member and provider awareness of activities designed to improve patient safety • Implement and monitor programs designed to improve the quality and safety of our members • Develop and implement programs based on population analysis that incorporates cultural diversity, and health care disparities
Development and usage of a sufficient health information system	• Monitor provider medical record-keeping including compliance with medical record documentation guidelines, record storage, handling and retention • Ensure the confidentiality of our members' health and personal information is always maintained • NCQA-certified HEDIS engine
Proper administration of quality assessment and performance improvement activities	• Collaborate with the State in the administration and coordination of care and services, the development of policy and procedures, and the process of oversight • Operate effective credentialing and re-credentialing processes for providers that comply with State, federal, and accreditation requirements • Coordinate and communicate QM activities with all appropriate functional areas, including but not limited to utilization management, member services, and provider relations • Ensure full compliance with all applicable State, federal, and accreditation requirements; provide delegation oversight

UniCare's QAPI program establishes quality improvement strategies and uses appropriate quality tools, resources, and quality improvement processes to accomplish its objectives. The QAPI program incorporates health promotion as well as performance monitoring to positively impact the quality of care and services delivered to members. ***Our program is responsive to our members' unique needs and all types of PH and BH conditions.***

Skilled and Experienced Quality Staff

UniCare's Fostering Healthy Lives QAPI will build on our current local QM initiatives. Our West Virginia Quality Director, Victoria Warner, leads a team that comprises staff with expertise in program management, process improvement, clinical quality, HEDIS, and other types of performance measurement. The Quality Director collaborates closely with the Health Plan President and receives direction and support from our Medical Director and BH Medical Director. Our West Virginia quality team collaborates with affiliates across the country to identify and share best practices. For the Fostering Healthy Lives model, we have collaborated with our Georgia affiliate to understand and adapt their successful model for serving children and youth in child welfare. Ms. Warner, who is uniquely qualified due to her education, experience, and interest in the child welfare market, will serve as Quality Director for the Specialized Managed Care for Children and Youth Program population. She has a Master of Public Health degree with a specialization in Social and Behavioral Sciences and four years' experience with the MHT program.



Prioritizing Areas for Improvement

UniCare's HEDIS® measure for Follow-up Care for Children Prescribed ADHD Medication increased nearly 33% between 2016 and 2018.

UniCare's leaders routinely monitor medical trends, grievances and appeals, and additional data points for emerging or persistent areas for improvement. We analyze data, including the management of chronic and acute care diseases and conditions, public health data, statewide and community trends, impacts to core critical functions, SDOH, disparities, and more. We also prioritize our initiatives based on the volumes and types of care gaps present among the membership. Where gaps exist, we review the impact for both short-term and long-term, sustainable health outcomes before implementing any new or modified programs.

Ongoing Quality Monitoring Activities (QU057)

Our goal is to make sure each member receives the most appropriate supports and services tailored to their needs to achieve critical safety, health, developmental, quality of life, and permanency goals. We analyze outcomes and demographic data for all our members to understand key drivers that may affect their ability to achieve improved health outcomes. This data drives our organization's focus and strategies for program enhancement. Additionally, we monitor and track member-specific outcomes, acting at the individual level to enhance the health and well-being of our members and to provide them with the necessary services and supports to achieve Care Plan goals.

Detailing Performance Measures in Our Annual QAPI Work Plan

We will establish an annual QAPI Work Plan for this program that defines specific goals and activities to drive results over each 12-month period. The Work Plan represents our road map for the upcoming year's priorities and performance targets and guides our team in measuring success in achieving established improvement goals. Our local QM team will evaluate our Work Plan progress throughout the year, including an annual evaluation of all Work Plan activities to measure their effectiveness at driving quality gains. As we do for our current contract, we will continue to build our Work Plan upon the needs of our members and the priorities and goals of DHHR. The annual Work Plan will describe how we will achieve full compliance with program requirements, including:

- Processes for all health plan initiatives to monitor and improve quality and timeframes for achievement
- Data collection processes, including HEDIS and contract-specific metrics
- Evaluation of PIPs
- Measuring quality with objective indicators, benchmarks, and goals

- Care coordination programs
- Provider Satisfaction Survey(s)
- SNS Provider Retrospective Reviews
- CAHPS Medicaid Questionnaire on member experience
- Cultural competency programs and training
- Schedule for reporting updates and outcomes to the governing body
- Schedule for DHHR reporting requirements
- Oversight of SNS
- Facilitation of focus groups on SNS and residential services
- Monitoring training program effectiveness
- Incorporating Advisory Group and Focus Group input

UniCare's 2018 Child CAHPS® scores exceeding the 95th percentile:
- Getting Care Quickly Composite
- Got Urgent Care as Soon as Needed
- Got Routine Care as Soon as Needed

Exceeding the 90th percentile:
- Getting Needed Care

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Tracking Member-specific Outcomes Through Care Coordination

UniCare monitors member-specific health outcomes to determine if a member is experiencing negative outcomes, GIC, or low satisfaction. We use this information to outreach to and engage the member, caregiver, and PCP to determine the level of support the member needs to achieve her or his Care Plan goals.



We evaluate the system's effectiveness in supporting members to achieve positive health outcomes through our care coordination program, providing clinical support by Care Coordinators, monitoring member risk scores, and tracking performance data. Using a System of Care approach, our Care Coordinators collaborate with all providers, system partners, natural supports, and community organizations involved in the member's care to develop a Care Plan that reflects the member's and/or their family's/caregiver's strengths, preferences, and needs. The Care Plan outlines specific actions that will be taken to support the member in achieving improved health outcomes. The Care Coordinator continuously monitors member progress toward Care Plan goals and tracks health outcomes. Further information on our Care Coordination monitoring can be found in our Quality Measurement in Reporting description.

Using Provider Performance Data to Improve Member Access to Care

We routinely share quality data with PCPs to enable them to act on GIC, compare their performance to minimum standards, and alert them to areas needing improvement. Our Network Relations Consultants and QM Practice Consultants collaborate with providers to interpret their data and develop improvement initiatives.

Enhancing Ongoing Quality Monitoring (QU058)

UniCare has a long history in West Virginia of implementing member- and provider-focused interventions to improve our performance, such as our award-winning School Based Clinic Check up Contest. The QAPI program works continuously to make enhancements to better meet member needs, and we will leverage quality interventions from affiliates that have been tailored for children and youth in child welfare. Beginning in the first year of this contract, these activities will include:

Between HEDIS® 2016 and HEDIS® 2018, UniCare improved scores in the following measure by more than 5 percentage points each:
- Adolescent Well Care Visits
- Annual Dental Visit
- Appropriate Testing for Children with Pharyngitis
- Childhood Immunization Status – COMBO 5
- Follow-up Care for Children Prescribed ADHD Medication – Initiation and Continuation & Maintenance Phases
- Human Papillomavirus Vaccine for Female Adolescents
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Activity and Nutrition)

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- **Alternative Payment Models.** As we expand our APM portfolio, providers who participate in our population health-focused APMs will receive detailed and actionable quality information through our PCMS system. PCMS displays results on GIC, quality measures (such as preventive and chronic care) as well as utilization (ER and ambulatory sensitive admissions) and overall medical cost performance relative to established targets.
- **Provider Profiling.** UniCare's data sharing and performance reporting for providers support their ability to monitor and improve their performance. We will work to establish provider profile reports with relevant indicators and engage stakeholders to develop reporting capabilities for the Program.
- **Medicaid Outbound Call Team.** We will deploy this newly developed team to assist in contacting members and caregivers to support improvement in targeted HEDIS measures or in support of a PIP. This team is charged with handling campaigns for measures where our monthly analysis indicates a feasible opportunity for improvement. One month in 2019, this team attempted to reach more than 3,300 Medicaid members in West Virginia about their care gaps. ***When calls were completed, our team successfully closed more than 35% of the care gaps*** by assisting with appointment scheduling or obtaining medical records to indicate the service was completed. With our technology, we can identify how many members are tied to an individual phone number and have a single conversation with the parent/guardian about all children in the household.
- **Promoting EPSDT visits.** To support timely completion of EPSDT checkups, our Fostering Healthy Lives Concierge team (Concierge Representatives) and Care Coordinators will contact members or caregivers. We will use Care Plans to track phone numbers for foster parents or others caring for members as well as the Department caseworker so that our outreach activities are effective. UniCare understands the importance of verifying that all contacts for each member's caregiver are updated in our system based on current placement. We will create workflows to be utilized when we are sending information of any type, that validate we are sending it to the appropriate contact.

We will update our QAPI Work Plan annually with new and/or revised quality monitoring goals and quality improvement initiatives. In addition, Call Center and EPSDT activities will be calculated and tracked monthly for rapid quality improvement responses, when warranted. In the annual QAPI Evaluation, we will continue to document key successes and potential barriers to continued improvement for further problem solving.

Data-driven Quality Initiatives (QU036)

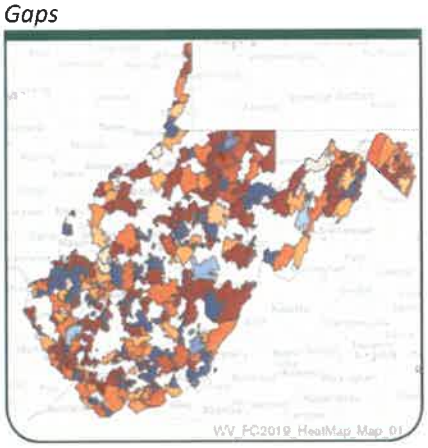
Our data driven QAPI program capitalizes on a technology infrastructure that supports capture and evaluation of performance measurement data across all functional areas. This technology foundation enables us to monitor performance by monitoring quality, cost, and utilization trends across our membership. Our tools facilitate quick identification of negative performance trends so that we can address them early. ***We systematically and objectively measure access to care, demand for services, and quality of care to improve member outcomes.***

Interactive Analytic Insights Quality Platform

Our robust quality infrastructure, including our Interactive Analytic Insights tool and HEDIS Data Warehouse, captures and evaluates performance measures across our membership to improve delivery of care and services. The proprietary Interactive Analytic Insights tool is a dynamic, responsive, and scalable platform that provides comprehensive information about our quality performance. It displays quality measure performance trended over time with performance benchmarks and comparable data from across the industry.

Using data, such as that in the heat map displayed in Figure E.7-3, we target intensive interventions to areas of the state that are most in need. These may include Clinic Days, where we collaborate with a provider to set aside time for UniCare members to be seen for overdue services, potentially in the evening or over the weekend. The visualization technology is flexible and can be customized to respond to changing DHHR priorities.

Figure E.7-3. 2018 Heat Map of UniCare Medicaid Member HEDIS Care Gaps



Performance Improvement Projects

UniCare will build on our extensive experience planning and operating PIPs in West Virginia to develop new PIPs tailored to children and youth in child welfare. UniCare will work with DHHR and its EQRO to identify clinical and/or non-clinical PIPs that target areas for program improvement.

For example, we currently manage a PIP to improve Follow-Up after Hospitalization for Mental Illness (FUH), with children and youth ages six and older in our MHT program. Interventions include a transition program linking inpatient and outpatient facilities, member incentives for completing follow-up appointments, application of evidence-based transition care management programs, and improved discharge planning by inpatient facilities. ***Between measurement year 2016 (HEDIS 2017) and the interim HEDIS 2018 (Q3 2018), UniCare achieved a 26% gain in the FUH score.***

For this contract, we have already identified several potential PIPs relevant for children and youth in child welfare. Once our work with this population is underway, UniCare will explore:

- **Developmental Screening Assessments.** Assess for completion of developmental screening via Medical Record Review process; verify providers are following the West Virginia EPSDT form and format produced by HealthCheck; and educate providers through QM Practice Consultants about needed improvements revealed by data patterns
- **Coordination with School-based Services.** Identify members with disabilities who have an individualized education plan (IEP) or are receiving school-based services during initial and ongoing assessments and increase integration of IEP goals with care plan goals
- **Assisting Transition Age Youth (TAY).** Document at least one youth-driven goal for each teen in our Fostering Independence model, such as making a medical appointment, identifying transportation options, or graduating from high school

Our West Virginia Medicaid PIPs from the last 24 months are outlined in Table E.7-9. We are proud to have achieved statistically significant improvements in at least one measure included in each PIP.

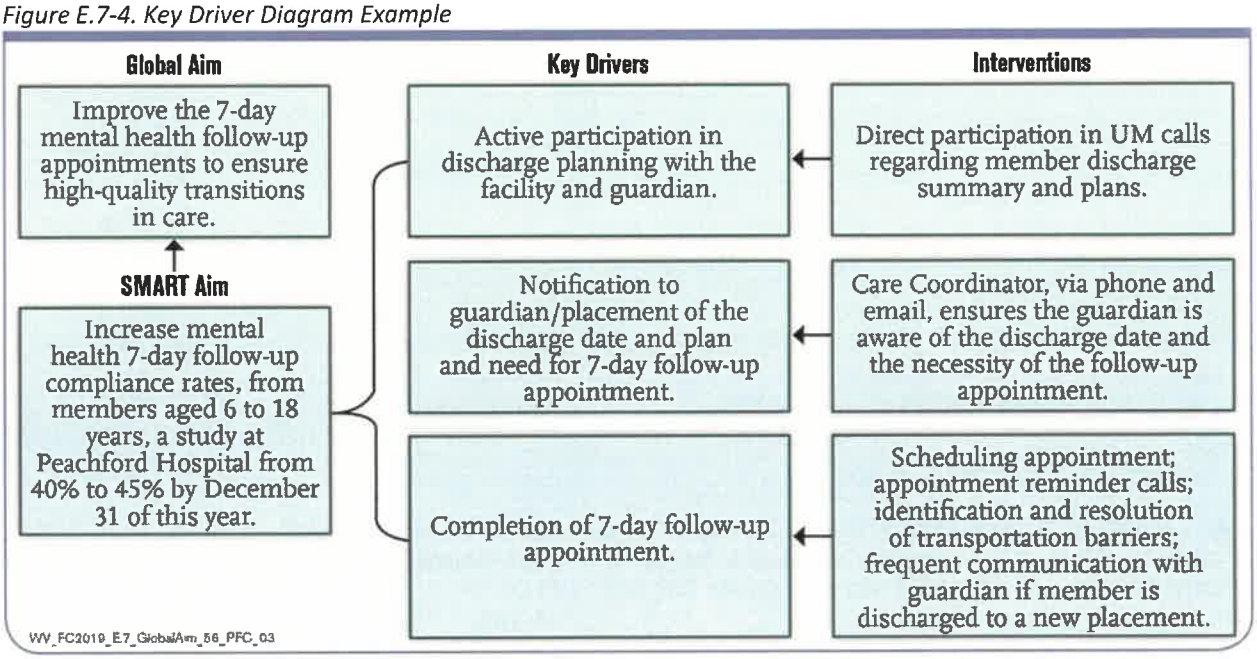
Table E.7-9. UniCare PIPs Within the Past 24 Months Resulted in Several Statistically Significant Improvements

Measure/Target	Summary of Intervention(s)	Baseline	Current Measurement	Significance
Dental Care for Children	• Text message reminder campaign • Outbound calls to families of members with GIC • Educating providers to accept 2-3 year olds for initial appointments • Time-limited member incentive for pregnant members	2017 Rates: • ADV Ages 2-3 = 39.87% • PDENT = 49% • Sealants = 25.02%	2018 Rates: • ADV Ages 2-3 = 41.17% • PDENT = 51.32% • Sealants = 38.25%	• ADV goal met, but not statistically significant • PDENT statistically significant (Z= -7.900) • Sealants goal met and is statistically significant (Z= -18.328)
Prenatal BH Risk Assessment and Postpartum Care Visit	• Calling members to ask if postpartum visit is scheduled and offer assistance • Calling providers after appointment to verify attendance • Members earn incentives for completed prenatal and postpartum visits • OB Practice Consultant working with providers	2016 Rates: • Postpartum Care = 62.04% • BH Risk Assessment = 39.58%	2018 Rates: • Postpartum Care = 68.86% • BH Risk Assessment = 26.76%	• Postpartum goal met, significantly exceeds benchmark rate • BH Risk Assessment not statistically significant
Follow-Up After Hospitalization for Mental Illness (FUH)	• Encouraging hospitals to begin discharge planning on the first day of admission • Members earn an incentive via Healthy Rewards (offered as a Value-Added Service [VAS]) for a completed visit • Contacting all members discharged to review medications, assess date of or access to post discharge appointments, transportation, support systems, and identify and assist in resolution of barriers, and offer case management services	2015 Rates: • FUH-7 = 15.48% • FUH-30 = 38.69%	2018 Rates: • FUH-7 = 31.11% • FUH-30 = 57.13%	• 7-Day rate statistically significant compared to benchmark (Z = -6.754 for 2015-2017) • 30-Day rate statistically significant (Z= 4.170)

Evidence of Successful Child Welfare PIP from Our Affiliate

UniCare's Georgia affiliate operated a PIP to improve rates of follow-up following discharge for BH and achieved a rate of compliance 30.35% higher than the baseline rate, meeting their SMART Aim. The PIP tested implementation of a Stabilization Team Care Coordinator and used methods such as a Key Driver Diagram and Failure Modes and Effects Analysis to plan and refine the intervention. We have applied lessons learned from this project to our model for West Virginia. Figure E.7-4 displays the Key Driver diagram and associated interventions used in Georgia.

Figure E.7-4. Key Driver Diagram Example



Identifying Problems in Quality of Care (QU032 QU033, QU034, QU035)

Our QM team investigates all potential quality of care issues, including preventable adverse events. We maintain a Quality of Care Policy and Procedure to guide this important process. We have the capability to identify quality of care concerns when conducting utilization review; reviewing or trending provider complaints, member grievances, and appeals; and monitoring physician practice activities. We may also learn of them from external sources, such as members, providers, CMS, or the State.

Upon receipt of an identified or potential quality of care issue, all relevant information is entered into our Quality of Care Event Tracking System and a reviewer thoroughly investigates, gathers information (such as claims and authorizations history, member communication logs, or medical management files), and obtains necessary consents for release of information. We gather medical records, obtain the provider's response, and develop an action plan to address the identified root cause. If a trend is identified as it relates to Quality of Care issues, it is reported through our health plan's quality committees. Member and provider education is conducted as indicated. If applicable, the Peer Review process is initiated and followed. Quality review of individuals may result in significant interventions depending on severity, including termination from the network, reporting to State licensing agencies, the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB).

Identifying Areas for Improvement or Corrective Action

Cross-functional leaders routinely monitor medical trends, grievances and appeals, and additional data points for emerging or persistent areas for improvement. We analyze data including the management of chronic and acute care diseases and conditions, public health data, statewide and community trends, impacts to core critical functions, SDOH, disparities, and more. We also prioritize our initiatives based on the volumes and types of care gaps present among the membership. Where gaps exist, we review the impact for both short-term and long-term sustainable health outcomes before implementing any new or modified programs.

When internal monitoring or notice from DHHR indicates potential for a serious issue that could affect members' care or our relationships with providers, we follow our policy for remedial action and respond rapidly to correct it. For example, we monitor and report performance in handling grievance and appeals data, including assessment of appropriate and timely handling, investigation, and resolution. There is a written plan to guide appropriate corrective action for inappropriate, substandard services or unfurnished covered services. Providers failing to meet established standards, whether identified through our re-credentialing process or through quality of care concerns, will be faced with Committee review and our recourse includes corrective actions, sanctions, or termination from the network. Related to ongoing operational performance, we also continuously track and trend our call center(s) and claims processing.

For any significant systemic problems, we will prepare a corrective action plan (CAP) within 30 calendar days of identification to mitigate and correct the issue. Our CAPs include all contractually required elements, including clear accountability to an assigned business owner or owners, specific actions, timeframes, and monitoring to completion. We monitor and evaluate the success of these changes to confirm effectiveness.

UniCare's NCQA-Compliant Committees Address Quality Issues

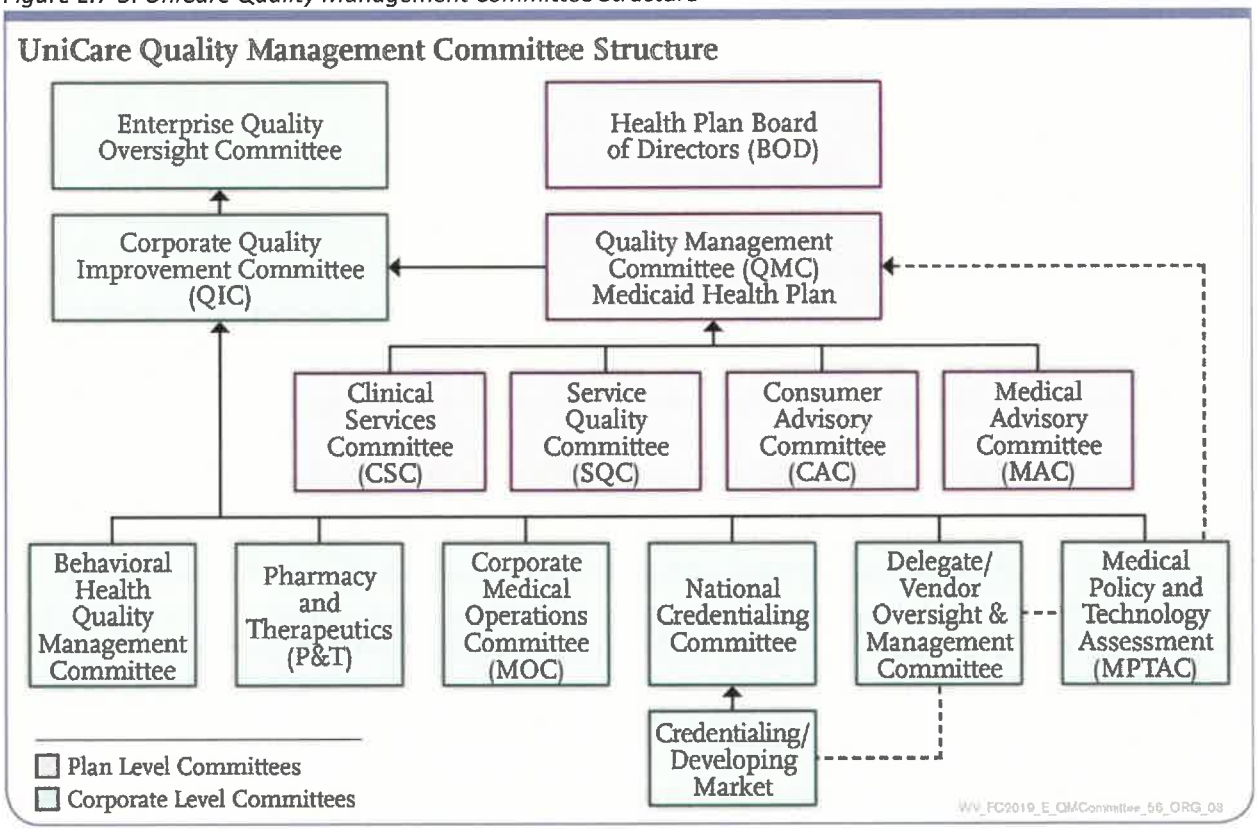
UniCare's robust QAPI Program includes numerous quality-related committees with responsibility for program oversight and improvement. UniCare's culture of quality is present throughout our committees, with leaders from functional areas across the health plan participating to present issues for discussion and action plan development. We structure our quality committees to serve as working groups to be sure all health plan decisions consider whole-person, integrated care.

Our work reflects a CQI philosophy and mode of action that goes beyond established regulatory and accreditation standards by engaging all UniCare staff as quality champions. CQI is woven throughout our health plan and our delivery system, and reflects:

- Most current health care quality improvement (QI) methodology and techniques
- Alignment with State quality strategies
- Quantitative and qualitative data collection and data-driven decision making
- Up-to-date evidence-based practice guidelines and explicit criteria developed by expert professionals
- Feedback provided by members and network providers used in the design, planning, and implementation of CQI activities

Figure E.7-5 reflects our QM Committee Structure.

Figure E.7-5. UniCare Quality Management Committee Structure



Quality Management Committee

Dr. Jessica McColley, a member of our MAC, has been instrumental in coordinating long acting reversible contraception services with harm reduction services through an alliance between Kanawha County Health Department and Cabin Creek FQHC.
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The Quality Management Committee (QMC) functions as the QAPI Committee and is the most senior quality-focused committee. The QMC provides oversight and direction to the MAC, Clinical Services Committee (CSC), Consumer Advisory Committee (CAC), and Service Quality Committee (SQC). The QMC leads all quality activities for the health plan, detects and addresses problematic issues, and ensures compliance with the QAPI Program Description and annual Work Plan. Our committee structure includes meaningful participation from providers and member representatives.

UniCare will have dedicated QM oversight activities specific to the Fostering Healthy Lives model. As such, our QMC will look at information from this population separately to assure focused attention during its quarterly meetings. Steps taken to resolve issues will depend on what is presented. However, all issues will be documented in QMC meeting minutes, and subsequent meetings will reinforce accountability of all assigned leaders' mitigation plans. Information on our Quality Committees is listed in Table E.7-10.

Table E.7-10. Quality Committee Key Functions

Committee	Key Functions

Quality Management Committee (QMC)	• Review and approve Quality Management Program Description, Work Plan, and Annual QM Evaluation that describe progress towards goals of the QM program, actions taken, improvements made, focused study results, and follow-up actions on identified opportunities
	• Review and approve reports on:
	  •Utilization Management
	  •Credentialing
	  •Case Management
	  •Pharmacy
	  •Disease Management
	  •Health Care Disparities
	  •Behavioral Health
	  •Population Health Management
	  •Clinical Practice and Preventive Health Guidelines
	  •Access and Availability Studies
	  •Member and Provider Satisfaction Surveys
	  •Recommend quality initiatives for possible implementation
	• Review and approve Corporate QM Policies and Procedures
	• Review and evaluate PIPs and provide feedback
	• Review and evaluate the quality, safety, accessibility, and availability of care and services

Medical Advisory Committee (MAC)	• Assess levels and quality of care provided to members and recommend, evaluate, and monitor minimum standards of care for members • Provide applicable advice and input to the corporate committee with oversight over the development and updating of CPGs; identify opportunities to improve services and clinical performance by establishing, reviewing/updating clinical practice guidelines based on review of demographic and epidemiologic information to target high volume, high cost, high risk, problem prone conditions • Conduct a peer review process that provides a systematic approach for monitoring of quality and appropriateness of care • Give advice to the health plan administration in any aspect of the health plan policy or operation affecting network providers or members • Provide oversight of the peer review process and drug utilization reviews • Provide guidance and feedback regarding technology assessment
Clinical Services Committee (CSC)	• Provide oversight and monitoring of all Clinical Operations functions ensuring effectiveness of clinical programs and regulatory compliance • Monitor over- and -under utilization • Annual review of Utilization Management (UM) and Care Management (CM) Program Descriptions and Evaluations • Clinical Practice Guidelines • Clinical Criteria for UM Decisions • Review of UM and CM Policies and Procedures ensuring compliance with federal, State, and NCQA requirements and standards • Reviews health care management system (HCMS) workflow processes ensuring coordination with all HCMS functions • Reviews approved medical necessity policy/criteria for use • Reviews nurse advice line criteria • Establish workgroups as needed to investigate and provide recommendations to improve the effectiveness of the clinical programs
Consumer Advisory Committee (CAC)	• Provide advice to the health plan operations regarding health education and outreach program development

Committee	Key Functions
	• Ensure that materials and programs meet cultural competency requirements, are understandable to the membership, and address the health education needs of the membership • Assist in the review, development, implementation, and evaluation of member health education tools for the outreach program • Review the health education plan and make recommendations on health education strategies • Provide a forum for consumers to provide guidance and recommendations
Service Quality Committee (SQC)	• Oversee and monitor customer service metrics and act when warranted • Provide a forum to discuss and formulate recommendations for interventions to be implemented regarding customer and provider service • Review data and develop action plans for improvement as needed to address: CAHPS, CLAS, Telephone Access, First Call Resolution, New Member Welcome Calls, Provider Satisfaction, Complaints/Grievances in relation to offered services, Geographical Access to Providers, Appointment Availability Survey/Secret Shopper Activities, Monthly Member Email Survey, Claim Processing and Payment

Fostering Healthy Lives Stakeholder Advisory Group and Parent and Caregiver Advisory Group

UniCare is deeply rooted in the fabric of the local community. As such, we are committed to cultivating relationships with members and their families or caregivers, providers, and stakeholders in the context of child welfare. Close collaboration enables us to gather insight into how we can best achieve the DHHR's goals while remaining attuned to stakeholder concerns. To engage the community about UniCare's programs for children and youth in child welfare, we will establish a SAG through which we will encourage open communication and dialogue with the community. By engaging with and listening to a broad array of stakeholders within the child welfare system from the outset, UniCare can best orient our program to be most responsive to the needs and priorities of the community, promoting optimal results and harmony.



We will also convene a voluntary Fostering Healthy Lives Parent and Caregiver Advisory Group comprised of foster, adoptive, and kinship parents from across the state to advise us on their perspectives. UniCare has the framework of this group already in place. ***Our already-established community advisory group includes foster parents, adoptive parents, natural parents, and kinship caregivers.*** This group will meet quarterly for the first year of the program and twice a year thereafter. We will offer stipends for participation, light refreshments, and offer options for virtual participation in addition to face-to-face. UniCare's Medicaid Member Advocate, in their capacity to connect members to services that promote positive outcomes, will have responsibility for convening this group with support from QM.

For each Advisory Group, UniCare staff will facilitate the meeting in a friendly and culturally competent manner, seeking to build commitment and confidence. The facilitator will manage the discussion and encourage all attendees to participate. We will distill the participants' recommendations and any potential solutions and bring them to health plan leadership for the development of concrete action plans. We will submit regular reports on our progress in addressing Parent and Caregiver Advisory Group recommendations to the secretary and Legislative Oversight Commission on Health and Human Resources Accountability. To promote transparency and engagement we will also make this report available on our member website.

Monitoring, Tracking, and Validating Subcontractor Data (QU049)

UniCare retains sole responsibility for fulfilling West Virginia Contract requirements. We are fully accountable for our subcontractors' performance through processes implemented to monitor, supervise, and enforce Contract compliance. Additionally, we promote frequent, open, and effective communication that emphasizes delivery of quality services to members. These well-defined processes have proven successful throughout our tenure in West Virginia and across our affiliate health plans in 21 other markets. We will continue to apply the same rigorous standards, lessons learned, and innovation shared through our affiliate plans to make sure we deliver services seamlessly to our West Virginia members, providers, and stakeholders, and in an integrated manner under the Program.

We contract with subcontractors only after a thorough evaluation process to determine they have the demonstrated capabilities and overall responsiveness to continuously improve the quality, efficiency, and value of services we deliver to our members, providers, and DHHR. We use a thorough audit process to evaluate prospective subcontractors, incorporating among other things, a review of the entity for compliance with all Contract requirements, State and Federal requirements, NCQA standards, financial solvency, measures, and any additional regulatory and accreditation standards for each market. Once we determine the preferred subcontractor, we request a pre-delegation audit, which is a comprehensive on-site review to evaluate the subcontractor's readiness, applicable licensure, and compliance, including Office of the Inspector General screenings.

UniCare's Health Plan Level Oversight

UniCare benefits from a multi-level approach to subcontractor management that is overseen at the health plan level, but supported by corporate departments focused on vendor management. At the local health plan level, UniCare's Subcontractor Oversight Committee (SOC) regularly meets with vendor representatives and our corporate subcontractor managers who are their day to day liaisons and review reports that allow us to monitor performance and compliance with requirements. The SOC is comprised of representatives from the health plan from compliance, quality, and operations. The committee has been led by the Plan Compliance Officer. However, UniCare will be hiring a West Virginia-based professional dedicated to Subcontractor Oversight who will pick up responsibility for leading the SOC and expand its scope under the Program.

A Subcontractor Oversight Manager is assigned to a subcontractor based on area of expertise and charged with keeping the SOC apprised of concerns with, or significant changes of the subcontractor, between regular meetings. This approach places a subject matter expert as the first line of oversight while giving UniCare overall responsibility for overseeing subcontractor performance.

National Oversight Committee

National oversight committees provide an additional level of support to our program. Regular communication between committees and our West Virginia Oversight Team maintains focus on delivering high-quality services. National oversight functions include the Delegate/Vendor Oversight and Management Committee (DVOMC) that oversees subcontractors serving multiple health plans. It is responsible for compliance with State, federal, NCQA, CMS, and program requirements and standards, as well as other regulatory or accreditation standards. They report to the National Medicaid Quality Improvement Committee quarterly.

Subcontractor Reports on Access to Care, Member Satisfaction, and Continuity of Care (QU050, QU051, QU052)

UniCare analyzes a variety of quarterly and annual reports to assess subcontractors' results. These reports are reviewed at monthly Joint Operations Committee (JOC) meetings that are held for both delegated entries (who have direct contact with members) and ancillary providers (who may or may not have direct contact with member) to assure that appropriate oversight and communication occur between the national teams, health plans, and Plan Compliance Officers. The JOC meeting agenda can include corporate and health plan updates, delegate updates, a delegated function report overview, market-specific issues and collaborative project reports, annual audit results, corrective action plans, identification and follow up on opportunities for improvement, review of sampling of denial and appeal letters (as applicable), and outreach efforts (where outreach is a subcontractor responsibility). The meeting minutes, including significant deficiencies identified and reported to the DVOMC, are made available for the annual State audit or internal audits. Mechanisms by which we track subcontractor performance on access to care, member satisfaction, and continuity of care are detailed in Table E.7-11.

Table E.7-11. Subcontractor Access to Care, Member Satisfaction, and Continuity of Care Oversight Reporting

Access to Care	Member Satisfaction	Continuity of Care
Medicaid GeoAccess®	Provider Satisfaction Survey	Performance Indicator Report
Medicaid Network Validation Attestation	Provider Demographic Change Report	Provider Demographic Change Report
834 Vendor Load Report		Authorization Denial Report
Provider Demographic Change Report		Appeal and Denial Letters

QUALITY MEASUREMENT AND REPORTING

UniCare demonstrates our commitment to transparency and accountability in improving health outcomes through delivery of quality measurement scores. Recognizing West Virginia has the highest rate in the country of very young children entering foster care, we share DHHR's goals to improve health outcomes for youth and families in the child welfare system, and focus on promoting well-being, permanency, and stability for our members. For the Program, we will build on our current expertise and tools and develop additional measures to demonstrate the positive impact of the program on members. We also offer our expertise in collaborating with DHHR on the design of its forthcoming Quality Withhold Program to select measures that are both meaningful and feasible. As a West Virginia Medicaid Program MCO, ***we have demonstrated responsiveness to West Virginia's priorities, increasing our performance-based withhold award for Medicaid by 13 percentage points over a three-year period.***

Quality Improvement Measures and Frequency (QU017, QU018, QO019, QU020, QU021, QU022, QU024)

Our QAPI program, led by an experienced local team, analyzes data across the health plan, including measures related to access to care, demand for services, quality of care, utilization, health outcomes, and client satisfaction to drive quality improvement strategies.

UniCare incorporates a myriad of performance measures and other information into our QAPI process including, but not limited to, those summarized in Table E.7-12, fostering a data-driven approach.

Table E.7-12. Comprehensive Measures to Drive Quality Improvement

Measure Description	Measures Included in QAPI Work Plan	Frequency
Access to Care	• Appointment and After-Hours Access	• Annually
	• CAHPS — Member Experience with Primary Care and Specialist Access	• Annually
	• HEDIS Access and Availability of Care Measures, such as Child and Adolescent Access to PCPs and Annual Dental Visit	• Monthly, Annually
	• Access Complaints and Grievances, including Enabling Services	• Monthly
	• Network Adequacy	• Quarterly, Annually
Demand for Services	• HEDIS Utilization Measures	• Monthly, Annually
	• Socially Necessary Services Utilization	• Quarterly
	• Outlier Reports for Under- and Over-Utilization	• Monthly
Quality of Care	• Quality of Care/Sentinel Event Reviews	• Quarterly
	• Adoption of Clinical Practice Guidelines	• Quarterly
	• Readmission rates for all causes within 30 days of discharge	• Monthly
	• Continuity and Coordination of Health Care, such as outpatient primary-care follow-up after ER visit; provider survey related to information received from PCPs, specialists, hospitals, and other facilities, home health agencies and outpatient therapy providers	• Annually
	• Continuity and Coordination between Medical and BH care; includes information exchange between BH and PCPs and appropriate diagnosis, treatment, and referral of BH conditions in primary care setting	• Annually
Health Outcomes	• HEDIS Effectiveness of Care Measures	• Monthly, Annually
	• Performance Improvement Projects	• Quarterly, Annually
Member Satisfaction	• CAHPS Member Experience Survey	• Annually
	• Monthly Member Email Survey	• Monthly
	• Member Complaints, Appeals, and Inquiries	• Monthly
	• Member Satisfaction with Care Coordination	• Annually

A data warehouse supports our operational processes, analytics, and reporting, and we receive data directly from the system of record to promote data quality, control, and consistency. The data warehouse collects and aggregates data into a comprehensive source of health information about our members and includes encounter data for medical, BH, and dental, as well as lab results and immunizations. We monitor HEDIS measures internally as frequently as every other week to guide rapid quality improvement responses, and then report official audited rates to DHHR and NCQA annually.

We are expanding our data assets to better address SDOH by gathering data on an individual and population level. The data warehouse supports access to member health data through Health Insight, our care management system; advanced data analytics, including predictive modeling; and operational, management, regulatory, and ad hoc reporting. We also analyze utilization data to monitor for under- and over-utilization monthly, assess turnaround times, and review services requiring pre-authorization to drive program and system improvements.

Frequent Quality Measurement Drives Performance Improvement

As part of our QAPI program, UniCare will incorporate all measures into our annual Work Plan for the Program, which summarizes all quality initiatives, their respective target measures, and interventions. The Work Plan will also include monitoring and reporting of HEDIS, non-HEDIS, and CMS Adult and Child Core Set measures as required. Monitoring of a complete set of clinical and non-clinical measures enables UniCare to establish a holistic view of member outcomes and the overall success of this program. At its quarterly meetings, the QMC will monitor progress toward these goals and adjust our interventions as necessary.

Our innovative Interactive Analytic Insights platform is a valuable tool in the quality improvement process as we use it to drive decision-making. This innovative tool is dynamic, responsive, and scalable, and provides visualization of performance over time and against applicable benchmarks. Equipped with actionable data, we will identify opportunities for improvement, plan and implement interventions, study the impact of those interventions, and then repeat the process using the rapid-cycle QI method. This ability to quickly tweak and refine interventions and processes and measure the results is the key to producing change.

Reporting All Measures as Required (QU008, QU009, QU010)

To consistently produce QAPI program reports and data analyses, our report generation protocols integrate subject matter experts who understand data, source systems, content, and meaning of reports; information technology experts who maintain and manage our systems; and analysts who know how to retrieve, associate, and process data to produce accurate, timely reports and validate that the data is meaningful and useful for identifying opportunities for intervention. Our system generates management and operational reports and delivers data to support program analytics. We apply rigorous edits and controls to verify the accuracy of all data, which provides a solid foundation for accurate reporting and data-driven decision-making.

UniCare will produce all measures and reporting for DHHR per requirements outlined in the SPA, including, but not limited to, annual submissions of our QAPI program documents, accreditation status, and HEDIS results. We are well versed in all types of quality measurement reporting, CAHPS surveys for member experience, CMS Child and Adult Core Set measures that enable national benchmarking in Medicaid and CHIP, EPSDT reports that track vital services for healthy development, and a variety of other homegrown indicators that monitor quality and drive quality gains.

Using HEDIS Scores to Assess Impacts (QU006)

Our HEDIS data collection and validation processes are thoroughly grounded in NCQA requirements and we carefully track and respond to edited measurement specifications released each year. We have over a decade of experience with annual HEDIS reporting in West Virginia, and our results are checked by an NCQA-approved auditor as part of our standard approach. We will submit finished HEDIS rates to DHHR each year on or before June 15.

As we describe throughout this response, UniCare has extensive experience with measures of all types, including NCQA's HEDIS indicators of clinical quality. We use an NCQA-certified HEDIS engine to facilitate HEDIS and any state-specific, HEDIS-like measure reporting. Our Quality team tracks and trends our measures through every other week and monthly reports, which we share with other departments and quality committees. With this data, we can readily identify opportunities for performance improvement, assess the impact of interventions, and monitor our performance relative to DHHR goals. Our reports include a listing of members who need EPSDT visits or other specific services measured by HEDIS, providing a resource that informs member and provider outreach.

Provider Payment Strategies Support HEDIS Improvements

UniCare has used provider incentives to drive improvements in quality and access in West Virginia since 2015. Our APMs increase the level of reward providers can earn based on improvements in quality measures like HEDIS and the associated member outcomes. Our network optimization and APM strategies help make sure our members receive care from high performing, engaged providers. Through our provider engagement model, we provide extensive support to our APM providers to optimize results through data sharing and performance reporting, expert consultation, and ongoing support to help providers meet quality and performance targets and implement targeted interventions. Further details of our provider incentive efforts in West Virginia can be found in Table E.7-1 in Attachment E.7, Quality.

UniCare was the top performing West Virginia health plan for HEDIS® 2018 in:

- Adolescent Well-Care Visits
- Annual Dental Visit
- Asthma Medication Ratio
- Comprehensive Diabetes Care—HbA1c Testing
- Follow up After Hospitalization for Mental Illness—7 days and 30 days
- Medication Management for People with Asthma-Medication Compliance
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-BMI percentile
- Well Child Visits in 3rd, 4th, 5th, and 6th Years of Life

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Measures Beyond HEDIS (QU007)

As a partner to DHHR in achieving successful outcomes for all stakeholders, UniCare will work with state agencies to combine data sources (such as Families and Children Tracking System [FACTS], juvenile justice data, education data, placement data) to develop new measures of child welfare system outcomes. These measures will address state goals, such as:

- Enhancing the coordination of care and access to services, including PH, BH, dental care and SNS
- Enhancing quality of care
- Delivering needed supports and services in the most integrated, appropriate and cost-effective way possible
- Improving health and social outcomes for youth and impact on families
- Including a comprehensive quality approach across the entire continuum of care services

To be comprehensive enough to be successful, these measures will rely on data sharing and the cooperation of multiple entities. UniCare will bring our in-house expertise in quality measurement and improvement to facilitate the process of designing new system-level measures. We will quantify systemic trends and contribute to successful outcomes for youth and families in child welfare by creating actionable data.

We propose additional measures in four areas: clinical outcomes beyond HEDIS, care coordination, UM, and member experience. UniCare's affiliates' experience serving children and youth in child welfare informed the development of our proposed set of measures. These actionable measures will promote positive changes and ultimately demonstrate a meaningful impact on the health outcomes of members. Table E.7-13 lists non-HEDIS measures and our improvement strategies for each category follow.

Table E.7-13. Non-HEDIS Measure Set to Assure Meaningful Impact

Category: Clinical Measures Beyond HEDIS
Developmental screening in the first three years of life
Reducing out-of-state placements
Perinatal substance use disorder claims
Suicide attempts and overdoses
Utilization of medication assisted treatment (MAT) by people with opioid use disorder (OUD)
Category: Care Coordination Performance
Initial outreach within five business days, with a goal of contacting members within two business days
Completion of the Health Risk Screener (HRS) within 30 days of enrollment
Care Coordinator assignment and member stratification within two business days of enrollment
Engagement rate
Number of completed outreach attempts completed (telephonic or face-to-face)
Completion of an initial Care Plan within 30 days of enrollment
Care plan updated to reflect change in placement or level of care
Category: Utilization Management Performance
ER visits for acute care per 1000 members
ER visits for Behavioral Health per 1000 members
Acute care inpatient visits per 1000 members
BH inpatient visits per 1000 members
Average length of stay for inpatient hospital admissions (acute and BH admissions)
Readmission rate for acute care within 30 days of discharge
Readmission rate for BH inpatient care within 30 days of discharge
Readmission rate to BH Crisis Stabilization Unit, Psychiatric Residential Treatment Facility, or Inpatient Acute Care Facility within 30 days of discharge
Category: Member Experience
Satisfaction with Care Coordinator and care coordination
Advisory Group and Focus Group input
CAHPS and CAHPS-like indicators, including: • Access to care • Access to specialized services • Getting needed information • Coordination of care and services

Clinical Outcomes Beyond HEDIS

Developmental Screening in the First Three Years of Life

This measure is anchored to developmental screenings recommended in the AAP Bright Futures guidelines that identifies children at risk for developmental, behavioral, and social delays. Tracking developmental screenings in the first three years of life helps to decrease disparities in care and improves the potential for early identification of children needing services to mitigate the effect of a developmental delay. This measure is included in the CMS Child Core Set of Measures for Medicaid and CHIP, further aligning our program with national priorities for quality improvement. We will utilize the specifications developed for that program to maintain consistency and comparability.

The cornerstone of our care coordination model is our Health Insight platform — a proprietary, integrated, social, and clinical care management system. Health Insight houses the Care Plans, captures health needs assessment results, incorporates member-specific utilization and claims, and provides information about member conditions. It also includes tools for Care Coordinators to track and monitor member touch points to make sure we are meeting targeted timelines for completion of key milestones, such as a provider completing a developmental screening for members who are young children.

Reducing Out-of-state Placements

Results & Successes

Between July 2015 and June 2017, we reduced the number of youths in out-of-state placements from 22 to 3, with an estimated savings of almost $2 million.

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To promote in-state care for children and youth, we recognize that improvement strategies will need to address both in-state provider capacity and family supports. Our Medical Director and Medical Management Director will conduct an ongoing review of placement data. They will work collaboratively with providers to prioritize utilization of the lowest level of care based on member needs, appropriately shorten length of stay in in-state facilities, and closely review progress of members in out-of-state facilities, monitoring availability of services in West Virginia to facilitate appropriate returns. Alternatives to PRTFs, for example, require the deployment of a wide array of community services and supports. Our Fostering Healthy Lives model will support families with intensive BH outpatient services and those in need of PCIT, respite care, and other community services to stabilize families and reduce further trauma exposure from multiple placements.

UniCare has a strong track record of success in this area. When BH services were carved in in 2015, we quickly realized that we had a number of members placed in out-of-state PRTFs. In response, we partnered with a provider to replicate the Safe at Home model for our members. As a component of this initiative, UniCare's UM and Care Management teams began integrated multidisciplinary case rounds in collaboration with the provider to hold residential providers accountable for their treatment plans and members' progress towards goals, including discharge back to West Virginia with appropriate community-based services and outpatient treatment. As a result of the PRTF initiative's success, UniCare has incorporated it into our standard processes to improve quality, and these positive trends have been sustained.

Further, we are proposing to implement our PRTQIP APM, which includes incentives for PRTFs to collaborate with us to facilitate successful transition of a member from the facility to an in-state community-based setting. A PRTF will receive a bonus if a member remains in the community for at least six months after discharge.

Decreasing Familial Events that Can Lead to Trauma and Contact with Child Welfare System

UniCare recognizes that to improve outcomes for young people in West Virginia, we must also be attuned to the experiences of their families. We know that West Virginia has suffered the greatest per capita impacts from the opioid crisis and has had a disproportionate increase in suicides. These crises have impacted families and contributed to the rise in the child welfare population. For our MHT members, we measure the interrelated issues of perinatal substance use disorder (SUD), suicide attempts and overdoses, and utilization of MAT among people with OUD.

UniCare has developed strategies to address these pressing concerns, including working closely with stakeholders, providers, universities, and policymakers to promote evidence-based practices for treatment and harm reduction. Examples include our LARC/Perinatal Partnership, Project ECHO® to promote MAT, the West Virginia Kids Health Partnership, and a targeted in-person care management program to reach hospitalized members in crisis. In association with these activities, UniCare is proud to have achieved the following between July 2016 and March 2019:

- An 80% engagement rate with Care Managers who meet hospitalized members face-to-face
- Perinatal SUD claims decreased by 26%
- Suicide attempts decreased by 21%
- Overdoses decreased 26%

Care Coordination Performance Measures

Given the complexity of needs in the child welfare population, every Fostering Healthy Lives member will be assigned a local Care Coordinator within two business days of enrollment. The local Care Coordinator will connect with and develop trusting relationships with our children and their caregivers. They will facilitate access to high-quality care that is holistic, meaningful, trauma-informed, and tailored to the child's strengths and needs.

Children and youth will benefit from our carefully designed care coordination approach. The Care Coordinator will work with the child and caregiver to develop a person-centered Care Plan that reflects the scope of personalized services (including PH, BH, SNS, and other social supports) that will drive optimal health and placement stability.

As listed in Table E.7-13, our Care Coordination program features a variety of process measures to provide continuous oversight so that key steps in the care planning process are completed. UniCare works to make our internal processes seamless and error-proof so that Care Coordinators can focus on member-centered delivery of services.

Working with children and youth in child welfare, our Georgia affiliate boasts a **95% completion accuracy rate** for individualized Care Plans in 2017 with a **98% participation rate** in Care Coordination.
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Care Coordination Improvement Strategies

UniCare will use meaningful process measures to assure high-functioning care coordination upon Contract award. We will configure reports in our Health Insight platform to produce a dashboard of measures on a daily, weekly, monthly, semi-annual, or annual basis, as appropriate. Under the direction of the Medical Director, we will run reports more frequently at the start of the program so that we can immediately detect and rapidly respond to performance aberrations. The Quality team will collaborate with clinical leaders to provide feedback to Care Coordinators, identify root cause analysis, and serve as an internal expert on process redesign. This collaboration will position us to not only meet, but to exceed required timeframes for care coordination processes.

Utilization Management Performance Measures

Utilization data is important to the overall view of quality because it tells us which services members are accessing. Analysis indicates where we can direct members and caregivers to less intensive treatment settings, such as regular appointments in primary care rather than inappropriate visits to the ER. As responsible stewards of State resources, the Medical Management Director and Medical Director will review UM measures for the program. With the goal of keeping members well, ***we will be proactive in helping to assure they receive the right care, in the right place, at the right time***.

Utilization Management Improvement Strategies

For clinical measures indicating members in need of services, UniCare delivers gap-in-care reports to PCPs and BH providers. This actionable data drives completion of recommended preventive care and promotes optimal health outcomes. ***Our intensive care management program will also play a key role in assuring a robust community-based set of services designed to reduce the need for ER and inpatient stays, visits to crisis stabilization units, and psychiatric residential treatment.*** Consistent with the tenets of High-Fidelity Wraparound, our Population Health Management and UM programs will focus on reducing preventable utilization. Our proposed Youth Records Access Portal (YouthRAP) will facilitate communication and coordination related to member discharge planning across all levels of care with DHHR, hospitals, PRTFs, residential providers, and PH and BH providers.

Member Satisfaction (QU037)

One of the most important components of our QAPI program is feedback from members to help UniCare support them in having a positive health care experience. To this end, we perform numerous activities to solicit and collect data on member satisfaction.

Satisfaction with Care Coordinator and Care Coordination

Since all members will have an assigned Care Coordinator who will play such a critical role in coordinating services throughout the system of care, we will continue to conduct a Care Coordination member experience survey quarterly. The results of the surveys will provide us with detailed data on the more complex service needs and care experience for our members in child welfare and their caregivers. An NCQA-certified survey Vendor will administer these surveys and each year we will summarize the findings as part of the QAPI program.

Advisory and Focus Groups

Our Fostering Healthy Lives program will utilize two Advisory Groups as well as ongoing, targeted focus groups to understand and respond to member and caregiver needs, including access barriers for members with specialized needs. The SAG has the broadest composition to allow for the inclusion of diverse perspectives and skills. This group will meet regularly to provide input into the program, addressing topics that include training gaps and needs, program challenges and recommendations, system challenges, and how UniCare can be a part of the solution. The Fostering Healthy Lives Parent and Caregiver Advisory Group will also convene regularly. With this group, we anticipate covering:

- Access to services
- Enrollment and continuity of care
- Communications from the health plan, including member materials
- Grievance and Appeal processes
- Responding to children and youth with special need health care needs
- Coordination with other systems (for example, juvenile justice or education)
- Education and training needs



As detailed under Monitoring Utilization and Enhancing Access to Services, UniCare will conduct no fewer than 24 focus groups throughout the year, half with youth, families, and foster parents that reside in the community and utilize SNS and the other half with youth, families, and foster parents that have received services within a residential treatment facility (including PRTF).

We will record all Advisory Group and focus group discussions, summarize themes, and identify actionable recommendations for UniCare to pursue for system improvements. The Medicaid Member Advocate will present recommendations and progress to the QMC no less than annually as part of our QAPI program.

CAHPS Surveys

Each year, UniCare engages a qualified vendor to administer the most current version of the CAHPS survey to query members on access to care and other key questions. We will augment our current surveys to produce dedicated rates and reporting specific for the Program population. UniCare's performance with member experience has been strong. ***In the 2018 survey, we scored over the 95th percentile on the following Child CAHPS measures:***

- Getting Care Quickly Composite
- Got Check-Up or Routine Care as Soon as Needed
- Got Urgent Care as Soon as Needed
- Health Plan Forms Were Easy to Fill Out

Member Experience Improvement Strategies

The Quality Director oversees the strategies in place to create a positive member experience. This includes the CAHPS survey administration process, grievance and appeal data analysis, and presentation of year-over-year results to discern trends and comparisons. Each year we compare data to national benchmarks, affiliates, and our own internal quantitative goals for member experience. This process informs the identification of improvement opportunities and helps us evaluate the effectiveness of our Care Coordination services and customer satisfaction. Health plan leaders from multiple departments review survey data and use it to inform staff training needs and program modifications to optimize member experience. Results of the member survey are reviewed by our SQC, which is tasked with bringing together clinical, customer service, and operations team leads with network stakeholders to identify improvement opportunities and specific strategies for improvement. UniCare's Quality Improvement team is responsible for updating the QAPI Work Plan with the proposed measures across all four domains, highlighting areas for improvement, and documenting and supporting improvement strategies.

MONITORING UTILIZATION AND ENHANCING ACCESS TO SERVICES

Analyzing Utilization Data to Monitor Quality Improvement Strategies (QU023)

UniCare strives to ensure members receive ***the right care, in the right place, at the right time***. We focus on improving outcomes for our members and serving as an effective steward of the State's resources. Utilization data is important to the overall view of quality because it tells us which services members are accessing. We regularly monitor for utilization outliers that could indicate that a child is not receiving the appropriate care. We also view detailed utilization trend data, look for patterns, and detect potential access barriers. Equipped with this information, our Quality Director, Medicaid Member Advocate, and other health plan leaders can enact both broad-based and targeted changes to improve quality outcomes.

Utilization Trends

UniCare understands the critical need for members to receive covered services in a timely, appropriate manner. Our Fostering Healthy Lives model is designed to optimize efficient and effective utilization that contributes to positive health outcomes. We will monitor for under- and over-utilization to assure members receive well-coordinated services, specifically monitoring for outliers in our trend data. Our performance reports identify both providers and members with utilization patterns that fall outside of the expected range. Under-utilization of services may indicate that a child is not connected to primary care and other specialty services. In that case, a Care Coordinator will contact the caregiver to determine if they need assistance in finding a doctor, scheduling, or addressing other barriers. After a new member enrolls, each Care Coordinator is aided by our dedicated Concierge team to assure required EPSDT services are obtained within the required 30-day and 90-day timeframes.

Conversely, consistent over-utilization may indicate that a child is experiencing a health crisis and may not be receiving the most appropriate services to meet their needs or in alignment with their care plan. In that situation, our Fostering Healthy Lives interdisciplinary care team (ICT) will be mobilized to consult with the caregiver and potentially adjust the Care Plan so that a member can be served in the most integrated setting available. See Table E.7-12 under Quality Measurement and Reporting for a listing of our UM measures.

We are experienced in using analysis to achieve efficient yet high-quality care for our current Medicaid members. For example, we recently identified a significantly increasing trend in skilled nursing visits with no apparent clinical cause. After re-educating the team of UM reviewers on appropriately

reviewing this service, visits were reduced by about half from 2017 to 2018. Additionally, our integrated Clinical Oversight Workgroup monitors utilization patterns trends, including use of emergency services. UniCare has successfully addressed ER over-utilization for West Virginia Medicaid programs through:

- **ER Case Management.** A short-term program that targets the highest utilizers and their caregivers for education about the appropriateness of different care settings and assistance in coordinating care for issues that contribute to ER use.
- **Facility Based Case Management.** Provides face-to-face support to members during an inpatient stay at many facilities statewide, including those in Morgantown, Fairmont, Beckley, and Princeton.
- **Community Paramedicine.** An outreach visitation program that engaged hard to reach, high cost, dual diagnosis members.

Partnering with Providers to Achieve Effective Utilization

Identifying Members in Need of Primary Care Services (QU053, QU056)

UniCare's Fostering Healthy Lives model focuses on reliable access to primary care and Patient Centered Medical Homes (PCMHs) when available to meet each member's needs. Per the AAP, children in foster care have often received sporadic health care prior to entering the system. About 50% have chronic PH problems such as asthma, anemia, or neurological disorders. About 35% of children entering foster care have significant dental and oral health problems. Understanding that children and youth in child welfare tend to have greater unmet or unidentified health needs, ***our Fostering Healthy Lives model is designed on the tenets of early identification of member needs to help eliminate GIC and establish a lasting linkage with a medical home***.

Fostering Healthy Lives Concierge Team

We will engage our Concierge team when we are notified that a member is eligible for the Fostering Healthy Lives model. The Concierge Representatives will assist members and families in coordinating and scheduling assessments, verifying and identifying the accuracy of member contact information, and assuring the care planning process begins with as much information from the member as possible. The Concierge Representatives will be available to answer inbound calls from members, caregivers, or DHHR staff to schedule assessments, connect members and caregivers to the Care Coordination team, and respond to immediate needs. The Concierge Representatives will locate information and records, and assist in identifying and addressing any known gaps and help assure members get the most appropriate care and supports they need quickly.

Reporting and Analysis

To identify members in need of primary care services, we will utilize the information collected in the HRS conducted within the first 30 days to identify outstanding health needs and State-mandated assessments and appointments. As members continue in the program, we will use claim and encounter data to run HEDIS and EPSDT gap-in-care reports on a monthly basis at minimum. We will build on our current PH and BH gap-in-care reports to increase their frequency and to add additional HEDIS measures relevant to the child welfare population, including Follow-Up After Hospitalization for Mental Illness (FUH) and Follow-Up After Emergency Department Visit for Mental Illness (FUM). Our Quality Director oversees the completion of the data analysis process and monitors that the appropriate outreach occurs to members and their caregivers as well as assigned PCPs via QM Practice Consultants. The QMC will review primary care utilization data for applicable populations on a quarterly basis to be sure this issue receives adequate attention.

We will also use the FACTS system, as allowed by DHHR, to research relevant data for our members and obtain a full picture of their health history and experience. Information found on FACTS will be entered into our systems and displayed on our newly developed member portal, YouthRAP. This portal will house all information in a consolidated record that records the member's history and will follow the member throughout engagement in child welfare, reducing potential for duplication of services.

UniCare's Georgia affiliate's Georgia Families 360° HEDIS® 2018 Measures Exceeding the 90th Percentile:

- Follow-Up After Hospitalization for Mental Illness (7 Days)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Childhood Immunization Status
- Immunizations for Adolescents
- Annual Dental Visits

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Contacting Members to Close Gaps in Care (QU054)

UniCare will use established processes already employed in West Virginia to close GIC and enhance them through our proven child welfare model. ***UniCare employs multiple strategies to contact members and caregivers early and often to facilitate access to needed care.*** The frequency and mode of contact will be dependent on individual member needs. Our Care Coordination team will monitor outreach attempts are occurring per the schedule and frequency outlined in each member's Care Plan. For any member identified by our quality analytics as not having received primary care services within the last six months, a Care Coordinator will promptly contact their current caregiver within two weeks of gap identification.

We will pursue partnering with the Office of Maternal, Child, and Family's Health Home Visitation Program to provide them with information to be shared with families and caregivers to encourage and support scheduling of regular primary care and EPSDT-related visits.

As part of broad-based member education and engagement strategies, we will reinforce the importance of preventive care and regular visits to PCPs, and encourage engagement with trauma-informed PCMHs where possible. These messages will appear in our new member welcome packet, member handbook, on our website, in our welcome calls, through community events, and through social media. The Concierge Representatives and Care Coordinators will also stress the need for establishing and maintaining good relationships with PCPs during conversation and care planning. UniCare will use "reminder" postcards, calls, emails, and texts, when permitted, to members and/or caregivers about upcoming needs for care.

Our YouthRAP platform will allow Care Coordinators to coordinate efforts with the Department caseworkers, and other entities as appropriate, to identify and resolve barriers to services through secure transmission of information.

Incentivizing Members to Access Needed Care



UniCare offers a Healthy Rewards member incentive program as a Value-Added Service to incentivize and reward healthy behaviors and preventive services. To that end, ***we have developed a comprehensive list of targets for which our Program member or caregiver can receive a monetary reward for completing the health-related service***. We have built upon our Medicaid experience in West Virginia to further customize this program to be responsive to this membership. During the term of this contract, UniCare plans to upgrade our Healthy Rewards platform to enhance personalization, reward redemption options, mobile-responsive design, and other features that will make the program more attractive to members. Figure E.7-6 shows each incentive activity.

Figure E.7-6. UniCare Healthy Rewards Member Incentives

Eligibility	Measure	Reward	Limits
Members ages 2+ years	Complete annual dental visit	$25	Once per 12 months
Infants ages 2 weeks or younger	First well-baby visits	$25	1 time
Children ages 0-15 months	6 well-baby checkups	$25	1 time
Children ages 3-6 years	Well-child Checkup	$25	Once every 12 months
Adolescents ages 12-21 years	Wellness checkup	$25	Once every 12 months
Members age 6-12 years prescribed ADHD medication	Complete follow-up with prescriber (three visits in a ten month timeframe)	$25	Once per 12 months
Pregnant members	1st prenatal checkup within 42 days of enrollment	$25	1 per pregnancy
Pregnant members	6 prenatal checkups	$25	1 per pregnancy
Pregnant members	Postpartum checkup 21-56 days after delivery	$25	1 per pregnancy
Female members ages 21+ years	Complete cervical cancer screening	$50	Once every 12 months
Members ages 18+ years with diabetes	Diabetes blood sugar (HbA1c) screening and kidney test	$50	Once every 12 months
Members age 6 years and up who have been discharged from a hospital for a mental health condition	Outpatient visit with mental health provider within 7 days of discharge	$20	1 per discharge; maximum of 4 every 12 months

Engaging Providers of Members Not Receiving Primary Care (QU055)

Stronger Together

UniCare has a strong statewide provider network and a history of working relationships with provider groups throughout West Virginia. We will call on this experience to engage PCPs to meet member needs. UniCare will utilize our dedicated Care Coordination team to outreach PCPs of members identified as not receiving primary care services within the last six months to encourage provider outreach to the member or caregiver. This contact will occur within two weeks of identification of this need, in parallel with our outreach to the member and caregiver. On an ongoing basis, our Care Coordinators will also work with our network of 106 NCQA-recognized PCMHs in West Virginia to offer actionable data to providers to help them better understand the health status and needs of their member panels through quality and medical cost management reports. We are also developing Foster Care PCMHs (FC-PCMHs) for the Program.

Support and Training for Providers

Provider Pledge

We will offer in-office provider support for quality improvement and care gap elimination. Working in coordination with our Community Engagement and Training team as well as our Provider Relations staff, our QM Practice Consultants will engage with PCMHs and other providers to support care gap closure, member satisfaction improvements, and facilitate information sharing. We will also encourage providers to make personalized reminder calls, sending providers emails and "blast" messages with information about members who are due to make or keep an appointment, and encouraging them to contact members in advance of the scheduled appointment. We engage providers in helping to verify prompt appointment scheduling and adherence, and monitor compliance through claims data and provider reports that are fully described in our response to Attachment E.1, Benefits Administration.

Nurse Practitioner Home Visit Model

INNOVATION

We are developing an innovative program to help meet our members where they are to receive needed care. Through our new Nurse Practitioner (NP) Home Visit model, we will coordinate with NPs in the network to offer an increased rate for home visits that close critical GIC for members. Our QM team will provide analytics that identify members in need, and our Care Coordinators will work with members and families to set up in-

home appointments for overdue services. We anticipate that this new option will benefit busy households, families, and caregivers with transportation barriers, and others who have under-utilized PCPs. We will first target members who have not been seen in primary care in the preceding six months and expand if the program is successful.

Using Provider Incentives to Promote Quality Improvement

We use our incentive programs to engage providers and encourage them to partner with us to improve member outcomes. UniCare's APMs increase the level of reward providers can earn based on improvements in quality. For example, we currently offer APMs to providers in West Virginia, and are further expanding them as described in Attachment E.7, Provider Incentives and Value-Based APMs:

- **School-based Well-visit Incentive Program (SBWIP).** To incentivize SBHCs for well visits for children in targeted age categories.
- **Foster Care Access Incentive Program (FCAIP).** To incentivize initial health assessments/EPDST/trauma assessments.
- **Pay for Quality (P4Q).** To incentivize providers for closure of high-priority GIC.
- **Provider Quality Incentive Program (PQIP).** PQIP incents select PCP practices to undertake systematic improvements that affect health care outcomes and cost trends. Practices must participate with us for at least one year and have at least 1,000 assigned members to participate. Currently, 64% of West Virginia's PCMHs participate in this program.
- **Behavioral Health Quality Incentive Program (BHQIP).** BHQIP incents Community Mental Health Centers (CMHCs) and high-volume BH professional groups to improve coordination of members' PH and BH needs and the quality of care provided to those with BH conditions. Providers receive incentive payments for achieving performance targets on specific measures important to members' health (for example, reduction in BH inpatient readmission rates, decrease in ER visits, increased PCP visits, and follow-up after discharge for treatment of a mental health disorder).

UniCare delivers gap-in-care reports detailing members due or overdue for services to PCPs, including specialists acting as PCPs, and BH providers. This actionable data drives completion of recommended preventive care evaluated by HEDIS and promotes optimal health outcomes. We couple reporting with provider and member incentives to drive improvements in accessing and receiving quality care.

Identifying Barriers to Care for Members with Specialized Health Care Needs (SHCN) (QU026, QU027, QU028, QU029, QU030)

UniCare recognizes there are many unique challenges in the child welfare population that lead to specialized health care needs and make obtaining access to needed services difficult. We are adept at handling placement and caregiver changes, children and youth with a history of trauma, significant BH needs, and the full range of specialized medical and social supports available. ***We make sure members with specialized health care needs, including those with disabilities (or at risk of developing a disabling condition), or a chronic or complex medical or BH condition are identified, screened, and referred to specialty providers for assessment and appropriate treatment intervention.*** As fully described in Attachment E.1, Benefit Administration, UniCare has established information systems and processes to identify members with specialized health care needs or with complex or serious medical conditions. UniCare will employ a variety of techniques to identify and decrease these barriers to care. We will primarily utilize our Care Coordinators in identifying and addressing access barriers, who work to authorize and link members to services. We will also leverage our UM processes to address gaps or barriers that may be identified during the initial and concurrent reviews.

Focus Groups

In addition to our two previously described Advisory Groups that will meet regularly to provide input into the program, UniCare will conduct no fewer than 24 focus groups throughout the year, half with youth, families and foster parents that reside in the community and utilize SNS and the other half with youth, families and foster parents that have received services within a residential treatment facility (including PRTF). Consistent with DHHR's vision, we will recruit willing participants and facilitate focus groups in a manner that yields helpful feedback on the scope, quality, and accessibility of services. We will work with the Bureau for Children and Families (BCF) on sets of questions to be used with each focus group, targeting similar topic areas across both types of groups but customizing the questions. Topics and sample questions include:

- **Access.** If you needed to access more or different services, do you know whom to contact?
- **Service Delivery.** What service or feature of the program has been most helpful to you?
- **Gaps in Support Systems.** Are you allowed visits with siblings, extended family, kin, or your friends you want to keep in touch with from home?
- **Engagement with System Staff.** Do you feel the people who work with you treat you respectfully?
- **Cultural Competency.** Do you help decide how to celebrate holidays or other special occasions?
- **Consumer Knowledge of Services and Supports.** Are you aware that UniCare's Care Coordinators can help you find a doctor and help you get to an appointment?

Real Stories

Anna, a 15-year-old UniCare member from Lewisburg, had been diagnosed with acute flaccid myelitis and become paralyzed from her neck down, requiring a tracheostomy with ventilator assistance and PEG tube for feedings. She had been admitted to a nearby hospital, but after she was medically stable, her care team determined that she needed more specialized treatment. The nearest facility that specialized in spinal cord injuries was in Atlanta, which required a more than $4,000 medical flight.

Anna made the trip to Atlanta and underwent a successful decannulation of her tracheostomy and removal of her feeding tube. Because the family did pay part of the flight cost up-front, Holly and other UniCare staff are working with the state on reimbursement for the out-of-pocket cost.

Anna was discharged and has returned home to Lewisburg, where she has made amazing improvements. She is able to walk short distances and has full movement of her arms. She was able to complete all of her make up school work and will start her sophomore year of high school right on schedule. In addition to coordinating Anna's medical care, UniCare will continue to follow up until the medical flight reimbursement is complete.

We will record all focus group discussions, summarize themes, and identify actionable recommendations for UniCare and BCF to pursue for system improvements. The QMC will review focus group recommendations and progress no less than annually as part of our QAPI program. In addition to the focus groups discussed, UniCare is open to collaboration regarding development of further focus groups as needs arise.

Surveys

Making sure services are available is of primary importance, particularly for Children with Special Health Care Needs (CSHCN). We contact providers to address appointment availability and capacity to meet timeframes for member assessment and treatment through recurring provider surveys. We also survey our members and inquire about satisfaction with provider

availability during member contacts, and analyze annual CAHPS metrics. Topics for member survey questions include:

- Difficulty setting up appointment
- Wait time between setting appointment and seeing doctor
- Receiving wellness/preventive care as soon as needed
- Having good experience with my doctor
- My doctor explaining things in a way I can understand
- My doctor listened to me carefully
- My doctor spent enough time with me

Our member experience improvement strategies, including review of CAHPS, have been described earlier. Results of these surveys will be reviewed annually by the SQC.

Secret Shopper

UniCare monitors practitioner appointment accessibility, after-hour accessibility, and telephone accessibility annually to ensure members have timely access to their medical and BH practitioners and prompt response to telephonic inquiries. We use a vendor to audit provider availability through random calls to providers asking how soon a member would receive an appointment, assessment, or treatment. UniCare's Provider Relations team oversees this process and reports results through the annual QAPI evaluation, where data is trended and compared to annual targets. ***In our most recent survey, high-impact specialists scored 100% in providing regular and routine care appointments.*** However, our root cause analyses often find that providers are not fully aware of appointment requirements and we are increasing our efforts to educate our network on the importance of urgent and routine appointment availability.

Aggregate Utilization Monitoring

UniCare's integrated PH and BH Care Coordination teams comprised of integrated tools and rounds will be fundamental to making sure that UM protocols accommodate the unique needs of each Fostering Healthy Lives member, including the specialized health care needs that some members will have. Care Coordinators will work closely with UM staff to add important details to the clinical information received from providers, as well as help incorporate a trauma-focused approach to service level decisions. We will work collaboratively to help assure that members receive needed services and seamless access to specialists in relation to their care planning. Our UM protocols support the use of appropriate health care professionals in assessing members to identify medical procedures to address and/or monitor the conditions, and development of treatment plans appropriate for members determined to need a course of treatment or regular care monitoring. ***We use systematic processes to assess needs and monitor treatment plans of members identified with specialized health needs,*** and we strive to eliminate barriers to care by providing direct access to experienced specialists within our network.

Using Data to Identify Access Barriers for Members with Specialized Needs (QU044, QU045, QU046, QU047, QU048)

UniCare will leverage both qualitative and quantitative data to measure and understand access barriers for CSHCN. We will glean this information through our suite of utilization reports and all the methods described in QU026-QU030, including the Advisory Groups, focus groups, and surveys. In addition, we will run dedicated reports to identify PCP change requests, out-of-network referrals, and ER usage, as patterns in any of these can indicate opportunities to better connect CSHCN to care.

In the CSHCN population, we are highly attuned to grievances, PCP change requests, out-of-network referrals, and frequent ER usage tools as potential flags for intervention. We monitor data from each of

these categories to identify any trends in care or provider practices that may be addressed. The QMC reviews grievance data inclusive of CSHCN on a quarterly basis and we will engage the Medicaid Member Advocate in any systematic improvements taken in response. In the case of out-of-network referrals, our provider services team will pursue the opportunity to add the provider to our network.

We examine data feeds for utilization that indicates potential for a specialized health care need to make referrals to the State's program for enhanced services and will continue this practice under this contract. UniCare will identify children that are consistently using certain types of services, such as Private Duty Nursing (PDN) or who have certain diagnoses such as cardiac conditions, epilepsy, and/or neurological disorders. Specifically, our CSHCN Care Coordinator checks the inpatient census daily for pediatric admissions with a Neonatal Abstinence Syndrome (NAS) diagnosis and reviews the output of our predictive model for children with certain indicators, such as a need for enteral feeding. This Care Coordinator also attends BH rounds to identify potential referrals. Once in this program, our Care Coordinators closely monitor CSHCN and coordinate with the State to solicit feedback regarding stabilizing members and overcoming access barriers that lead to poor outcomes, such as overutilization of ERs.

Our Care Coordination team also examines data regarding services for this population that have been authorized but for which we do not have an indication of utilization. When identified, we conduct outreach to determine the reasoning or root cause and check that the member is not missing needed care or supports.

UniCare uses systematic processes to assess needs and monitor treatment plans of members identified with specialized health care needs, and we strive to eliminate barriers to care by providing direct access to experienced specialists within our network. We will monitor PCP change requests for indications that CSHCN are dissatisfied with care and could be better served with a different medical home. Should a trend with a provider be uncovered, it will be reported through our MAC for potential corrective action. We also understand that members with complex or specialized health care needs may benefit from having a specialist assume the role of their PCP, and facilitate that process when desired. If appropriate based on the member's specific health condition, we will offer the opportunity to be assigned to a chronic condition health home that provides comprehensive services to facilitate coordination and management of their complex health condition. If a member is participating in a chronic condition health home, we provide enhanced coordination of services to the health home and make sure the health home is promptly notified of any use of emergency services, inpatient admission, or discharge.

We will also work with specialists serving as PCPs to make sure that if they are also providing primary care services, they have the education and support needed to fulfill the requirements of EPSDT. We will enhance our EPSDT toolkit with new resources specifically targeted to specialists who may be acting in a primary care role, so they have full awareness of benefits and how to fulfill the schedule of visits and other requirements.

In addition, our QM Practice Consultants may identify opportunities to improve a provider's coordination activities during provider chart audits. Once identified, the Care Coordinator works with our Network Relations Consultant to identify actions to improve the provider's coordination activities, beginning with provider education that includes a review of coordination responsibilities and resources available to support coordination, including Care Coordination and system resources. Providers with ongoing quality issues will be required to develop a written corrective action plan and to demonstrate compliance within a specified timeframe and may be referred to our Medical Directors for peer consultation as needed. In addition, our Care Coordinators will advise the Engagement and Training team when they identify a need to reinforce this requirement so that this responsibility can be emphasized in provider training.

Reporting (QU025)

Because of the importance of this issue, quality measures of access can be found in nearly all our QAPI documentation. UniCare will report to DHHR all measures as required by the SPA as detailed in Table E.7-14, including those specifically targeting access.

Table E.7-14. Schedule of Reporting to DHHR Inclusive of Access Indicators

Measure	Frequency
HEDIS	Annually
Medical Grievance and Appeals Report	Quarterly
Socially Necessary Grievance and Appeals Report	Quarterly
Dental Grievance and Appeals Report	Quarterly
Behavioral Health Grievance and Appeals Report	Quarterly
Written Description of PIPs and Results	Annually
PIP Progress Report	Quarterly
HEDIS	Annually
QAPI Annual Evaluation	Annually
QAPI Corrective Action Plan	Within 30 days of identification of systemic problem
CAHPS Member Survey Analysis, Action Plan, and Evaluation	Analysis Annually, Updates Quarterly
Accreditation Review Report	Upon completion or change in status
EPSDT Services and Reporting	Annually
Adult and Child Core Quality Measures	Annually
Parent and Caregiver Advisory Group Report	Annually
Focus Group Report	Annually

8. VALUE-ADDED SERVICES

In addition to the above subject matter areas from ***Appendix 1: Detailed Specifications,*** the Vendor should include any Value-Added Services to be offered in this section, as well as any eligibility requirements and potential limits for these services. Vendors are not required to propose value-added benefits, but inclusion of such services may impact the Vendor's overall evaluation. The Vendor's narrative response should not exceed 5 pages.

UniCare will offer a comprehensive array of ***22 Value-Added Services (VAS) specifically for West Virginia's children, youth, and families (Figure E.8-1)***. We are committed to providing services in addition to those covered under standard benefits and ones that augment services we believe are particularly critical, such as socially necessary services (SNS). Our VAS always complement, but never duplicate, what is already available and accessible. From the youngest members, older youth, and the families and caregivers who take care of them, we offer age-appropriate VAS to help improve health and social outcomes and impacts on families.

In selecting the most appropriate VAS, our first priority is to listen. We leverage feedback from members, families, and stakeholders, including providers and community organizations. Coupled with our own experience serving West Virginia, we designed our VAS to achieve the following goals:

- Support education — a significant social determinant of health — as youth in the child welfare system often lag behind their peers academically
- Foster a sense of normalcy, so kids in child welfare can participate in developmentally and age-appropriate activities and enjoy the experiences of "being a kid" just like their peers
- Encourage family togetherness and parent-child bonding to strengthen families and stability
- Address any gaps in covered services to help enhance program results

Figure E.8-1. UniCare Categorizes VAS into Key Areas of Support

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

Tools for Transitions	Educational Supports	Tools to Strengthen Families	Healthy Behaviors
1. New Placement Welcome Wardrobe	7. In-home Tutoring Services	11. Foster Care Toolkit	17. Extracurricular Support
2. New Placement Welcome Portfolio	8. Educational Milestone Program	12. Kinship Care Toolkit	18. Youth Club Memberships
3. Comfort Kit	9. Toddler Development Kit	13. Medicine Safety Kit	19. Online Well-being Program
4. Jump Start Program	10. Summer Reading Benefit	14. Gas Card	20. Scholarships to Camp Catch Your Breath
5. Home Essentials Kit		15. Family Activity Coupon Book	21. Scholarships to Camp Kno-Koma
6. Lifeline Smart Phone Benefit		16. Community Resource Link	22. Healthy Rewards Program

Tools for Transitions

Tools for Transitions

We designed several VAS (Table E.8-1) to help support younger children entering the foster care system or adjusting to a new placement. Any transition can be stressful, so we offer ways to support children, such as our New Placement Welcome Wardrobe and Portfolio and a Comfort Kit. ***We also offer VAS to help older youth in reaching their full potential as they transition into adulthood.*** Many youth who exit the foster care system are more likely than their peers to face difficulties, such as housing instability, unemployment, mental health and substance abuse issues, and more.

Table E.8-1. UniCare's VAS Help Support Youth Transitioning to New Placements and Transitioning into Adulthood

1. New Placement Welcome Wardrobe

VAS Description: Through our work in West Virginia Medicaid and by listening to the needs of youth and families, we discovered many children in foster care need financial assistance to help purchase clothing and shoes. In response, we developed this VAS, which ***provides a $150 retail gift card to members every time they are placed in new foster families to help purchase essential clothing.***
Eligibility & Limits: All members enrolled in foster care and placed with a new family are eligible. One store card ($150) per member, per year.

2. New Placement Welcome Portfolio

VAS Description: Welcoming a new child into a home can be exciting, but challenging. This VAS can help families get to know each other, and help ease both the child's and the caregiver's transition. ***Contents include coloring book, markers, crayons, and colored pencils so a child can express themselves and let their foster families know more about them.***
Eligibility & Limits: All members are eligible. One welcome portfolio per member, per placement.

3. Comfort Kit

VAS Description: ***Our Comfort Kit includes a reusable duffel bag plus essentials to help members transition to a new home.*** Children up to age nine will receive a kit that includes a duffel bag, identification tag, youth dental hygiene kit, reusable lunch bag, plastic beverage tumbler, and a stuffed animal. Children ages 10 and older will receive a comfort kit that includes a duffel bag, identification tag, teen dental hygiene kit, reusable lunch bag, plastic beverage tumbler, blanket, and a fidget spinner.
Eligibility & Limits: All members are eligible. Limit one kit per member, per year.

4. Jump Start Program

VAS Description: Jump Start is an ***online learning platform through which members can complete a skills assessment to identify and bolster their current skills as well as advance their health and financial literacy.*** Members will receive live one-on-one coaching to help determine next steps, such as obtaining a GED or attending trade school. The program offers exam preparation for certifications, a personalized job search tool, and access to more than 100 courses to help with essential skills for the workforce. We offer technical support and coaching via phone and email, plus a library of work-related modules for tablets and smartphones.
Eligibility & Limits: All members are eligible for an initial three months of online access, with the option to renew if necessary.

5. Home Essentials Kit

VAS Description: ***To show our support as youth move into independent living arrangements, we will provide a catalogue of items that will benefit them as they set up their new living areas.*** Members can select up to $100 of household essentials, such as bedding, dishes, or coffee pots.
Eligibility & Limits: Members age 18 years and older moving to their own place are eligible. One lifetime benefit of $100.

6. Lifeline Smartphone Benefit

VAS Description: ***This benefit helps maximize independence for members living in the community by making sure they always have a way to contact us.*** Under the Federal Lifeline program, members can receive a free cell phone, monthly minutes, unlimited text, and data. As a VAS, members will receive 200 bonus minutes at enrollment and 100 bonus minutes during their birthday month. Members will receive unlimited calls to our toll-free Fostering Healthy Lives Concierge Line.
Eligibility & Limits: All members age 18 years and older are eligible.

Educational Supports


Educational Supports

UniCare's VAS support education (as shown in Table E.8-2), from helping the youngest learn their first words to minimizing academic gaps that commonly occur. ***Our VAS promote learning, improve study habits, reduce dropout rates, and improve confidence, setting kids up for continued success.***

Table E.8-2. UniCare's VAS Offer Educational Supports to Help Children and Youth Succeed Academically

7. In-home Tutoring

VAS Description: Even though tutoring is provided as a covered SNS, many children will need additional one-on-one guidance to help them succeed in school and become independent learners. ***We will provide up to 24 hours of one-on-one, in-person tutoring services completed in the location that best suits the child*** (such as their home, school, during a stay at a hospital or group home, or public location such as a library). Tutoring is available in all subjects, including math, science, social sciences, and foreign languages.

Eligibility & Limits: All members age 6 to 18 are eligible, but some may need to exhaust covered services first. We will provide tutoring services for members who do not qualify for SNS, including those who fall under the Preservation Reunification, Adoption Preservation, or Chafee cohorts. We will also offer this VAS for members in Kinship Care and Adoption Assistance. All members, regardless of their IEP/504 Plan status, will be eligible for additional tutoring services after exhausting the covered benefit. The VAS must be authorized by a Fostering Healthy Lives Care Coordinator, and members must be at risk of failing a particular subject or class in school. The VAS limit is 24 hours per member, per year.

8. Educational Milestone Program

VAS Description: This VAS is designed to motivate and reward 11th and 12th graders to excel in school. A high grade point average (GPA) can help boost confidence and lead to additional financial assistance, which can help reduce student debt upon graduation. ***When members send us copies of their report cards showing they achieved at least a 10% improvement in grades from the previous report card, or have maintained a 3.0 GPA or higher, we will reward them with the choice of a $25 retail gift card.***

Eligibility & Limits: All members in grades 11 and 12 are eligible. Limited to $25 per member, per year.

9. Toddler Development Kit

VAS Description: ***This kit will help our youngest members reach their developmental milestones.*** The kit includes the *First 100 Words* board book includes color photographs and 100 simple first words, an Oball toy with large holes for little hands, and a baby play mat that can be used for tasks like diaper changing.

Eligibility & Limits: All members up to age two are eligible. Limited to one benefit per member, per year.

10. Summer Reading Benefit

VAS Description: ***This VAS offers members the chance to select up to $100 worth of books, to encourage a lifelong love of learning.*** Summer is an important time for children in foster care — they should have the same opportunities to continue learning so they stay ahead in their academics and avoid falling behind (which can occur as a result of multiple moves and disruptions). Studies have found this learning loss is sizable and may help explain the substantial reading achievement gap between more and less economically advantaged students in the U.S.

Eligibility & Limits: All members ages six to 18 are eligible. Limited to one per member, per year.

Tools to Strengthen Families



Families are invaluable in helping children heal from a history of trauma and thrive by providing stability and safety and by teaching life lessons. We know foster parents and kinship caregivers face unique challenges, and we offer resources to help support them as they adjust to a new family composition. ***Our VAS (Table E.8-3) help reduce barriers, bolster connections, and are rooted in the community.***

Table E.8-3. UniCare's VAS Help Strengthen Families

11. Foster Care & 12. Kinship Care Toolkits

VAS Description: ***Our toolkits offer information for new foster or kinship care parents.*** Contents include a Foster Parent or Kinship Care Application Checklist and information on behavioral health benefits, respite care resources available via the Foster Parent Association, and State resources for families around childcare, education, and training vouchers as well as non-profit, faith-based, and clothing resources.

Eligibility & Limits: All members in foster care and kinship care are eligible and will receive a free toolkit. Limit one toolkit per household.

13. Medicine Safety Kit

VAS Description: ***This VAS can help prevent the misuse of prescription drugs.*** The kit includes a lockable medicine box, prescription destroyer gel, childproof prescription caps, and pill case covers that reset when opened — all of which help families maintain control over medications, help prevent accidental ingestion, help prevent misuse of prescription medicines, and encourage conversations about responsible medication use among families.

Eligibility & Limits: All members are eligible. Limit one kit per household.

14. Gas Card

VAS Description: ***To provide safe transportation for children and families, particularly in rural areas without public transportation, we offer a $100 gas card.*** Children and families can use these resources to help access grocery stores, extracurricular activities, and after-school programs, as well as non-provider community locations and events that support positive health outcomes.

Eligibility & Limits: Members age 16 and older are eligible, as are foster care parents or caregivers who can receive on behalf of the member. Limited to $100 per household, per year ($25 per quarter).

15. Family Activity Coupon Book

VAS Description: Sometimes the best way for a family to bond is to share an activity. For families in foster or kinship care arrangements, ***we offer a Family Activity Coupon book filled with special discounts for local retailers, restaurants, and entertainment*** to offset financial concerns and help establish cohesive family units, the foundation of a socially and emotionally healthy population.

Eligibility & Limits: All members are eligible. One coupon book per household, per year.

16. Community Resource Link

VAS Description: This online resource locates and displays all available local community-based programs, benefits, and services, so that ***children and families have resource options for housing, food, employment, transportation, independent living, and social services at their fingertips.*** This online tool promotes increased personal responsibility and self-management by educating members and families about all locally available supplemental supports and services of which they may be unaware.

Eligibility & Limits: All members are eligible and there are no limitations to this benefit.

Healthy Behaviors



Our age-appropriate VAS (shown in Table E.8-4) help support the goals of health, safety, stability, and permanency for children and youth in the child welfare system. Further, we focus on what matters to them, helping to ensure they have the same opportunities, experiences, and supportive environment as their peers. Many of our VAS, such as covering youth club memberships, are meant to help facilitate and foster a sense of normalcy, giving these kids access to fun, healthy, and new social experiences.

Table E.8-4. UniCare's VAS Support Healthy Behaviors for Children and Youth

17. Extracurricular Support

VAS Description: ***Members can receive up to $100 to help cover the cost of school-based clubs and activities*** (such as debate team, drama club, student newspaper, sports, or music). As reported by ChildTrends.org, participation in club activities during middle school is linked to higher academic performance and self-esteem, while participation in sports is linked to higher social competence and contributes to better health and lower obesity rates.

Eligibility & Limits: All school-age members are eligible. Limited to $100 per member, per year.

18. Youth Club Memberships

VAS Description: ***This VAS will help cover the costs of after school youth club memberships, such as the YMCA, Boys and Girls Clubs, Boys & Girls Clubs Summer Camps, The National FFA Organization, and 4-H.*** These clubs represent a safe place for children to learn, grow, and develop in a setting that fosters a sense of belonging.

Eligibility & Limits: Members age six to 18 are eligible. Limit $100 per member, per placement (maximum of five).

19. Online Well-being Program

VAS Description: We are committed to caring for both the mind and the body. Children and youth in foster care are four to five times more likely to be impacted by a mental health issue than children and youth who are not in foster care. ***Our Online Well-being Program includes a convenient tool easily accessed via a computer, tablet, or mobile app, and helps members manage stress, anxiety, depression, substance use, chronic pain, sleep disruption, and other challenges.*** Additionally, this VAS comprises a suite of self-help resources that incorporate cognitive behavioral therapy, motivational interviewing, positive psychology, and mindfulness. The VAS is also available to support foster parents and kinship caregivers.

Eligibility & Limits: All members are eligible and there are no limitations to this benefit.

20. Scholarships Camp Catch Your Breath and 21. Scholarships to Camp Kno-Koma

VAS Description: ***These scholarships provide kids diagnosed with asthma or diabetes the chance to attend a camp designed to help them manage their condition.*** They provide a fun and educational experience, with supervision by staff who are physicians, nurses, dieticians, pharmacists, and other medical staff, and counselors. Kids participate in swimming, tubing, fishing, dancing, crafts, and nature studies. Camp Catch Your Breath is offered by West Virginia University's United Hospital Center and Camp Kno-Koma is offered by the Diabetes Camp of West Virginia, Inc.

Eligibility & Limits: All members age eight to 13 years who have asthma are eligible to attend Camp Catch Your Breath, and all members age seven to 15 years who have diabetes are eligible to attend Camp Kno-Koma. There are no limitations on this benefit. Members will receive a free week-long, overnight stay. For members eligible to receive the $200 allowance under SNS, we will cover the additional costs to attend.

22. Healthy Rewards Program

VAS Description: ***This VAS offers rewards for reaching health goals and attending appropriate appointments.*** Every time a child completes certain health activities, they (or caregiver on their behalf) can receive a reward.

Eligibility & Limits: All members must successfully complete incentive measures to be eligible for rewards.

- Infants age two weeks or younger who receive a first well baby visit: $25 (one-time incentive)
- Children 0 to 15 months who have completed six well baby checkups: $25 (one-time incentive)
- Children age 3 to 6 who have completed a well child checkup: $25 (once every 12 months)
- Adolescents or adults age 12 to 21 who have completed a wellness check: $25 (once every 12 months)
- Females 21 and older who complete a cervical cancer screening: $50 (once every 12 months)
- Members 18 and older with diabetes who complete a blood sugar screening and kidney test: $50 (once every 12 months)
- Members age 6 and older discharged from a hospital for a mental health condition who complete an outpatient visit with a provider within seven days of discharge: $20 (one per discharge, maximum of four every 12 months)
- Members age 2 and older who complete an annual dental visit: $25 (once every 12 months)
- Members age 6 to 12 prescribed ADHD medication who complete three follow-up visits with the prescribing physician within a 10-month timeframe: $25 (once every 12 months)
- Pregnant women who have first prenatal checkup within 42 days of enrollment: $25 (one per pregnancy)
- Pregnant women who receive six prenatal checkups: $25 (one per pregnancy) or choice of a car seat or crib once all six prenatal visits have been completed
- Pregnant women who receive a postpartum checkup 21-56 days after delivery: $25 (one per pregnancy)

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Instructions for Completion of Appendix 1 - Detailed Specifications

1. The Vendor should self-score each requirement listed in the ***Capability Assessment*** column of *Tab 3 - Specification & Responses*, using only the values that appear in the drop-down list.
2. ***Capability Assessment*** values are outlined below:
    1. "Will Meet": Vendor agrees to specification.
    2. Will Not Meet": Vendor declines to meet the specification.
3. All specifications should contain one of the values identified above. Any specification without a ***Capability Assessment*** response value will be considered as "Will Not Meet."
4. In addition, the Vendor should provide the ***Attachment***, ***Section***, and ***Page Number(s)*** where its detailed narrative response for each specification resides, providing the Department with a crosswalk, ensuring that each specification is addressed. Be advised that the "Attachment" column has been pre-populated with the location that the Department anticipates the requirement response to reside; however, the Vendor may respond to a requirement in a different location. It is up to the Vendor to update the Attachment, Section, and Page Number(s) columns.
5. Please note that during implementation and in operations, the Department will have the right to review and approve the Vendor's approach to meeting all specifications, including, but not limited to, the Vendor's policies and procedures.
6. ***Hierarchy Level:*** The hierarchy level column defines relationships between parent and child specifications. The Department refers to parent specifications as specifications that rely on the content of a subset of related specifications (children) to fully define the scope of the requirement. The Department refers to child specifications as specifications that rely on additional context provided by a higher-level specification (parent) to fully define the scope of the specification. A hierarchy value of 1 denotes the highest-level specification. A hierarchy level 2 is a child to the nearest prior hierarchy level 1.
7. When included in a specification, the phrase "for applicable populations" is typically used to delineate between covered services provided for populations within the Vendor's MCO services versus ASO services. For example, the Vendor would not be expected to assign a member who is only eligible for SNS to a primary care provider (PCP) or ensure the member receives primary care services.

Vendor Responses to Detailed Specifications

Tabs in this spreadsheet	
1. Worksheet Instructions	Instructions for completion of this RFP supplement.
2. Worksheet Information	This tab including information about the contents of this workbook.
3. Specification & Responses	Contains the specifications and all related data.
4. Code Values	Contains coded values for use in the specifications tab, and explanations as appropriate.

Columns on the Specifications & Responses Tab			
Section	**Column(s)**	**Description**	**Corresponding Code Values**
Specifications	*Spec ID #*	The unique ID of the specification.	N/A
	Specification Text	The text of the specification.	N/A
	Vendor Response Guidance	Information requested in the Vendor response to each specification. The Vendor is not limited to providing only the information requested in this column.	N/A
	Subject Matter Area	How the specification is categorized.	Specification Subject Matter Areas
Vendor Response	*Capability Assessment*	Vendor is expected to indicate its compliance with the specification using one of the supplied values.	Vendor Response - Capability Assessment
	Attachment	Vendor is expected to provide a reference to the appropriate attachment where more detailed information about the specification can be found. The expected attachment is identified for Vendor convenience.	Response Templates
	Section and Page Reference	Vendor is expected to provide a reference to the appropriate section and page number within the specified attachment where more detailed information about the specification can be found.	N/A

WEST VIRGINIA Department of Health & Human Resources

Vendor Responses to Detailed Specifications

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA001	1	The Vendor should establish and implement authorization criteria for socially necessary services (SNS).	The Vendor should provide proposed authorization criteria for these services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	20
BA002	1	The Vendor should establish and implement a process for providers to request authorization for socially necessary services (SNS).	The Vendor should describe the provider authorization request process for these services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	21
BA003	1	The Vendor should establish and implement a process to review authorization requests for socially necessary services (SNS).	The Vendor should describe the authorization request review process for these services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	22
BA004	1	The Vendor should apply utilization management guidelines to retroactively review socially necessary services (SNS).	The Vendor should describe its process to retroactively review socially necessary services (SNS).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	23
BA005	1	The Vendor should coordinate socially necessary services (SNS) for the member and/or their family.	The Vendor should describe in detail the process to coordinate these services for the member and/or their family.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	24
BA006	1	The Vendor should verify the most appropriate provider of socially necessary services (SNS) is used to meet the member's needs.	The Vendor should describe both the verification process and how the Vendor proposes to define "most appropriate" for the purposes of verification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	25
BA007	1	The Vendor should support the Department caseworker in the development of the member individualized service plan (ISP).	The Vendor should describe the procedures and protocols for how will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	29
BA008	1	The Vendor should use family service plan (FSP) and individualized service plan (ISP) information, as applicable from the Department caseworker, to authorize socially necessary services (SNS).	The Vendor should describe the procedures and protocols for using the family service plan (FSP) and individualized service plan (ISP) to authorize socially necessary services (SNS). *Note: Link to additional information: https://dhhr.wv.gov/bcf/Reports/Documents/West%20Virginia%20Child%20and%20Family%20Services%20Plan%20%28CFSP%29%202015-2019.pdf*	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	26
BA009	1	The Vendor should establish medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for applicable populations.	The Vendor should demonstrate its understanding of medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, according to the Vendor's experience and the policies, procedures, and requirements outlined in the Service Provider Agreement (SPA).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	49
BA010	1	The Vendor should establish processes specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in all geographic areas, for applicable populations.	1) The Vendor should specify activities that will be performed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and responsible staff/departments. 2) The Vendor should demonstrate its understanding of American Academy of Pediatrics (AAP) EPSDT standards, including, but not limited to, timeframes for a child placed within foster care to receive the initial health assessment and comprehensive EPSDT exam. 3) The Vendor should demonstrate its understanding of the Department Foster Care Child Welfare Policy and the HealthCheck program, including, but not limited to, evaluation timeframes and periodicity schedules. 4) The Vendor should detail how its plan will be accomplished in all geographic areas.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	50
BA011	1	The Vendor should develop and distribute materials to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, for applicable populations.	1) The Vendor should explain what materials it will develop to inform members, parents, and providers about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. 2) The Vendor should explain how it will emphasize EPSDT services to children receiving primary care from a specialist.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	52

WEST VIRGINIA Department of Health & Human Resources

Vendor Responses to Detailed Specifications

Specifications					*Vendor Response*			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA012	1	The Vendor should use reports to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.	The Vendor should describe reports, and other tools if applicable, that will be used to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	55
BA013	1	The Vendor should work with caregivers and families to help track appointments members are scheduled for and may miss without further reminders or assistance.	The Vendor should describe how it will work with caregivers and families to meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	56
BA014	1	The Vendor should assist in rescheduling appointments and removing potential obstacles to care, including, but not limited to, transportation.	1) The Vendor should describe how it will work with caregivers and families to meet this specification. 2) The Vendor should give an example of an obstacle of care and how the Vendor would work to remove it. The Vendor may use transportation as this example but is not required to do so.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	56
BA015	1	The Vendor should develop and review utilization management guidelines for physical health and behavioral health services.	The Vendor should describe its process to develop and revise physical health and behavioral health services utilization management guidelines.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	11
BA016	1	The Vendor should apply utilization management guidelines to authorize payments or services for physical and behavioral health.	The Vendor should provide proposed physical and behavioral health utilization management guidelines that reflect an understanding of this contract's population, services, and stakeholders.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	18
BA017	1	The Vendor should apply utilization management guidelines to retroactively review payments or services for physical and behavioral health.	The Vendor should describe its process to retroactively review payments or services for physical and behavioral health.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	19
BA018	1	The Vendor should help expedite the submission and return of service authorization data from providers.	The Vendor should describe its process to help expedite the submission and return of service authorization data.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	20
BA019	1	The Vendor should leverage a utilization management system with the ability to include text fields, including, but not limited to, the following:	The Vendor should: 1) Describe the system it would leverage for utilization management services. 2) Describe that system's ability to include the requested text fields.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	80
BA020	2	Clinical notes	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	80
BA021	2	Inpatient requests	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	80
BA022	2	Review criteria	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	81
BA023	2	Case history	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	81
BA024	1	The Vendor should leverage a utilization management system with the ability to support claims payment for physical and behavioral health services by interfacing with other Vendor systems, as applicable, and Department enterprise systems, including, but not limited to, the following:	The Vendor should: 1) Describe its utilization management system's ability to support claims payment for physical and behavioral health services. 2) Identify necessary interfaces.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	81
BA025	2	Medicaid Management Information System (MMIS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	81
BA026	2	Call Center	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	81
BA027	1	The Vendor should leverage a utilization management system with the ability to support inbound member and provider inquiries by interfacing with other Vendor systems, as applicable, and Department enterprise systems, including, but not limited to, the following:	The Vendor should: 1) Describe its utilization management system's ability to support inbound member and provider inquiries. 2) Identify necessary interfaces.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	83
BA028	2	Medicaid Management Information System (MMIS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	83
BA029	2	Call Center	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	84

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BA030	1	The Vendor should establish interface(s) and conduct testing that meets all Department-specified interface requirements, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	84
BA031	2	Medicaid Management Information System (MMIS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	84
BA032	2	Families and Children Tracking System (FACTS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	84
BA033	2	Integrated Eligibility Solution (IES), when applicable	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	84
BA034	1	The Vendor should leverage a system with the ability to maintain case history.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	85
BA035	1	The Vendor should establish utilization management processes for members, including, but not limited to, the following:	The Vendor should describe how its utilization management processes support members, both for the processes listed and any other processes the Vendor identifies as supporting members.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	14
BA036	2	Medical necessity review	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	14
BA037	2	Social necessity review	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	14
BA038	2	Approvals	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	14
BA039	2	Denials	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	17
BA040	1	The Vendor should operate utilization management monitoring activities in conjunction with fraud and abuse detection activities.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	30
BA041	1	The Vendor should prevent and detect fraud and abuse related to pharmacy services.	The Vendor should describe how it will meet this specification, if the Department chooses to carve in pharmacy services at a later date.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	87
BA042	1	The Vendor should modify its standard utilization management protocols when reviewing referral and treatment requests for members with special healthcare needs, including, but not limited to, the following:	The Vendor should: 1) Identify factors that may require modification of its standard utilization management protocols. 2) Give at least one example of each factor, and describe how the standard protocols would be changed as a result.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	63
BA043	2	Standing referrals	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	65
BA044	2	Expedited utilization review processes	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	63
BA045	1	The Vendor should establish condition-specific protocols or standards that will be used to manage members with special healthcare needs.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	66
BA046	1	The Vendor should update and share condition-specific protocols or standards with primary and specialty care providers.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	31
BA047	1	The Vendor should establish, implement, and update guidelines for the services or types of services that require prior authorization (PA) by the Vendor.	The Vendor should list the services or types of services that require prior authorization by the Vendor.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	32
BA048	1	The Vendor should establish, implement, and update guidelines for the services or types of services that can be approved by the member's primary care provider (PCP) for physical and behavioral health services.	The Vendor should list the services or types of services that can be approved by the member's primary care provider (PCP).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	33
BA049	1	The Vendor should establish, implement, and update guidelines for the services or types of services to which the member can self-refer.	The Vendor should list the services or types of services to which the member can self-refer.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	34

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BA050	1	The Vendor should establish and implement a required length of time for providers to request prior authorizations (PAs) for services.	1) The Vendor should provide its proposed required length of time for providers to request prior authorizations (PAs) for services. 2) If this varies by service or circumstance, the Vendor should provide the applicable length of time for each service/situation.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	34
BA051	1	The Vendor should establish and implement levels of authority for prior authorizations (PAs).	The Vendor should provide its proposed levels of authority for prior authorizations (PAs).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	34
BA052	1	The Vendor should provide prior authorization (PA) approval/denial letters to members, providers, and caseworkers, as appropriate.	1) The Vendor should explain which elements would be included in prior authorization (PA) approval/denial letters to members, providers, and caseworkers, and how the Vendor would define "as appropriate." 2) The Vendor should provide sample letter(s).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	35
BA053	1	The Vendor should develop and use clinical guidelines for prior authorizations (PAs) for physical and behavioral health services.	1) The Vendor should provide proposed clinical guidelines for physical and behavioral health services. 2) The Vendor should describe how it develops and uses guidelines. 3) The Vendor should provide a specific example that follows a prior authorization (PA) through the process.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	11
BA054	1	The Vendor should honor medical, behavioral health, pharmacy, and socially necessary services (SNS) authorization approvals from previous coverage during the transition period.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	36
BA055	1	The Vendor should notify providers and/or members regarding expiration of existing medical, pharmacy, and socially necessary services (SNS) authorizations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	37
BA056	1	The Vendor should authorize out-of-network services, including, but not limited to, the following:	The Vendor should describe how it will meet these specifications.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	38
BA057	2	Emergency situations	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	38
BA058	2	Non-emergency situations, including, but not limited to, both medically necessary and non-medically-necessary services	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	38
BA059	1	The Vendor should grant members a standing referral to a specialist provider according to guidelines that the Vendor develops and the Department approves, including, but not limited to, the duration and/or number of visits usually granted or maximally allowed.	1) The Vendor should describe the circumstances under which a member might be granted a standing referral to a specialist provider. 2) The Vendor should propose durations and/or number of visits usually granted or maximally allowed.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	65
BA060	1	The Vendor should develop and implement physical health and behavioral health guidelines for the extent to which a specialist provider may:	The Vendor should provide proposed guidelines.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	67
BA061	2	Admit patients for inpatient care	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	68
BA062	2	Choose the hospital of admission	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	68
BA063	2	Determine that the patient must remain hospitalized	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	68
BA064	2	Schedule or provide ancillary services, such as laboratory testing	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	68
BA065	2	Refer patients to sub-specialists or other providers	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	68
BA066	1	The Vendor should refer members to out-of-network providers using guidelines that the Vendor develops and the Department approves.	The Vendor should describe circumstances in which members might be referred to out-of-network providers.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	38
BA067	1	The Vendor should establish and implement a process through which members and/or providers can request out-of-network referrals.	The Vendor should describe the process for members and/or providers to request out-of-network referrals.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	39

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BA068	1	The Vendor should ensure that information from non-network providers is shared with the member's primary care provider (PCP).	The Vendor should explain the procedures for ensuring that information from non-network providers is shared with the member's primary care provider (PCP).	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	40
BA069	1	The Vendor should review and process medical referrals according to guidelines that the Vendor develops and the Department approves.	The Vendor should: 1) Provide proposed timeframes for reviewing and processing medical referrals. 2) Describe the average duration of medical referrals.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	69
BA070	1	The Vendor should develop and implement guidelines under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the Vendor's network) if it is considered to be in the best medical interest of the member, as determined by the member's primary care provider (PCP) and/or the Medical Director.	The Vendor should: 1) Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider that leaves the managed care organization's [MCO's] network) if it is considered to be in the best medical interest of the member. 2) Specify how long it will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	70
BA071	1	The Vendor should perform ongoing monitoring of emergency room (ER) usage.	The Vendor should separately describe ongoing monitoring of emergency room (ER) usage.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	42
BA072	1	The Vendor should apply the "prudent layperson" standard for all emergency room (ER) visits.	The Vendor should explain: 1) Application of the "prudent layperson" standard for all emergency room (ER) visits. 2) If it would not require prior authorization (PA) for screening and stabilization of members.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	45
BA073	1	The Vendor should transition the member from an out-of-network provider to an appropriate in-network provider if the member is currently seeing a provider that does not participate in the network.	The Vendor should: 1) Describe the process by which the Vendor will work to meet these specifications. 2) Explain how the Vendor would propose to define an "appropriate" in-network provider.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	41
BA074	1	The Vendor should assist in transferring necessary clinical information to the foster care member's new in-network physical health or behavioral health provider.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	41
BA075	1	The Vendor should inform members of their choices in Family Planning services, for applicable populations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	71
BA076	1	The Vendor should facilitate timely payment for Family Planning services for in-network and out-of-network providers, for applicable populations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	73
BA077	1	The Vendor should identify pregnant women at enrollment and on an ongoing basis.	The Vendor should describe the mechanisms it will employ to identify pregnant women, both at enrollment and on an ongoing basis.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	73
BA078	1	The Vendor should promote "early and often" prenatal care for women who are identified as being pregnant, for applicable populations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	73
BA079	1	The Vendor should identify individuals with complex or serious medical conditions on an ongoing basis, for applicable populations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	60
BA080	1	The Vendor should use information systems to identify members with special needs.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	62
BA081	1	The Vendor should use information systems to isolate data specific to eligibility category or diagnosis.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	63
BA082	1	The Vendor should ensure timely access to crisis stabilization services.	1) The Vendor should indicate if crisis stabilization services are subject to medical necessity review criteria. If so, the Vendor should describe how it will ensure timely access to these services and state what it considers as timely access to such services 2) The Vendor should address an approach to these services when they are provided out of network.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	45

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BA083	1	The Vendor should manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	88
BA084	1	The Vendor should develop and implement prescription limits, including, but not limited to, limitations on brand name and generic prescriptions.	1) The Vendor should describe how it would meet this specification, if pharmacy benefits are carved in at a future date. 2) If applicable, the Vendor should provide the policies and procedures for how limits would be managed and how cases of medical necessity would be handled.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	89
BA085	1	The Vendor should identify and manage polypharmacy utilization.	The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	91
BA086	1	The Vendor should monitor potential abuse or inappropriate utilization of controlled prescription medications.	The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	91
BA087	1	The Vendor should manage members with a history of prescription drug abuse, including, but not limited to, lock-in.	1) The Vendor should provide a general description of the strategies it would use to meet this specification, if pharmacy benefits are carved in at a future date. 2) The Vendor should describe any data that would be needed from the Department to facilitate this transition.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	91
BA088	1	The Vendor should ensure that primary care providers (PCPs) maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations, including, but not limited to, in a patient's medical record.	The Vendor should describe the process for how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	27
BA089	1	The Vendor should inform primary care providers (PCPs) about changes in a member's behavioral health, including, but not limited to:	The Vendor should: 1) Describe how it will meet this specification. 2) Explain how it proposes to define what constitutes a change in behavioral health status.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	28
BA090	2	Hospitalization	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	28
BA091	2	Emergency room (ER) usage	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	28
BA092	2	Change of medication	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	28
BA093	1	The Vendor should assist members in accessing additional services as a result of change in behavioral health status, including, but not limited to, the care coordinator's assistance in making appointments for members.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	29
BA094	1	The Vendor should provide dental services for individuals under 21 years of age as covered services in an amount, duration, and scope to achieve the purpose for which the services are furnished, for applicable populations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	95
BA095	1	The Vendor should remind members of upcoming initial and periodic dental screenings, for applicable populations.	The Vendor should describe the mechanisms it will use to meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	96
BA096	1	The Vendor should make arrangements with inpatient and outpatient facilities for the provision of dental services to members with special needs, for applicable populations.	The Vendor should describe the arrangements it will make to meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	98
BA097	1	The Vendor should monitor dental screening utilization on an ongoing basis, for applicable populations.	The Vendor should describe the process and mechanisms it will use to meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	98
BA098	1	The Vendor should intervene if a member has not had a dental screening in over one year, for applicable populations.	The Vendor should describe how it will meet this specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Section E.1 BA	54

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CM001	1	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and care coordinators with an integrated care plan for all children.	The Vendor should provide a detailed description of its approach to meeting this specification. The description should reflect an understanding of this contract's population, services, and stakeholders.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	25
CM002	1	The Vendor should share information required for continuity of care with the member and their family or caregiver(s).	The Vendor should describe how it will meet this specification, including, but not limited to, communication paths, methods, and/or frequency.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	35
CM003	1	The Vendor should provide training to ensure an integrated care plan is jointly developed and shared among the primary care provider (PCP) and/or specialist serving as a principal coordinating physician, and the child and caregiver(s).	The Vendor should describe how it will meet this specification and who will participate in training.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	26
CM004	1	The Vendor should evaluate and report member progress in meeting goals identified in the individualized service plan (ISP).	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	24
CM005	1	The Vendor should collaborate with the Department's pharmacy program to help provide coordinated care for the member, including, but not limited to, those members accessing psychotropic medications, for applicable populations.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	39
CM006	1	The Vendor should establish and maintain patient-centered medical homes for its members (in applicable populations) in alignment with the American Academy of Pediatrics (AAP) guidelines in the Health Care Issues for Children and Adolescents in Foster Care and Kinship Care manual, including, but not limited to, the following:	The Vendor should describe in detail how it will meet these specifications.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	48
CM007	2	The application process for providers	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	49
CM008	2	Assessment of whether foster care members can continue to receive healthcare in their medical home of origin, and if not, how best to establish and maintain new medical homes	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	51
CM009	2	Communication with members and/or their caregivers/families, as appropriate, about patient-centered medical homes for applicable populations	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	51
CM010	2	Annual reporting processes	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	51
CM011	1	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others on discharge planning needs of a member leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	52
CM012	1	The Vendor should collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and others to ensure outpatient services have been established prior to the member leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	52
CM013	1	The Vendor should coordinate with the Department to ensure that all needed medication is available to the member after leaving an inpatient facility or changing levels of care.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	56
CM014	1	The Vendor should engage in the Individualized Care Planning process for foster care members.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	22
CM015	1	The Vendor should collaborate with caseworkers to support members experiencing home removals and changes in placement based on Department foster care requirements.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	57

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CM016	1	The Vendor should collaborate with caseworkers to minimize the need for removals and changes in placement.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	57
CM017	1	The Vendor should identify and track new members with high physical or behavioral health needs to assure continuity of care, for applicable populations.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	20
CM018	1	The Vendor should monitor members' physical or behavioral health needs and respond to changes in acuity over time, for applicable populations.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	34
CM019	1	The Vendor should use telemedicine, telehealth, and telemonitoring services to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	68
CM020	1	The Vendor should use internet and/or web-based services to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	73
CM021	1	The Vendor should identify and implement opportunities to use video conferencing to improve quality and/or access to care.	1) The Vendor should describe how it would use these services. 2) The Vendor should provide examples of successful use of these services.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	75
CM022	1	The Vendor should identify members for participation in Intensive Care Management (ICM) teams for individuals with one or more chronic conditions, for applicable populations.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	20
CM023	1	The Vendor should determine the composition of the Intensive Care Management (ICM) team for participating members, for applicable populations.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	23
CM024	1	The Vendor should develop plans specific to each case for members participating in Intensive Care Management (ICM) teams, for applicable populations.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	23
CM025	1	The Vendor should conduct ongoing gap analyses to determine the types of services and resources not available in the State.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	60
CM026	1	The Vendor should work with the Department and community partners to increase capacity for those services and resources identified as not available in the State.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	64
CM027	1	The Vendor should leverage population health management risk stratification tools to support stratification of members into risk tiers for care coordination services.	The Vendor should provide a detailed description of its approach to meeting this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	11
CM028	1	The Vendor should capture data related to social determinants of health, as defined by bodies including, but not limited to, the Centers for Disease Control and Prevention (CDC).	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	14
CM029	1	The Vendor should incorporate data about social determinants of health into its care coordination services.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	15
CM030	1	The Vendor should establish committees with family members, the member, providers, the care coordinator, and a Department lead to help develop the most appropriate care plans for the member.	The Vendor should: 1) Describe how it will meet this specification. 2) Explain how it proposes to define the "most appropriate" care plans.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	21
CM031	1	The Vendor should develop and implement access to care standards and methodology.	The Vendor should describe how it will meet this specification, including, but not limited, to proposed standards and methodology.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	62

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Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM032	1	The Vendor should develop and implement care guidelines for working with youth who may have been exposed to adverse childhood experiences (ACEs).	The Vendor should: 1) Provide proposed guidelines. 2) Describe direct experience working with youth who may have been exposed to adverse childhood experiences (ACEs).	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	43
CM033	1	The Vendor should establish an organizational structure and treatment framework to recognize, understand, and respond to the effects of all types of trauma, per American Academy of Pediatrics (AAP) guidelines for a trauma-informed practice.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	43
CM034	1	The Vendor should facilitate coordination of care between primary care providers (PCPs) and children's dental providers for applicable populations, including, but not limited to, for children with special healthcare needs.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	41
CM035	1	The Vendor should provide a care coordination model with stratified services for eligible members according to clinical, social, or other criteria.	1) The Vendor should provide a detailed description of its care coordination model. 2) The Vendor should describe how the care coordination department is organized and the integration of the service types. 3) The Vendor should describe its proposed clinical, social, or other criteria. 4) If applicable, the Vendor should include an explanation of how the Vendor will work with other parties to administer this care coordination, including, but not limited to, subcontractor(s) and affiliate advocacy group(s). *Note: The Department expects all members to be eligible for care coordination services.*	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	8
CM036	1	The Vendor should screen members for stratification into care coordination services upon enrollment.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	10
CM037	1	The Vendor should monitor screening timelines for member care coordination stratification.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	42
CM038	1	The Vendor should assign members to an appropriate healthcare professional who is formally responsible for coordinating the member's overall healthcare, including, but not limited to, behavioral health, for applicable populations.	The Vendor should: 1) Describe its protocol for assigning members. 2) Explain how the Vendor proposes to define an "appropriate" healthcare professional. 3) Specify whether services are coordinated by the member's primary care provider (PCP) or through some other means, including, but not limited to, a care coordinator.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	26
CM039	1	The Vendor should use clinical, social, or other criteria to assign members to a care coordinator within a timeframe that the Department approves.	The Vendor should: 1) Describe its protocol for assigning members. 2) Describe its proposed clinical, social, or other criteria. 3) Provide the expected timeframe for care coordinator assignment to the identified member.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	10
CM040	1	The Vendor should develop education, member materials, and outreach strategies that are appropriate for adults and children and adhere to federal and State marketing regulations.	The Vendor should: 1) Describe any differences in how it will approach adults versus children. 2) Describe any internal processes that may vary between approaching adults and children, including, but not limited to, education, member materials, and outreach. 3) Explain how it proposes to define "appropriate for adults and children."	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	66

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Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM041	1	The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals.	The Vendor should describe how it will meet this specification. This description should reflect an understanding of the West Virginia (WV) Children with Special Health Care Needs program.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	17
CM042	1	The Vendor should perform screening, assessment, and/or utilization analysis to identify and provide services for members with special needs.	1) The Vendor should describe its methods for meeting this specification. 2) The Vendor should describe any additional screening tools used in this process. 3) If the Vendor proposes to conduct its own health risk assessment, the Vendor should provide a template for the form or protocol.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	18
CM043	1	The Vendor should perform screening and assessment to identify and provide services for members with behavioral health needs.	1) The Vendor should describe its methods for meeting this specification. 2) The Vendor should describe any additional screening tools used in this process. 3) If the Vendor proposes to conduct its own health risk assessment, the Vendor should provide a template for the form or protocol.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	18
CM044	1	The Vendor should complete health risk assessments that will be made available upon enrollment to members in applicable populations and/or their caregiver(s), including, but not limited to, assessments specific to members with special healthcare needs.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	13
CM045	1	The Vendor should provide targeted education programs and identify who will receive these programs.	The Vendor should: 1) Describe its approach to targeted member or medical management education programs. 2) Identify the audience for these programs. 3) Provide the timeframe for creating education materials and educating community engagement and care coordination staff.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	36
CM046	1	The Vendor should use specialized care coordinators for certain conditions, including, but not limited to, experienced pediatric or cardiac nurses and behavioral health specialists.	The Vendor should indicate whether the Vendor will use specialized care coordinators for certain conditions, and describe the rationale behind its approach.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	11
CM047	1	The Vendor should develop and maintain qualifications and training for Vendor staff who will be involved in coordinating care.	The Vendor should describe: 1) Qualifications and training for Vendor staff who will be involved in coordinating care 2) The Vendor's plan for hiring care coordination staff, including, but not limited to, timeframes, number of care coordinators, and maximum case load *Note: Care coordinators should be dually trained in both Bureau for Children and Families (BCF) and Bureau for Medical Services (BMS) policies.*	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	28
CM048	1	The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.	The Vendor should describe in detail: 1) Steps care coordinators will take to establish relationships with their assigned members. 2) A protocol for addressing a member who does not want a care coordinator or cannot be reached once a care coordinator has been assigned.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	31
CM049	1	The Vendor should establish and implement guidelines for when care coordinators should have face-to-face contact with their assigned members, including, but not limited to, when requested by a Department worker.	The Vendor should describe its approach to care coordinators' face-to-face contact with assigned members, including, but not limited to: 1. Frequency 2. Circumstances resulting in a need for face-to-face contact 3. Goal of face-to-face contact at this frequency and/or in these circumstances	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	31

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Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CM050	1	The Vendor should develop and implement standards for how often the care coordinators will contact members after the initial care coordination contact, based on the member's acuity level.	The Vendor should provide and describe proposed standards for this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	31
CM051	1	The Vendor should collect statistics, according to a set frequency, on care coordinators' progress toward establishing relationships with members.	The Vendor should describe what statistics it proposes to collect and how often.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	42
CM052	1	The Vendor should monitor and evaluate care coordinators in regards to establishing relationships with members.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	42
CM053	1	The Vendor should identify members in need of treatment plans.	The Vendor should describe the process and/or mechanisms for identifying members in need of such a plan.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	27
CM054	1	The Vendor should develop, update, and use clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, community and social support, and/or carved-out services for members identified as having special healthcare needs, based on that member's needs.	1) The Vendor should describe in detail the process for developing, updating, and using these treatment plans. 2) The Vendor should provide a sample treatment plan.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	27
CM055	1	The Vendor should share care plans with a member's primary care provider (PCP) at a set frequency.	The Vendor should: 1) Provide the frequency with which care plans will be shared with primary care providers (PCPs) and other providers. 2) Describe the manner (including, but not limited to, letters or phone calls) in which care plans will be shared with PCPs or other providers. 3) Describe who is responsible for sharing care plans with a member's PCP.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	25
CM056	1	The Vendor should share care plans with a member's primary care provider (PCP) outside of the established schedule according to guidelines developed by the Vendor and approved by the Department.	The Vendor should describe what events or circumstances will prompt the Vendor to share care plans outside of the established schedule.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	25
CM057	1	The Vendor should track the completion of care plans.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	42
CM058	1	The Vendor should provide episodic and/or catastrophic care coordination interventions.	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	20
CM059	1	The Vendor should identify providers that do not perform coordination activities and take action to improve coordination.	The Vendor should describe the protocol for addressing a provider that does not perform coordination activities.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	27
CM060	1	The Vendor should coordinate services with community resources and social services for members in the area served by the Vendor, including, but not limited to, those with special healthcare needs.	The Vendor should describe: 1) Procedures that will be in place for coordination with community resources and social services for members, including those with special health needs 2) Timeframes for identification of such resources and services	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Section E.2 CM	33
CS001	1	The Vendor should coordinate care across child-serving systems, including, but not limited to, the educational system, community services, and after-school programs.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of child-serving systems in the State.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	4
CS002	1	The Vendor should establish relationships with Child Protective Services (CPS) workers and coordinate the needs of the child to reduce duplication of services and improve access to service needs.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the Child Protective Services (CPS) system in the State. With regard to improving coordination, the Vendor should describe how it will structure interactions between CPS workers, providers, and the Vendor to be efficient and effective.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	10

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Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
CS003	1	The Vendor should establish relationships with child welfare workers in addition to Child Protective Services (CPS), including, but not limited to, workers who provide case management, case planning, and permanency planning while the child is in care.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the child welfare system in the State.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	12
CS004	1	The Vendor should establish communications with the judicial system to help drive that the services being ordered for the child are in the child's best interest and most medically and/or socially appropriate.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of the interactions between the judicial system and child welfare system in the State.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	13
CS005	1	The Vendor should inform the court of alternative services that best meet the child's needs, as deemed appropriate by the Department.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of court orders, how the Vendor's expertise and care coordination can help inform services provided, and circumstances under which the Vendor would provide these alternatives.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	15
CS006	1	The Vendor should establish relationships with applicable Department agencies and State advocacy groups, including, but not limited to, the following:	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of Department organization and State advocacy stakeholders.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	15
CS007	2	Child advocacy centers (CACs)	See the parent specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	16
CS008	2	Court appointed special advocates (CASAs)	See the parent specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	17
CS009	2	The West Virginia Child Abuse Network, as defined by applicable State Code, as defined by the Department.	See the parent specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	16
CS010	1	The Vendor should establish communications with foster parents based on Department foster care guidelines.	The Vendor should provide a detailed description of how it will meet this specification. This description should reflect an understanding of the foster care system in the State.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	17
CS011	1	The Vendor should collaborate with the Bureau for Public Health (BPH) to increase the number of families enrolled in the West Virginia (WV) Home Visitation Program.	The Vendor should describe how it will meet this specification. *Note: This program has demonstrated that its engagement in the lives of families has helped to reduce the risk of a child being removed. More information can be found at https://www.wvdhhr.org/wvhomevisitation/*	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	18
CS012	1	The Vendor should engage community-based child welfare organizations to help provide family-centered treatment that goes beyond traditional medical care.	The Vendor should provide a detailed description of how it will meet this specification. The description should reflect an understanding of State community-based child welfare organizations and family-centered treatment.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	20
CS013	1	The Vendor should provide initial (during implementation) and ongoing training for advocates and other stakeholders.	The Vendor should describe in detail the audience(s), frequency, method(s), and topic(s) for this training.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	21
CS014	1	The Vendor should coordinate with child placement agencies to ensure each agency has access to the most up-to-date records, as appropriate.	The Vendor should describe how it will meet this specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Section E.3 ES	24
MS001	1	The Vendor should identify and reach out to members (or their caregiver or caseworker as appropriate) with the most immediate service needs leading up to and immediately following implementation of a program.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	15
MS002	1	The Vendor should provide outreach and training on an ongoing basis to youth and young adults and their respective caregivers who are eligible for services.	The Vendor should describe the audience(s), frequency, method(s), and topic(s) for this outreach and training.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	16

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Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
MS003	1	The Vendor should collaborate with community partners to help design materials that best meet the needs of the populations being served.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	12
MS004	1	The Vendor should leverage information technology (IT) solutions to improve access to information, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	38
MS005	2	Member health records (by the member, caregiver, and/or provider as appropriate)	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	38
MS006	2	Appeal processes	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	39
MS007	2	Other member rights and responsibilities	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	40
MS008	1	The Vendor should distribute an informational welcome packet to families impacted by the transition.	The Vendor should describe any particular communication strategies it would use or information it would include in this welcome packet, including, but not limited to, the Vendor's appeals process.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	11
MS009	1	The Vendor should develop a community resource library, including, but not limited to, member handbooks, newsletters, and/or care coordinators.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	27
MS010	1	The Vendor should facilitate connecting members to community resources and social services.	The Vendor should describe how it will connect members to community resources and social services, and should demonstrate its understanding of available community resources and social services in the State.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	22
MS011	1	The Vendor should develop materials for members, including, but not limited to, members with special healthcare needs, in accordance with federal and State marketing regulations.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	5
MS012	1	The Vendor should consult with persons with disabilities and advocacy groups while developing materials for members with special healthcare needs.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	13
MS013	1	The Vendor should use a methodology, including, but not limited to, claims history and proximity, to assign members in applicable populations to a primary care provider (PCP)	The Vendor should describe in detail its proposed methodology for primary care provider (PCP) assignment, particularly for new members when auto-assigning to a PCP.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	28
MS014	1	The Vendor should notify members in applicable populations of primary care provider (PCP) assignment.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	29
MS015	1	The Vendor should educate members in applicable populations of the right to change primary care providers (PCPs).	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	29
MS016	1	The Vendor should conduct follow-up communications to ensure members in applicable populations are aware of the primary care provider (PCP) assignment.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	29
MS017	1	The Vendor should conduct outreach and transition planning efforts directed toward members with special healthcare needs.	The Vendor should describe how this outreach will be conducted.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	15
MS018	1	The Vendor should mail member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:	The Vendor should provide a proposed turnaround time for mailing, on an ongoing basis, updates to the member handbook and ad hoc handbook requests.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	11
MS019	2	Updates to the member handbook	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	11
MS020	2	Handbooks requested ad hoc by a member	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	11
MS021	1	The Vendor should provide enabling services--including, but not limited to, assistance with complaints and grievances--to members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	40

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MS022	1	The Vendor should ensure the Contract Liaison/Medicaid Administrator monitors grievances--including, but not limited to, grievances related to subcontractors--for enabling services for members with physical or developmental disabilities.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	41
MS023	1	The Vendor should provide methods for members to contact the member services department, including, but not limited to, the following:	The Vendor should: 1) Describe methods for members to contact the Vendor member services department. 2) Describe hours of operation. 3) Describe its member services hotline call transfer protocols and decision trees.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	30
MS024	2	An emergency hotline	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	31
MS025	2	A toll-free number	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	30
MS026	1	The Vendor should transfer calls between the member services department and subcontractors for review, if applicable.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	32
MS027	1	The Vendor should educate members about the ability to request out-of-network referrals.	The Vendor should describe its processes and mechanisms--including, but not limited to, the member handbook--for meeting this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	29
MS028	1	The Vendor should educate member services representatives on the out-of-network referral process.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	29
MS029	1	The Vendor should train member services representatives on topics including, but not limited to, the following:	The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	35
MS030	2	Serving members with disabilities and chronic conditions	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	26
MS031	2	The culture of disability	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	36
MS032	2	Resources available to members	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	37
MS033	1	The Vendor should, on an ongoing basis and at a set frequency, provide training to staff who perform outreach to members with special healthcare needs upon enrollment.	The Vendor should describe how it will meet this specification, including, but not limited to, proposed training frequency and curriculum.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	37
MS034	1	The Vendor should use and report to the Department on customer service performance standards, including, but not limited to, the following:	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	33
MS035	2	Member-to-representative ratios	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	33
MS036	2	Call answering time, with a minimum of 83% of calls answered in 30 seconds	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	34
MS037	2	Call abandonment rate not to exceed five percent (5%)	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	34
MS038	2	Single contact resolution	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	34
MS039	2	Turnaround time for member requests	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	34
MS040	1	The Vendor should use warm transfer protocols for its member services and other applicable departments.	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	32
MS041	1	The Vendor should establish and implement a new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment. This process should include, but not be limited to, the following:	The Vendor should describe its new member enrollment and education process, including member contact, from the time of initial notification of the member's enrollment through the first month of actual enrollment. This description should establish the order of steps and associated timeframes.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	7

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MS042	2	Member contact, including, but not limited to, welcome calls, welcome letters, and/or home visits	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	8
MS043	2	Outreach to members who are difficult to contact, including, but not limited to, disabled members and members without telephones	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	8
MS044	2	Processing and issuing identification cards	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	10
MS045	2	Distributing member handbooks	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	11
MS046	1	The Vendor should distribute to members preferred drug list (PDL) and formulary changes affecting members' care.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date. This description should include, but not be limited to, timeframes and methods of delivery.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	12
MS047	1	The Vendor should work with the State health exchange during the first six months of the contract to deliver to the Department an implementation plan for an electronic health record (EHR) system that serves as a health passport for members.	The Vendor should describe how it will meet this specification. Per the American Academy of Pediatrics (AAP), the health passport should include, but not be limited to, the child's chronic health problems, allergies, medications, psychosocial and family histories, trauma history, and developmental and immunizational information.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	41
MS048	1	The Vendor should provide a publicly accessible, secure website with information targeted to members that adheres to federal and State marketing regulations.	The Vendor should describe how it will leverage its website to help meet the needs of members.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	24
MS049	1	The Vendor should provide a secure member portal that allows members to log in and access benefit information, including, but not limited to, the following:	The Vendor should describe the abilities of its member portal and how the portal will be leveraged to help meet the needs of members.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	24
MS050	2	Medical records	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	24
MS051	2	Authorization status	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.4 MS	24
ND001	1	The Vendor should establish a statewide provider network containing providers that can provide a multi-disciplinary and comprehensive service array, either through their own practice or through collaboration with other providers.	The Vendor should provide a detailed description of how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	7
ND002	1	The Vendor should establish a statewide provider network that is accessible to children and their caregiver(s).	The Vendor should provide a detailed description of how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	10
ND003	1	The Vendor should establish a statewide provider network that incorporates evidence-based best practices and interventions.	The Vendor should provide a detailed description of how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	10
ND004	1	The Vendor should establish a statewide provider network that provides for continuous communication with stakeholders.	The Vendor should provide a detailed description of how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	13
ND005	1	The Vendor should establish a statewide provider network that has capacity in rural areas.	The Vendor should provide a detailed description of how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	14
ND006	1	The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health.	The Vendor should provide a detailed description of how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	15
ND007	1	The Vendor should address deficiencies in the Essential Provider and Specialty Provider networks in relation to travel times and distances that may be experienced by a member.	The Vendor should describe what constitutes a deficiency in the Essential Provider and Specialty Provider networks, based on its understanding of Department provider network standards, and its approach to addressing these deficiencies.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	28
ND008	1	The Vendor should measure and regularly verify network compliance standards.	The Vendor should describe its methods and how often it will verify network compliance standards.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	30

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Specifications					*Vendor Response*			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND009	1	The Vendor should take action if notified of inappropriate wait times before a member is seen by a provider.	The Vendor should describe its standards for member wait times.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	32
ND010	1	The Vendor should continue to build upon the provider network and credential new providers across the State for applicable populations.	The Vendor should provide a detailed description of how it will meet this specification, including, but not limited to, a general recruitment plan with mechanisms to build network access.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	16
ND011	1	The Vendor should provide monthly reports to the Department on underserved areas of the State where the Vendor believes additional socially necessary services (SNS) providers should be permitted to enroll to address a gap in care.	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	33
ND012	1	The Vendor, and/or any benefits management subcontractor(s), should monitor and evaluate ongoing access to services, including, but not limited to, the following:	The Vendor should provide a detailed description of the methods it will use to meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	33
ND013	2	Time/distance	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	34
ND014	2	Appointment timeliness, by provider type	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	35
ND015	1	The Vendor should ensure member access to covered services in areas where the provider network standards do not require a specialist.	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	38
ND016	1	The Vendor should recruit specialty care providers and hospitals, for applicable populations.	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	17
ND017	1	The Vendor should offer crisis response to children and their caregiver(s), as well as families at risk, to the extent that these services are covered under the Bureau for Medical Services (BMS) Children with Serious Emotional Disturbance Waiver (CSEDW).	The Vendor should describe how it will meet this specification. *Note: Although not all populations in the specification are included inthe scope for this procurement, the Vendor should demonstrate an understanding of the populations listed. For crisis services outside the Children with Serious Emotional Disturbance Waiver (CSEDW), the Department may carve in these services at a later date.*	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	15
ND018	1	The Vendor should develop and implement a recruitment strategy for the following providers:	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	17
ND019	2	Federally Qualified Health Centers (FQHCs)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	17
ND020	2	Rural Health Clinics (RHCs)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	17
ND021	1	If the Vendor elects not to contract with Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), the Vendor should develop and implement a strategy to ensure that members in applicable populations can access these providers.	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	18
ND022	1	The Vendor should develop and implement a recruitment strategy for the following publicly-supported providers:	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	18
ND023	2	Local Health Departments	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	18
ND024	2	Critical Access Hospitals	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	18
ND025	2	Primary Care Centers	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	18
ND026	2	School-Based Health Centers (SBHCs)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	18
ND027	2	Right from the Start (RFTS) Providers	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	19

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Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND028	2	Bureau for Public Health (BPH) Laboratories	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	19
ND029	2	Children with Special Health Care Needs (CSHCN) Program	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	19
ND030	1	If the Vendor elects not to contract with the publicly supported providers, the Vendor should develop and implement a strategy to ensure all members have access to services.	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	19
ND031	1	The Vendor should develop and implement recruitment strategies for new or modified provider types.	The Vendor should describe how it will meet this specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	19
ND032	1	The Vendor should establish and implement guidelines for which specialists will be able to serve as a primary care provider (PCP) for applicable populations, including, but not limited to:	1) The Vendor should provide proposed guidelines. 2) The Vendor should describe its proposed processes to meet these specifications.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	38
ND033	2	The circumstances and process under which a member may select a specialist as his/her primary care provider (PCP)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	38
ND034	2	Any managed care organization (MCO) approvals required	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	39
ND035	2	Any restrictions on the types of specialists that can serve as primary care providers (PCPs) for foster care members or other members with complex needs	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	39
ND036	1	The Vendor should ensure that the contracted network has a suitable range of pharmaceutical therapies to meet member needs, including, but not limited to, the following:	The Vendor should provide a general description of how it would meet these specifications, if pharmacy benefits are carved in at a future date.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	40
ND037	2	Availability of compounds	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	40
ND038	2	Availability of specialty drug pharmacies	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	40
ND039	1	The Vendor should make additional outreach efforts to the following types of pharmacies:	The Vendor should provide a general description of how it would meet these specifications, if pharmacy benefits are carved in at a future date.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	42
ND040	2	High volume	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	42
ND041	2	Rural	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	42
ND042	2	Public health entities administering the Vaccines for Children (VFC) program	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	42
ND043	1	The Vendor should ensure that pharmacy services are available to members in a timely manner, including, but not limited to, nights and weekends.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	42
ND044	1	The Vendor should establish and implement a provider re-credentialing cycle for physical health and behavioral health providers.	1) The Vendor should describe the proposed provider re-credentialing cycle. 2) The Vendor should indicate if this cycle would be different for pharmacy providers, if pharmacy benefits are carved in at a future date.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Section E.5 ND	27
PS001	1	The Vendor should provide initial (during implementation) and ongoing training for existing providers.	1) The Vendor should explain the proposed process, schedule, and content for providing ongoing training to existing providers. 2) The Vendor should provide an overall summary of training topics for existing providers.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	7
PS002	1	The Vendor should provide initial and ongoing training targeted to new providers.	1) The Vendor should explain the proposed process and schedule for providing ongoing training to new providers. 2) The Vendor should provide an overall summary of training topics for new providers.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	7

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Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
PS003	1	The Vendor should provide training on mandated reporters to support applicable State Code, as defined by the Department.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	10
PS004	1	The Vendor should coordinate with the member's primary care provider (PCP) and behavioral health provider, for applicable populations, to ensure each provider has access to the most up-to-date medical records.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	14
PS005	1	The Vendor should establish a quality rating system for its contracted providers and disseminate this information to help members make informed choices about their care.	The Vendor should describe how it will meet this specification, including an approach to establishing quality ratings and how the Vendor will disseminate the information.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	13
PS006	1	The Vendor should distribute provider manuals according to set timeframes and methods of delivery.	The Vendor should describe how it will meet this specification, including proposed timeframes and methods of delivery.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	14
PS007	1	The Vendor should accept and pay claims on time for physical and behavioral health services, as defined by the Service Provider Agreement (SPA).	The Vendor should describe how it will meet this specification. The response should include, but is not limited to: •A breakdown of turnaround times for paper vs. electronic data interchange (EDI) claims •Claim turnaround report for each of the past 12 months, indicating the percentage of total claims that are clean, and the percentage of clean claims processed within 30 days, and within 90 days	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	15
PS008	1	The Vendor should establish and implement guidelines to approve out-of-network provider claims for physical health and behavioral health services--including, but not limited to, hospitals--on an ongoing basis (after the 90-day exemption timeframe).	1) The Vendor should describe how it will meet this specification. 2) The Vendor should state whether it will reimburse these providers using the Medicaid fee schedule(s) or an alternate fee schedule.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	15
PS009	1	The Vendor should establish and implement a review process for payments for emergency services for applicable populations, including, but not limited to, the following:	1) The Vendor should describe how it will meet this specification. 2) If algorithms are used to evaluate pended claims, the Vendor should describe how it will ensure that the "prudent layperson" standard is upheld.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	15
PS010	2	Which types of claims are automatically paid	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	15
PS011	2	Which types of claims are automatically pended	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	15
PS012	2	Evaluation of pended claims for payment, upholding the "prudent layperson" standard	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	15
PS013	1	The Vendor should educate primary care providers (PCPs) on their responsibility to coordinate a member's overall health, for applicable populations.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	10
PS014	1	The Vendor should conduct outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services, for applicable populations.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	14
PS015	1	The Vendor should educate and provide guidance to primary care providers (PCPs) on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health and/or socially necessary services (SNS), for applicable populations.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	11

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Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
PS016	1	The Vendor should educate primary care providers (PCPs) about the importance of dental screenings to ensure appropriate referrals to dental providers, including, but not limited to, training PCPs to verify that beginning at six (6) months after the first tooth erupts or by 12 months of age (as part of the Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] process), the member should be referred to dental providers, for applicable populations.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	11
PS017	1	The Vendor should educate and monitor primary care providers (PCPs) regarding administration of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, for applicable populations.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	11
PS018	1	The Vendor should educate providers about the ability to request out-of-network referrals.	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	12
PS019	1	The Vendor should support e-Prescribing functions.	The Vendor should provide a general description of how it would meet this specification, if pharmacy benefits are carved in at a future date.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	17
PS020	1	The Vendor should educate primary and specialty care physicians about foster care members and members with complex needs, including, but not limited to, the following:	The Vendor should provide a detailed description of how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	12
PS021	2	Opportunities for standing referrals	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	12
PS022	2	Opportunities for specialists to serve as primary care providers (PCPs)	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	12
PS023	2	Availability of disease management	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	12
PS024	1	The Vendor should provide a publicly accessible, secure website with information targeted to providers.	The Vendor should describe how it will leverage its website to help meet the needs of providers.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	19
PS025	1	The Vendor should provide a secure portal--accessible by providers, Department caseworkers, and other stakeholders as permitted by the Department--that allows these stakeholders to log in and access information as permitted by the Department, including, but not limited to, the following:	The Vendor should describe how it will leverage its website to help meet the needs of providers, Department caseworkers, and other stakeholders as permitted by the Department. *Note: The Medicaid fiscal agent will provide member eligibility information.*	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	19
PS026	2	Medical records	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	19
PS027	2	Authorization status	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.6 PS	19
PS028	2	Confirmation of services previously provided to avoid duplication	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	19
QU001	1	The Vendor should reward physical and behavioral health providers that adhere to the quality or performance standards of the Department.	The Vendor should describe how it will meet this specification, as well as any other ways they would actively work with network providers to ensure accountability and improvement in the quality of care provided.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	16
QU002	1	The Vendor should share best practice methods or programs with physical and behavioral health providers, and should provide identified best practice methods or programs to the Department for consideration in sharing with socially necessary services (SNS) providers.	The Vendor should describe how it will meet this specification, as well as any other ways it would actively work with network providers to ensure accountability and improvement in the quality of care provided. The Vendor should describe which best practice methods it employs to its provider network.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	17

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Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU003	1	The Vendor should take action against physical and behavioral health providers that demonstrate unacceptable performance, and should share identified socially necessary services (SNS) provider performance deficiencies with the Department.	1) The Vendor should describe the standards it uses to assess provider performance. 2) The Vendor should describe how it will meet this specification, as well as any other ways they would actively work with network providers to ensure accountability and improvement in the quality of care provided.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	19
QU004	1	The Vendor should adopt strategies to simplify administrative procedures.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	22
QU005	1	The Vendor should administer a Quality Assurance and Performance Improvement (QAPI) Program.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	26
QU006	1	The Vendor should use Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	42
QU007	1	The Vendor should use measures beyond Healthcare Effectiveness Data and Information Set (HEDIS) scores to assess its programs' and policies' impacts on West Virginia's youth and families.	The Vendor should describe proposed measures beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS).	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	43
QU008	1	The Vendor should report measures to the Department according to the requirements in the Service Provider Agreement (SPA), including, but not limited to, the following:	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	42
QU009	2	Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	42
QU010	2	Measures that go beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	42
QU011	1	The Vendor should use alternative payment structures for those providers over which the Vendor has direct contract oversight--including, but not limited to, provider incentives and/or overcoming limitations of diagnosis-driven eligibility--for the percentage of provider contracts identified in the Service Provider Agreement (SPA) to increase healthcare quality and efficiency through collaboration and innovation to improve access to comprehensive healthcare.	The Vendor should describe: 1) A plan for alternative payment structures 2) Mechanics by which incentive payments to providers to improve quality of care would be made 3) Quality metrics that would be required for provider incentives and shared savings	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	7
QU012	1	For those providers over which the Vendor has direct contract oversight, the Vendor should identify and incorporate into alternative payment structures opportunities including, but not limited to, the following:	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	13
QU013	2	Cost savings	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	13
QU014	2	Reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	13
QU015	1	The Vendor should design and implement payment models with network providers (over which the Vendor has direct contract oversight) that tie reimbursement to measurable outcomes and ensure appropriate care is delivered in the most appropriate place and time.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	15
QU016	1	The Vendor should report annually to the Department on its activities related to alternative payment structures for those providers over which the Vendor has direct contract oversight, according to the Service Provider Agreement (SPA).	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	16

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Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU017	1	The Vendor should monitor quality improvement strategies with measurements including, but not limited to, the following:	The Vendor should describe in detail how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU018	2	Access to care	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU019	2	Demand for services	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU020	2	Quality of care	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU021	2	Health outcomes	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU022	2	Member satisfaction	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU023	1	The Vendor should analyze utilization data to monitor quality improvement strategies.	The Vendor should describe in detail how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	48
QU024	1	The Vendor should collect and analyze quality measures at a set frequency.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU025	1	The Vendor should report annually to the Department on its activities related to access to care, according to the Service Provider Agreement (SPA).	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	56
QU026	1	The Vendor should use data to identify barriers to care for individuals with special healthcare needs, including, but not limited to, the following data collection methods:	The Vendor should describe in detail how it will meet these specifications.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	52
QU027	2	Focus groups	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	52
QU028	2	Surveys	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	52
QU029	2	"Secret shopper calls"	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	52
QU030	2	Aggregate utilization monitoring	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	52
QU031	1	The Vendor should develop, update, and disseminate clinical guidelines to participating providers.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	20
QU032	1	The Vendor should follow a process to address quality issues, including, but not limited to, the following:	The Vendor should describe in detail how it will meet these specifications.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	34
QU033	2	What steps will be taken	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	34
QU034	2	Who is responsible for addressing issues	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	34
QU035	2	Timeframes for resolution	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	34
QU036	1	The Vendor should initiate data-driven clinical initiatives that yield improvements in clinical care for applicable populations.	The Vendor should describe: 1) Data-driven clinical initiatives that the Vendor initiated within the past 24 months that have yielded improvement in clinical care. 2) Statistically significant improvements generated by these clinical initiatives.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	31
QU037	1	The Vendor should establish and collect member satisfaction measures following the implementation date.	1) The Vendor should provide proposed member satisfaction measures. 2) The Vendor should describe past Vendor efforts to assess member satisfaction.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	47
QU038	1	The Vendor should profile the quality of care delivered by network providers, including, but not limited to, the following:	1) The Vendor should describe its practice of profiling the quality of care delivered by network providers. 2) The Vendor should provide the methodology for determining which and how many providers will be profiled.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	23

WEST VIRGINIA Department of Health & Human Resources

Vendor Responses to Detailed Specifications

Specifications					*Vendor Response*			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU039	2	Primary care providers (PCPs)	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	23
QU040	2	High-volume specialists	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	23
QU041	2	Hospitals	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	23
QU042	2	Other acute care providers	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	23
QU043	1	The Vendor should monitor and reinforce primary care provider (PCP) compliance with program requirements for applicable populations.	1) The Vendor should describe how it will meet this specification, in general. 2) The Vendor should describe specifically how it will meet this specification for program requirements including, but not limited to, 24-hour coverage, appointment scheduling, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity standards.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	21
QU044	1	The Vendor should use data to identify access barriers for members with special needs, including, but not limited to, the following data:	The Vendor should describe in detail how it will meet these specifications.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	54
QU045	2	Complaints and grievances	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	54
QU046	2	Primary care provider (PCP) change requests	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	54
QU047	2	Out-of-network referrals	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	54
QU048	2	Emergency room (ER) usage	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	54
QU049	1	The Vendor should use reports/data from subcontractor(s), as applicable, to ensure appropriate subcontractor oversight and the following member-related outcomes:	The Vendor should describe how it will meet these specifications.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	39
QU050	2	Access to care	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU051	2	Member satisfaction	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU052	2	Continuity of care	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	40
QU053	1	The Vendor should run data at a set frequency to identify which members in applicable populations have not received primary care services.	The Vendor should describe: 1) Types of data the Vendor will use to determine which members have/have not received primary care services 2) Any other mechanisms the Vendor will use to determine which members have/have not received primary care services 3) Who is responsible for tracking this data 4) How frequently the Vendor will run this data	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	49
QU054	1	The Vendor should contact members within a set timeframe after identifying which members in applicable populations have not received primary care services.	The Vendor should describe how it will meet these specifications.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	50
QU055	1	The Vendor should contact the member's primary care provider (PCP) within a set timeframe after identifying that a member has not received primary care services, for applicable populations.	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	51
QU056	1	The Vendor should analyze and synthesize reports on data about members in applicable populations who have not received primary care services.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	49

Vendor Responses to Detailed Specifications

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU057	1	The Vendor should establish and implement ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	The Vendor should describe how it will meet this specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	29
QU058	1	The Vendor should periodically enhance ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.	1) The Vendor should describe how it will meet this specification. 2) The Vendor should describe when it will perform quality initiative monitoring activities.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Section E.7 QU	30

Vendor Responses to Detailed Specifications

Vendors should not edit this worksheet.

Vendor Response - Capability Assessment	
Capability Assessment	**Description**
Will Meet	Specification will be met by the Vendor.
Will Not Meet	Specification will not be met by the Vendor.

Response Templates	
Response Template	**Description**
Attachment A	Cost Workbook
Attachment B	Vendor Qualifications and Experience
Attachment C	Project Organization and Staffing
Attachment D	Mandatory Requirements
Attachment E	Detailed Specifications Approach
Attachment F	Sample Case Scenario
Attachment G	Terms and Conditions Response Template

Specification Subject Matter Areas	
Abbreviation	**Subject Matter Area**
BA	Benefit Administration
CM	Care Management
CS	Community/Stakeholder Engagement
MS	Member Services
ND	Network Development
PS	Provider Services
QU	Quality

ATTACHMENT F: SAMPLE CASE SCENARIO

Instructions: A sample case scenario is described below. The Vendor should explain how they would care for the child using the question-and-response format provided beneath the scenario. The Vendor's response to Attachment F should not exceed 10 pages.

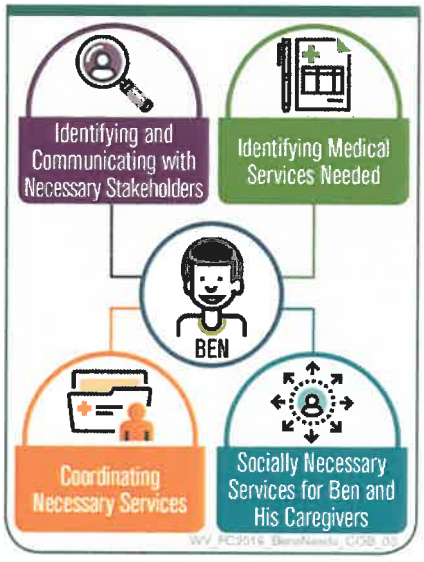
Case Scenario

Ben is six (6) years old. CPS has just conducted an evaluation of Ben's household and determined that based on parental substance abuse issues, Ben needs to be removed from the home and taken into State custody. Ben is currently placed in an emergency shelter while CPS staff work on placement options but will ultimately be placed with a kinship relative. Ben has had a history of needing various durable medical equipment (DME) supplies and behavioral health supports to help address his medical needs. The court has ordered socially necessary services to help Ben adapt to his new environment.

Please answer the questions below as to the Vendor's approach in helping Ben from the point of removal through placement and then ongoing.

Vendor Response

1. **Starting with the notification by the Department caseworker that Ben has been taken into custody, please describe your approach to communicating with all necessary stakeholders (Vendor should identify all parties to communicate with), identifying the spectrum of medical services needed and coordinating those services, and coordinating socially necessary services.**



UniCare Health Plan of West Virginia, Inc. (UniCare) is committed to supporting every child, youth, and young adult enrolled in the West Virginia Specialized Managed Care for Children and Youth Program (the Program). Our Fostering Healthy Lives model will help to provide services to child welfare members in the most integrated environment through a holistic, person-centered, trauma-responsive approach that assures safety, permanency, and well-being. We will use our Fostering Healthy Lives model to serve Ben and his family in a way that is specific to their situation and needs.

Prompt, Proactive Response to Needs

The Department of Health and Human Resources (DHHR) has been called to investigate Ben's home due to alleged substance abuse issues by Ben's parents. As a result of their investigation, Ben is taken into custody and placed in an emergency shelter pending approval of a kinship placement. This unfortunate string of events is new for Ben, and this is the first time he has been admitted to an emergency shelter and become a UniCare member. His membership is activated the moment he enters the custody of DHHR, through the emergency provision of coverage enrollment prior to formal notification. ***We will collaborate with the Department caseworker to see that Ben's care is delivered in the least restrictive environment, that his safety is continually assured, and his permanency plan is in no way delayed by barriers to necessary care.***

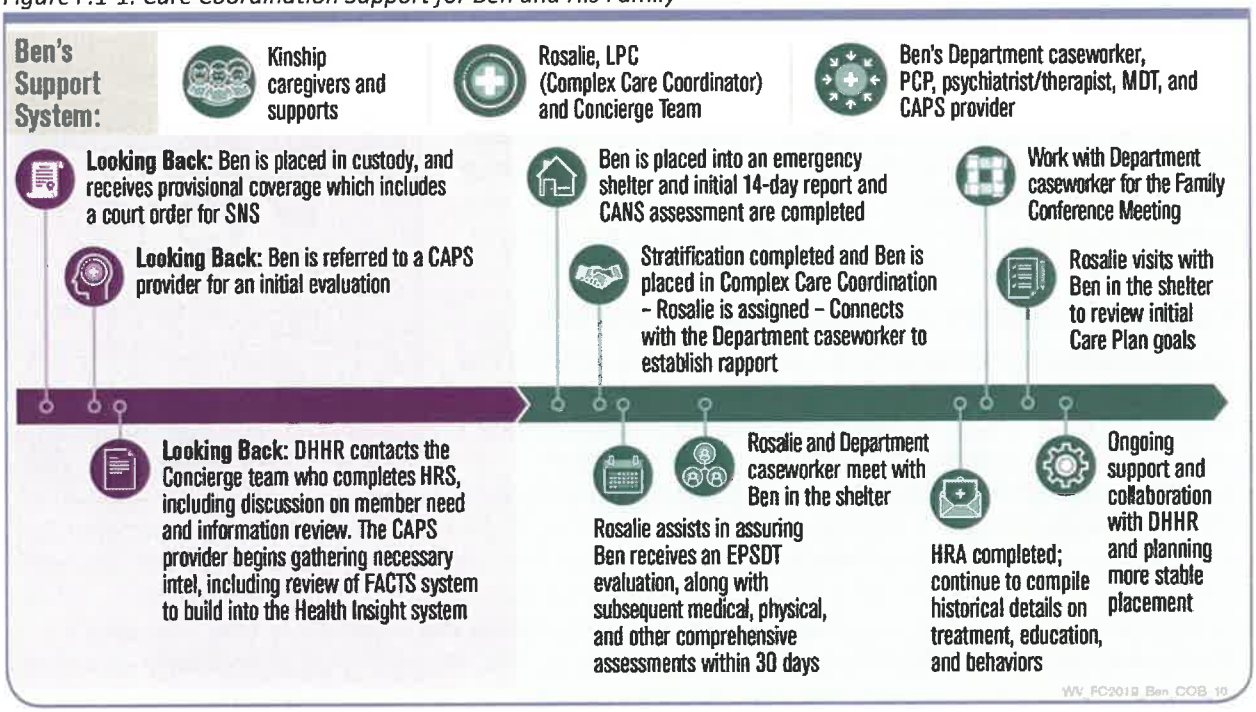
Timely Interventions for Ben's Safety and Care

The Department caseworker contacts our Fostering Healthy Lives Concierge Line (Concierge Representatives) to provide information about Ben's placement and to request assistance for necessary planning and health care services. The Concierge Representative begins gathering information regarding Ben's current living situation, his emergent needs, his history concerning treatment, and any identified providers. The Concierge Representative also arranges with the Department caseworker a time to complete Ben's Fostering Healthy Lives Health Risk Screening (HRS) in the upcoming days. The HRS is a proprietary tool designed specifically for children and youth engaged with the child welfare system to identify the need for additional health risk, trauma, condition-specific, or social determinants of health (SDOH) assessment. The HRS will additionally identify if Ben is prescribed medication and if he has been taking it as prescribed. If Ben needs medication, the Concierge Representative will work with the Department caseworker to verify if Ben has an adequate supply or to arrange for authorization and dispensing with the State pharmacy program.

The Department caseworker notes Ben needs socaially necessary services (SNS) in addition to his current medical, durable medical equipment (DME), and behavioral health (BH) services. Since SNS are limited due to SNS service exclusion while Ben is at the shelter, we work with the Department caseworker to arrange for the SNS connection visit, BH care, and DME needs until SNS pre-unification can be arranged. During this time, the Comprehensive Assessment Planning System (CAPS) provider begins the process of conducting Ben's initial evaluation.

Because care coordination starts with our Concierge team, the team collaborates with the Department caseworker and the CAPS provider to initiate discussions regarding Ben's needs and to conduct a review on available information about Ben's current health status and any previous treatment records. Figure F.1-1 depicts events and activities during Ben's first 30 days in placement that drive interventions by DHHR and UniCare designed to maintain Ben's safety and provide services necessary to treat his health care conditions.

Figure F.1-1. Care Coordination Support for Ben and His Family



Identifying and Communicating with Necessary Stakeholders

In order to assure all members of Ben's Fostering Healthy Lives interdisciplinary care team are involved in developing his Fostering Healthy Lives Care Plan (Care Plan), we will communicate directly telephonically and in person with all stakeholders who will be providing services for Ben, including those below. The stakeholders are important to development of his Care Plan and in helping determine his needs.

- Department caseworker
- Emergency shelter staff
- Fostering Healthy Lives Care Coordinator (Care Coordinator)
- Ben's kinship caregivers
- Ben's physical and BH providers
- SNS Liaison
- CAPS provider

As shown in Figure F.1-1, a key step within the timeline of events are the CAPS process, including administration of the Child and Adolescent Needs and Strengths (CANS) Assessment, the initial 14-day report, the final 30-day Comprehensive Assessment Report (CAR), the 30-day Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit, arranging for DME needs, BH services, and the multidisciplinary treatment team (MDT) process.

Identifying Medical Services Needed

Upon completion of the HRS, the Concierge Representative also engages the Fostering Healthy Lives Care Coordination team to review the gathered information and to communicate the results of the HRS. After this consultation, the Care Coordination team determines Ben would be best served at the complex care coordination level based on his needs identified through the HRS and other information, including claims data and our proprietary foster care analytics model. ***The Care Coordination team assigns Ben to the complex care coordination level within two business days of enrollment.*** At this level, Ben's Care Coordinator will connect with him at least twice per month, or more as needed, conduct a monthly Care Plan review, and address Ben's needs for DME and BH supports. Complex care coordination is a high-intensity level indicated for children and youth. Ben may be flagged for any of the following:

- Children with Special Health Care Needs
- Comorbid conditions not successfully managed
- High medication use or indication of non-adherence to a medication regimen
- Higher predictive modeling score
- Involvement of many State agencies
- Recent or current psychiatric residential treatment facility admission
- Multiple inpatient admissionsWithin the two-day period, the Care Coordination team assign Rosalie as Ben's Care Coordinator. Rosalie is a West Virginia-licensed professional counselor with experience coordinating comorbid physical and BH care for children and youth.

Care Coordinator Assignment – Rosalie

Rosalie has experience working within the child welfare system. She is matched to Ben as his Care Coordinator based on his needs, placement in the emergency shelter, and her experience working with children and youth with comorbid physical and BH conditions. Rosalie reaches out to Ben's Department caseworker to introduce herself and begin the collaboration process to support his needs based on the results of the CAPS process.

Rosalie is a licensed professional counselor, with five years' experience working with children in foster care. She also has nine years' overall experience coordinating integrated care for children with comorbid physical health and BH conditions.
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First, We Listen

While Ben is still in the shelter, Rosalie outreaches to Ben and the Department caseworker in person. Rosalie employs the person-centered approach, focusing on Ben as the center of all planning activity and ensures he is an active member of the team. This approach gives Ben an opportunity to state his needs, wishes, and goals to be included in his person-centered Care Plan. The Care Plan is individualized and unique to Ben and includes a crisis plan as well as trauma-informed interventions in support of Ben's identified individualized service plan (ISP) goals. By taking this approach, Ben has an age-appropriate voice, choice, and personal investment in his care, making him an active participant in his treatment.

Because of the integrated approach of our Care Coordination team, we leverage our Concierge team to support Rosalie and the Department caseworker. We use this approach to gather information about Ben's current and past treatment for identified health concerns. This informs the ongoing assessment and planning process as Rosalie supports the Department caseworker's permanency planning activities for Ben, as well as develops his Care Plan.

Coordinating Necessary Services for Ben

In addition to all information received from DHHR assessments and other resources, such as the courts, schools, and providers, as well as our HRS and other assessments completed, Rosalie works with Ben, the Department caseworker, and available caregivers to complete the health risk assessment (HRA) within no more than 30 days of Ben's assignment to complex care coordination. Specifically, the HRS leads to the administration of the HRA, which includes information regarding immediate, current, and past health care, BH, and substance use disorder (SUD) needs, as well as additional SDOH needs, including:

Our screening and assessment process for Ben is focused on his individual needs. Because Ben has BH and DME needs, and possible medication management needs, we use the following instruments to get more detail about the care he requires:

- Fostering Healthy Lives Health Risk Screener
- Health Risk Assessment
- Pediatric Assessment
- BH assessment for children

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- Psychosocial, functional, and cognitive needs
- SDOH needs for Ben and those SDOH factors that affect his family
- Ongoing conditions or needs requiring treatment or care monitoring
- Current care being received, including health care services or other community-based care management or care coordination
- Current medications prescribed and taken
- Educational needs
- Support network, including caregivers and other social supports
- Other areas requiring assessment as identified by DHHR, the MDT, or the Care Coordinator

Rosalie also arranges for additional specific evaluations and assessments, as indicated, which will complement the CAPS process.

From the outset, Rosalie's primary focus is to support the Department caseworker's efforts to ease Ben's transition and reduce the exacerbation of trauma associated with his placement.

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During a conversation about Ben's needs, the Department caseworker asks Rosalie to participate in the MDT to present HRA results. Rosalie attends and obtains additional information not previously provided regarding physical and BH concerns, treatment history, and current challenges.

Rosalie also reviews Ben's risk factors identified from our proven, child welfare-specific data analytics and Fostering Healthy Lives predictive modeling tools. As claims data, assessment data, and other information become available, it is incorporated into our data analytics process, generating a risk score that

may be helpful to Rosalie throughout Ben's engagement in care coordination. As his needs change, this information informs changes to his care coordination stratification level.

Care Planning and Support

Combined with the information obtained from the CAPS process (including the CAR, CANS results, and CANS supplemental assessments), our HRS and HRA results, consultation with involved stakeholders, and discussions with Ben, the emergency shelter staff, and caregivers, Rosalie develops a complete picture of Ben's situation, needs, and the appropriate therapeutic interventions to help Ben regain stability. Rosalie uses additional relevant information from the following, as available, to aid in the development of the Care Plan.

The DHHR Family Service Plan (FSP). The Department caseworker develops the FSP and it contains specific strategies and actions designed to reduce risk and address needs and contributing influences to Ben's family situation. Rosalie incorporates the strategies and actions as steps to achieve the goals in Ben's Care Plan. In this way, the FSP and the Care Plan complement one another and will not be in conflict.

Individualized Service Plan. Rosalie integrates the ISP, developed by the Department caseworker, into Ben's Care Plan. ISP goals are included as goals in the Care Plan so that as the Care Plan is reviewed and updated, the ISP goals will also be reviewed.

Provider Treatment Plans. Provider treatment plans contain health condition-specific goals and recommended actions to resolve the conditions, if applicable. Rosalie uses these plans to make sure all of Ben's health care is included in his Care Plan and is reviewed on a regular basis to verify adherence to provider recommendations, especially prescribed medication regimens.

Ben's Care Plan supports the goals identified by the DHHR case plan and the MDT and addresses and coordinates necessary physical and BH needs, SDOH needs, care recommendations, and community resources. Our Care Plan, which integrates the DHHR and MDT information, supports Ben's identified goals and capitalizes on Ben's and his caregivers' strengths. The Care Plan also puts supports in place to address identified needs and risks and that work toward permanency.

Rosalie works with Ben's available family and caregivers, as permitted, to obtain relevant histories related to prior treatment and health care services and to determine if he has established providers. Rosalie works with the Department caseworker to provide coordinated care to assist DHHR in addressing the need for additional caregiver supports and formal SNS, in support of permanency planning.

We use our Youth Records Access Portal (YouthRAP) to aid in communication-sharing between the Department caseworker, providers, and others involved with Ben's care and permanency planning. The YouthRAP is a standalone portal that enables collaboration between Ben, our Care Coordination teams, his caregivers, the Department caseworkers, and others as part of the delivery of care. YouthRAP has the capability to assign role user access, provide access to Care Plans, medical record data and authorization status, and send notifications.

Ben's Fostering Healthy Lives Care Plan

Rosalie uses motivational interviewing to work with Ben, his caregivers, and the Department caseworker to pinpoint the opportunities, solutions, and resources, including SNS, currently available to address his health concerns and Care Plan goals while also identifying SDOH barriers impacting his situation. To do this, Rosalie focuses on what Ben wants and needs in this process. Ben's Care Plan is detailed in Table F.1-1.

Table F.1-1. Ben's Care Plan

Ben's Goals	Action Steps to Achieve His Goals	Family Involvement in Goal and Actions
"I need help sometimes"	• Arrange for DME and medical needs • Provide needed medication interventions if indicated • Arrange for psychiatric evaluation and BH therapy	• Coordinate SNS delivery • Offer in-home family therapy and supports • Educate prospective caregivers
"I want to go back home"	• Therapeutic work to help Ben adapt to temporary placement • Trauma-informed care to process Ben's removal from his home • Complete safety and crisis plan	• Family therapy to work toward reunification • Parenting education and life skills development • SUD treatment for parents
"I want to go to school"	• Arrange school attendance close to his original home, if reunification is a possibility	• Engage in community supports for peer connections and community organizations

Ben's Care Plan includes planned interventions and supports that facilitate permanency across the following domains:

- Trauma/traumatic stress experiences
- Life domain functioning
- Behavioral/emotional needs
- Developmental status
- Caregiver needs and strengths
- Ben's strengths
- Acculturation
- Risk behaviors (truancy, run risk, oppositional for example)
- Life skills

Ben's Care Plan will be updated monthly and loaded into the Health Insight platform. The Care Plan is shared with relevant stakeholders, including the Department caseworker, providers, and other MDT participants, as needed. The Department caseworker may also authorize other individuals or organizations to receive copies of the Care Plan.

Rosalie partners with the Department caseworker to make sure appointments are scheduled for the interventions and treatments recommended by the MDT and included in Ben's Care Plan.

Collaborating and Communicating with All Stakeholders

To reduce the administrative burden for DHHR and enhance overall communication, Rosalie remains a single point of contact for the Department caseworker, Ben, his family, and caregivers. She works with the Department caseworker to support the DHHR-required activities taking place while Ben is residing in the shelter.

The Department caseworker requests Rosalie participate in the MDT process, so Rosalie coordinates her participation with the CAPS provider, who may have begun planning the MDT conference. We offer education on the available Medicaid services, UniCare Value-Added Services (VAS), SNS availability and delivery, and how our care coordination services can be leveraged to enhance MDT decisions. As part of this collaboration and coordination, Rosalie connects with parties involved in Ben's care, supporting their activities, sharing information and assessment results, and jointly facilitating implementation and positive results. These parties include:

- DHHR staff
- CAPS provider
- Emergency shelter staff
- Representatives of the court
- Clinical providers, including Ben's primary care provider (PCP), specialists, and BH providers (therapist, psychiatrist, psychologist), if indicated

Rosalie consults with the Department caseworker to determine if it would be appropriate or necessary for her to join the Family Conference Meeting. This meeting offers an opportunity for

Rosalie to meet Ben's parents, if available, and his proposed kinship caregiver ahead of the presentation of the CAR, get to know them, build rapport, and gather information regarding their needs and desires so that these can be included in the Care Plan.

Socially Necessary Services for Ben and His Caregivers

Together, the UniCare Utilization Management (UM) Clinician and Rosalie review the SNS recommendations from the MDT and authorize the request for SNS for Ben and his caregivers. Rosalie will work with Ben's Department caseworker to make sure the SNS are authorized appropriately — those services he is eligible for while he is in the shelter and those he will receive once he is placed outside of the shelter.

Ben's case is staffed in coordination with the SNS Liaison to make sure providers are aligned to meet Ben's needs. The SNS requested by Ben's Department caseworker include supervised visitation, the family connection visit, transportation, intensive therapeutic recreation, and other identified services to serve Ben's needs. The Department caseworker has identified the preferred SNS providers and Rosalie confirms inclusion in the UniCare network and that these are the most appropriate providers for Ben and his caregivers' services.

Part of our review of these providers is to determine their geographic proximity to Ben and his caregivers and whether the provider can represent or be sensitive to any cultural sensitivities Ben and his caregivers may have. Rosalie also reviews for potential SNS duplication, fragmentation, or opportunities to bundle SNS with a fewer number of providers to ease the process for Ben and his caregivers. We monitor the progress reports submitted by SNS providers to assure appropriateness of services, to verify the services are being provided as authorized, or to identify other needed services. Our UM Clinician authorizes the SNS within 24 hours, per Rosalie's and Department caseworker's request, and electronically submits an electronic authorization file to the Families and Children Tracking System (FACTS).

Rosalie partners with the Department caseworker, Ben, and his caregivers to identify available SNS providers for the requested service who meet their preferences, and she confirms geographic convenience and their ability to quickly initiate services. They also review opportunities to locate a single provider who can deliver multiple authorized SNS. Consolidating whenever possible will ease the burden on Ben's caregivers and reduce fragmentation of services.

Ben received his CAPS Comprehensive Assessment through Samaritan House, a shelter operated by Youth Service Systems, Inc., which also provides SNS and BH services. Samaritan House promotes continuity of care for access to community-based services, SNS, and outpatient BH services for Ben and his caregivers. Somaritan House helps with individual and family relationship issues, behavioral problems, parental concerns, abuse/neglect issues, school problems, emotional health issues, and problem-solving and decision-making in order to promote Ben's safety, permanency, and well-being.

Rosalie contacts Samaritan House to confirm their capacity and acceptance of the referral. If they do not have the immediate capacity or are unwilling to accept the referral, Rosalie uses our Health Insight platform to create a provider list based on requested service type, geographic location, specialties, and other details to identify and contact alternate SNS providers until one is located who best meets Ben's and his caregivers' needs and preferences. While reviewing available providers, Rosalie prioritizes selection of SNS providers whose performance data (provided by DHHR and incorporated into our system) indicates positive results or performance and connects Ben and his caregivers to these providers.

During periodic Care Plan reviews, Rosalie will review all services, including SNS, to verify they continue to be appropriate and are achieving the identified goals. All identified SNS, whether for Ben or his caregivers, are documented in Ben's Care Plan. Throughout Ben's involvement with DHHR, SNS include the supports in Table F.1-2.

Table F.1-2. SNS Resources for Ben and His Family

SNS Resource	What It Provides	Providers of the Resource
Administrative Services Organization (ASO) Private and Agency Transportation	SNS transportation assists families and ASO providers with visitations, SNS, and any related education/court/MDT appointments	• Youth Service Systems, Inc. • Ben's kinship caregivers/parents
SNS Foster Care: Adult Life Skills, Individualized Parenting, Supervised Visitation 1 and 2, Connection Visits, Family Crisis Response, Situational or Behavioral Respite, and Daily Respite, Pre-reunification Support, Intensive Therapeutic Recreation Experience	Improves basic life skills, develops social/emotional support, and role modeling; improves parental competence and knowledge; pre-reunification visit; evaluates appropriateness of interaction; ensures safety and appropriate interaction is maintained; temporary relief from caregiver responsibilities to avoid a placement disruption; addresses and intervenes to de-escalate emergencies and maintain placement/family unity; positive behavior change for children through practicing positive social skills, reinforcing positive risk-taking behavior, and enhancing self-image	• Youth Service Systems, Inc. • Ben's kinship caregivers/parents (connection visits)
Reunification: Safety Services Bundle (Supervision, Individualized Parenting, Family Crisis Response, Adult Life Skills, Emergency Respite)	Eyes-on oversight required to provide structure and assure performance of developmentally appropriate activities to carry out activities of daily living and assure safety; provides monitoring and structure; develops skills; intervenes in/de-escalates family emergencies to assure safety	• Youth Service Systems, Inc.

Rosalie supports the Department caseworker in coordinating necessary additional SNS to begin Ben's transitional overnight visits with the proposed kinship caregivers and to observe the interactions as they adjust to the new placement. The SNS provider reports include recommendations regarding the placement based on the results of visits.

Family Engagement

Ben has been impacted by his home environment and his parents' SUD. Working collaboratively with the Department caseworker, Rosalie helps engage and refer services for the parents' SUD stabilization and BH services. We use this collaboration to help determine whether SNS Parenting and Adult Life Skills are appropriate for the parents to help initiate reunification if community resources to help parenting are not sufficient.

STABILIZING and STRENGTHENING FAMILIES

Rosalie assists Ben's parents and Department caseworker to find an appropriate comprehensive SUD treatment center, community support group, Narcotics Anonymous/Alcoholics Anonymous meetings and counseling, and Family Resource Network community support referrals to empower the family to reach their highest potential. If Ben's parents' mental capacity assessment indicates their lack

of basic parenting skills to maintain Ben's safety, health, and well-being while in their care, we can assist the Department caseworker with referrals to and coordination of Individualized Parenting and Adult Life Skills to facilitate reunification once these services are recommended by the MDT. If the parents are in a SUD residential rehabilitation treatment facility (SNS exclusion), these services will be postponed until they are discharged from treatment. If the parents previously had the skill but lost the ability to perform parenting tasks due to the severity of their BH conditions, a mental health professional will be consulted to determine if the parents meet medical necessity for Basic Living Skills in the Medicaid Rehabilitation Manual.

Depending upon school transportation access and geographical location of Ben to his school of origin, we will initiate contact with the Board of Education (McKinney–Vento Homeless Assistance Act of 1987) to coordinate transportation. Rosalie also arranges for SNS transportation to IEP/504 meetings.

Parent-Child Interaction Therapy Training (PCIT). We offer the support of the PCIT program to Ben's kinship caregivers and will make it available to his parents of origin once they have been approved to take care of Ben. PCIT is a behavioral training model that teaches skills using live coaching of parents and children together. Live coaching provides immediate prompts to parents while they interact with children. During this hands-on modality, Ben's caregivers are guided to demonstrate specific relationship-building and discipline skills. The benefits of live coaching are significant and include:

- Parents/caregivers are provided with opportunities to practice newly taught skills
- Therapists can correct errors and misunderstandings on the spot
- Parents/caregivers receive immediate feedback
- Parents/caregivers are offered support, guidance, and encouragement as they learn
- Treatment gains (for example, increases in child compliance) are recognized by the parent "in the moment," which supports continued use of effective parenting skills

The PCIT curriculum uses a two-phase approach, addressing relationship enhancement (Child-directed Interaction) and discipline and compliance (Parent-directed Interaction). The original PCIT was adapted for use with various populations and cultures, including child welfare.

Supporting and Facilitating Visitation

We support the Department caseworker in coordinating approved visitation between Ben and his parents. We aim to support DHHR's goal to assure family permanency while sustaining Ben's safety and overall wellness. We work within DHHR guidelines regarding Ben's visitation, recognizing visitation needs are specific to him. We value the family's right to reasonable visitation with him and the importance of promoting Ben's stability, unless specifically restricted by a court order. Rosalie verifies the Care Plan includes specific requirements regarding visitation as noted in the Visitation Plan in FACTS.

We support DHHR goals for permanency planning and know in most instances, children placed close to their family and communities are more likely to have parent visitation and return home. We support transportation to and from visitation appointments through our VAS if there is a transportation hardship, and we make sure visitation occurs when scheduled.

Informal Visitation. In response to the Department caseworker's request, Rosalie coordinates with Ben's kinship caregiver to transport Ben and his biological parents to a community recreational area for informal visitation. If the cost of travel is a constraint for the caregivers, SNS transportation reimbursement is available. In order to access this SNS reimbursement, we work with the Department caseworker to connect Ben's kinship caregiver with the Mission West Virginia Relatives as Parents Program (RAPP) prior to the court date to sign up to become an ASO

foster-adoptive parent provider. This also includes assistance with the SNS transportation reimbursement process through authorization and billing when the reimbursement is required.

Formal Visitation. To assess interactions between Ben and his biological parents, we coordinate the Supervised Visitation 2 recommended by the MDT. This coordination occurs with the SNS agency according to the agency's geographic location and its ability to provide the full SNS array expected by DHHR to meet the family's needs. The SNS agency evaluates the level and appropriateness of the interaction. This type of visitation cannot be held at the shelter and must be billed once Ben is placed outside of the emergency shelter. The Department caseworker assesses the outcome of the visit, as well as the family's strengths and concerns.

During any type of visitation process, UniCare continues to wrap Ben, his family of origin, and his kinship caregivers in additional community supports, such as those described in Table F.1-3.

Table F.1-3. Community Supports to Facilitate Placement and Permanency

Community Support	Description
Al-Anon	Al-Anon is a mutual support program for people affected by someone's drinking. By applying Al-Anon principles, families and friends of alcoholics can bring positive changes to their and their family's individual situations.
Value-Added Services	Our VAS for Ben and his kinship caregivers, for example: **Education** • In-home Tutoring Services • Summer Reading Benefit **Healthy Behaviors** • Youth Club Memberships • Online Well-being Program **Promoting Togetherness** • Family Activity Coupon Book **Tools for Transitions** • New Placement Welcome Wardrobe • Lifeline Smart Phone Benefit **Tools for Foster Care Parents** • Foster Care Toolkit • Kinship Care Toolkit • Gas Card • Community Resource Link
SNS	Services available to the kinship caregiver to support the family and kinship caregivers for Ben's safety, permanency, and well-being.
Caring for Caregivers	UniCare's approach to supporting caregivers includes: • Providing training on addressing trauma, BH conditions, crisis planning, and the importance of self-care, strength-based and person-centered • Identifying SDOH issues, ongoing care coordination, and linkage to necessary services and supports • Working closely with foster parents and kinship caregiver associations and programs to identify possible partnerships • Providing specific resources for kinship caregivers, including enhanced benefits as applicable and targeted training
Regional Family Resource Networks	The West Virginia Family Resource Networks are organizations that respond to the needs and opportunities of the community. They partner with community members and public and private organizations to develop innovative projects and provide needed supports and resources.

Rosalie continues to work with Ben and support the Department caseworker as placement with his kinship caregivers is pursued. Ben received his needed DME while in the emergency shelter and completed initial visits with PH and BH providers and scheduled follow-up appointments. Rosalie assures his providers have all of Ben's available records, screening and assessment results, and PCP records to complete a well-informed and thorough evaluation. She has convened an Intensive Care Management (ICM) with the clinical team to review recommended services for Ben and alignment with his Care Plan. Rosalie continues to provide complex care coordination; she also arranges for twice monthly contacts with Ben and provides updates to his Care Plan as needed. Rosalie provides support to the Department caseworker and Ben's kinship caregivers as needed to promote placement permanency and assure follow-up appointments are kept.

ATTACHMENT G: TERMS AND CONDITIONS RESPONSE TEMPLATE

1. INSTRUCTIONS

The Vendor should review ***Attachment G: Terms and Conditions Response Template***, signing each provided signature block using blue ink in order to note the Vendor's acknowledgement and intent of compliance. The Vendor should identify any exceptions to the Terms and Conditions. If exceptions are not noted in ***Attachment G: Terms and Conditions Response Template*** of the RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interests of the State.

2. RFP TERMS AND CONDITIONS

RFP Terms and Conditions consist of provisions throughout this RFP. Moreover, these provisions encapsulate instructions, State and federal procedures, and the State's expectations of the Vendor when submitting a proposal. The Vendor should understand and strictly adhere to the RFP Terms and Conditions. Failure to follow any instructions within this RFP may, at the State's sole discretion, result in the disqualification of the Vendor's proposal.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of these RFP Terms and Conditions.

Todd Haynes — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

3. STATE CUSTOMARY TERMS AND CONDITIONS

The selected Vendor will sign a contract with the State to provide the goods and services described in the Vendor's response. The following documents shall be included in any contract(s) resulting from this RFP:

- ***Section 3: General Terms and Conditions (attached PDF file Section_2_Instructions_To_Vendors_Submitting_Bids_and_Section_3_General_Terms_and_Conditions)***
- ***Section 7: Provisions Required For Federally Funded Procurements***
- ***Appendix 3: Service Provider Agreement (SPA)***
- ***Business Associate Agreement***

Please provide a signature stipulating the Vendor's acknowledgement and complete review of these documents.

Todd Haynes — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

ATTACHMENT G: TERMS AND CONDITIONS RESPONSE TEMPLATE

1. INSTRUCTIONS

The Vendor should review ***Attachment G: Terms and Conditions Response Template***, signing each provided signature block using blue ink in order to note the Vendor's acknowledgement and intent of compliance. The Vendor should identify any exceptions to the Terms and Conditions. If exceptions are not noted in ***Attachment G: Terms and Conditions Response Template*** of the RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interests of the State.

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Todd Haynes _____ 8/13/19
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- ***Business Associate Agreement***

Please provide a signature stipulating the Vendor's acknowledgement and complete review of these documents.

Todd Haynes _____ 8/13/19
Printed Name / Signature of Authorized Personnel — Date

If the Vendor is not taking exceptions to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

Todd Haynes — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

4. MANDATORY REQUIREMENTS AND TERMS

The following items are Mandatory Terms and Documents. Please be advised, the Vendor **should** provide its affirmative acceptance of these items in order to move forward with consideration under this RFP.

- Attachment D: Mandatory Requirements (attached Microsoft Excel file, ***Attachment D – Mandatory Requirements)***
- Attachment B, Section 2: Mandatory Qualifications
- In no event shall the State agree to terms that (a) require indemnification by the State of the Contractor; (b) waive the State's right to a jury trial; (c) establish applicable law anywhere other than the State of West Virginia, or jurisdiction in any venue other than the applicable court (d) designate a governing law other than the laws of the State of West Virginia; (e) constitute an implied or deemed waiver of the immunities, defenses, rights, or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution; (f) limit the time within which an action may be brought; (g) require arbitration, (h) require the ability to defend lawsuit without the approval of the Attorney General's Office; or (i) pay attorney fees.
- Business Associate's Agreement

Vendors that are not able to enter into a contract under these conditions should not submit a bid.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of the Mandatory Requirements and Terms stipulated in this section.

Todd Haynes — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

If the Vendor is not taking exceptions to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

Todd Haynes — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

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- Business Associate's Agreement

Vendors that are not able to enter into a contract under these conditions should not submit a bid.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of the Mandatory Requirements and Terms stipulated in this section.

Todd Haynes — 8/13/19

Printed Name / Signature of Authorized Personnel — Date

5. COMMERCIAL MATERIALS

The Vendor should list any commercial and proprietary materials it will deliver that are easily copied, such as Commercial Software, and in which the State will have less than full ownership ("Commercial Materials"). Generally, these will be from third parties and readily available in the open market. The Vendor need not list patented parts of equipment.

As noted below in Section 6, Exceptions, and pursuant to the guidance provided by the state as part of Addendums 5 and 6, Vendor Questions and Responses Questions 076-078, Section 5, Commercial Materials, is not applicable to Vendor proposals for this bid.

Notwithstanding, UniCare understands, and will comply with, the obligations outlined in the draft contract, Service Provider Agreement, Section 6.15 MCO Operations Transition, in the event this Contract is terminated or expires, pertaining to data and information transfer, including those requirements related to software transfer, to the Department or a subsequent contractor.

6. EXCEPTIONS

The Vendor should indicate exceptions to the State's Terms and Conditions in this RFP. Any exceptions should include an explanation for the Vendor's inability to comply with such term or condition and, if applicable, alternative language the Vendor would find acceptable. Rejection of the State's Terms and Conditions, in part or in whole, or without any explanation, may be cause for the State's rejection of a Vendor's Proposal. If an exception concerning the Terms and Conditions is not noted in this response template, but raised during contract negotiations, the State reserves the right to cancel the negotiation, at its sole discretion, if it deems that to be in the best interests of the State.

The terms and conditions of a Vendor's software license, maintenance support agreement, and service level agreement, if applicable, will be required for purposes of contract negotiations for this project. Failure to provide the applicable Vendor terms, if any, as part of the RFP response may result in rejection of the Vendor's Proposal.

Instructions: Identify and explain any exceptions to the State's terms and conditions using the tables provided below, adding tables, as needed. If no changes are listed, the Vendor is indicating that no changes to the Terms and Conditions are proposed, and that the Vendor intends to accept them as written if the Vendor's Proposal is selected. Mandatory Requirements and Terms noted in this RFP are non-negotiable.

- The Vendor may add additional tables, as appropriate.
- Do not submit Vendor's Standard Terms and Contracting Provisions in lieu of stipulating exceptions below.
- Making revisions to State statutes and regulations is prohibited.
- The State has no obligation to accept any exception(s).

6.1 Exception #1 – Attachment G, Section 5, Commercial Materials

Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken)	Vendor's Explanation (Required for Any Rejection/Exception)	Vendor's Proposed Alternative Language (If Applicable) Cross-Reference to specific section of Vendor's Terms, If Any Provided As Part of the RFP Response
Attachment G, Section 5, Commercial Materials	As noted above in Section 5, Commercial Materials, and pursuant to the guidance provided by the state as part of Addendums 5 and 6, Vendor Questions and Responses Questions 076-078, Section 5, Commercial Materials, is not applicable to Vendor proposals for this bid. Notwithstanding, UniCare understands, and will comply with, the obligations outlined in the draft contract, Service Provider Agreement, Section 6.15 MCO Operations Transition, in the event this Contract is terminated or expires, pertaining to data and information transfer, including those requirements related to software transfer, to the Department or a subsequent contractor.	
NOTES/COMMENTS: <FOR STATE USE ONLY>		

6.2 Exception #2 – Attachment G, Section 6, Exceptions

Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken)	Vendor's Explanation (Required for Any Rejection/Exception)	Vendor's Proposed Alternative Language (If Applicable) Cross-Reference to specific section of Vendor's Terms, If Any Provided As Part of the RFP Response
Attachment G, Section 6, Exceptions, Introductory Language	Pursuant to the guidance provided by the state as part of Addendums 5 and 6, Vendor Questions and Responses Questions 079-081, the introductory language to Section 6, as noted specifically within those questions, "[t]he terms and conditions of a Vendor's software license, maintenance support agreement, and service level agreement, if applicable…Failure to provide the applicable Vendor terms, if any, as part of the RFP response may result in rejection of the Vendor's Proposal." is not applicable to Vendor proposals for this bid. Notwithstanding, UniCare understands, and will comply with, the obligations outlined in the draft contract, Service Provider Agreement, Section 6.15 MCO Operations Transition, in the event this Contract is terminated or expires, pertaining to data and information transfer, including those requirements related to software transfer, to the Department or a subsequent contractor.	
NOTES/COMMENTS: <FOR STATE USE ONLY>		

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

, President
(Name, Title)
Tadd Haynes, President, UniCare Health Plan of West Virginia, Inc.
(Printed Name and Title)
200 Association Drive, Suite 200, Charleston, WV 25311
(Address)
Phone Number: (888) 611-9558 / Fax Number: (877) 833-5729
(Phone Number) / (Fax Number)
Tadd.Haynes@Anthem.com
(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

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

, President
(Authorized Signature) (Representative Name, Title)

Tadd Haynes, President
(Printed Name and Title of Authorized Representative)

7/25/19
(Date)

Phone Number: (888) 611-9558 / Fax Number: (877) 833-5729
(Phone Number) (Fax Number)

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(Printed Name and Title of Authorized Representative)

7/25/19
(Date)

Phone Number: (888) 611-9558 / Fax Number: (877) 833-5729
(Phone Number) (Fax Number)

Revised 06/08/2018

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West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Pursuant to *W. Va. Code* § 6D-1-2, a state agency may not enter into a contract, or a series of related contracts, that has/have an actual or estimated value of $1 million or more until the business entity submits to the contracting state agency a Disclosure of Interested Parties to the applicable contract. In addition, the business entity awarded a contract is obligated to submit a supplemental Disclosure of Interested Parties reflecting any new or differing interested parties to the contract within 30 days following the completion or termination of the applicable contract.

For purposes of complying with these requirements, the following definitions apply:

"Business entity" means any entity recognized by law through which business is conducted, including a sole proprietorship, partnership or corporation, but does not include publicly traded companies listed on a national or international stock exchange.

"Interested party" or *"Interested parties"* means:

(1) A business entity performing work or service pursuant to, or in furtherance of, the applicable contract, including specifically sub-contractors;
(2) the person(s) who have an ownership interest equal to or greater than 25% in the business entity performing work or service pursuant to, or in furtherance of, the applicable contract. (This subdivision does not apply to a publicly traded company); and
(3) the person or business entity, if any, that served as a compensated broker or intermediary to actively facilitate the applicable contract or negotiated the terms of the applicable contract with the state agency. (This subdivision does not apply to persons or business entities performing legal services related to the negotiation or drafting of the applicable contract.)

"State agency" means a board, commission, office, department or other agency in the executive, judicial or legislative branch of state government, including publicly funded institutions of higher education: Provided, that for purposes of W. Va. Code § 6D-1-2, the West Virginia Investment Management Board shall not be deemed a state agency nor subject to the requirements of that provision.

The contracting business entity must complete this form and submit it to the contracting state agency prior to contract award and to complete another form within 30 days of contract completion or termination.

This form was created by the State of West Virginia Ethics Commission, 210 Brooks Street, Suite 300, Charleston, WV 25301-1804. Telephone: (304)558-0664; fax: (304)558-2169; e-mail: ethics@wv.gov; website: www.ethics.wv.gov.

Revised June 8, 2018

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

Name of Contracting Business Entity: UniCare Health Plan of West Virginia, Inc. **Address:** 200 Association Drive, Suite 200 Charleston, WV 25311

Name of Authorized Agent: Tadd Haynes **Address:** 200 Association Drive, Suite 200 Charleston, WV 25311

Contract Number: CRFP 0511 BMS1900000001 **Contract Description:** Specialized Managed Care for Children and Youth

Governmental agency awarding contract: Department of Health and Human Resources

☐ **Check here if this is a Supplemental Disclosure**

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below *(attach additional pages if necessary)*:

1. **Subcontractors or other entities performing work or service under the Contract**
   ☐ Check here if none, otherwise list entity/individual names below.
   See attached

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**
   ☐ Check here if none, otherwise list entity/individual names below.
   UniCare Health Plan of West Virginia is a wholly owned ultimate subsidiary of Anthem, Inc.

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**
   ☒ Check here if none, otherwise list entity/individual names below.

Signature: _____ Date Signed: 8/6/18

Notary Verification

State of West Virginia, County of Kanawha

I, Yegbeh Kouroma, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 6th day of August, 2018.

Yegbeh Kouroma
Notary Public's Signature

To be completed by State Agency:
Date Received by State Agency: _____
Date submitted to Ethics Commission: _____
Governmental agency submitting Disclosure: _____

OFFICIAL SEAL
Notary Public, State Of West Virginia
YEGBEH KOUROMA
307 Eastwood
Charleston, WV 25302
My Commission Expires April 05, 2024

Commissioned June 8, 2018

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

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   ☒ Check here if none, otherwise list entity/individual names below.

Signature: _____ Date Signed: 8/6/19

Notary Verification

State of West Virginia, County of Kanawha

I, Yegbeh Kouroma, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 6th day of August, 2019.

Yegbeh Kouroma
Notary Public's Signature

To be completed by State Agency:
Date Received by State Agency: _____
Date submitted to Ethics Commission: _____
Governmental agency submitting Disclosure: _____

OFFICIAL SEAL
Notary Public, State Of West Virginia
YEGBEH KOUROMA
307 Eagle Rock
Charleston, WV 25302
My Commission Expires April 05, 2024

Revised June 8, 2018

#	Subcontractor Name	Type of Service
1	Anthem, Inc.	Administrative support services
2	Advanced Medical Reviewers, LLC	Utilization management, clinical chart reviews
3	Exela Technologies, Inc.	Front end claims processing
4	SKYGEN USA, LLC	Dental benefits manager
5	Symphony Performance Health, Inc. d/b/a SPH Analytics	Survey administration services
6	Vision Service Plan Insurance Company	Vision benefits manager
7	Wipro Limited	Claims adjudication, claims processing

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STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

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

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

DEFINITIONS:

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

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

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or 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: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

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

Authorized Signature: _____ Date: 08/06/2019

State of West Virginia

County of Kanawha, to-wit:

Taken, subscribed, and sworn to before me this 6th day of August, 2019.

My Commission expires April 5th, 2024.

AFFIX SEAL HERE

OFFICIAL SEAL
Notary Public, State Of West Virginia
YEGBEH KOUROMA
307 Lee St. W.
Charleston, WV 25302
My Commission Expires April 05, 2024

NOTARY PUBLIC _____

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

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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: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

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

Authorized Signature: _____ Date: 08/06/2019

State of West Virginia

County of Kanawha, to-wit:

Taken, subscribed, and sworn to before me this 6th day of August, 2019.

My Commission expires April 5th, 2024.

AFFIX SEAL HERE

OFFICIAL SEAL
Notary Public, State Of West Virginia
YEGBEH KOUROMA
307 Lee St. W
Charleston, WV 25302
My Commission Expires April 05, 2024

NOTARY PUBLIC _____

Purchasing Affidavit (Revised 01/19/2018)

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A Better Life for Transition Age Youth Through Stepping Stones

UniCare extensively collaborates with Stepping Stones to support and expand their transition age youth (TAY) programs. Stepping Stones works to provide TAY needed skills and supports as they age out of foster care, while providing needed life skills, training, and well-being supports. The program is born from the increased influx of youth engaged in the foster care system as a direct result of the opioid epidemic. In the past 18 months, we have provided Stepping Stones with over $100,000 for bridge funding for a Transition Coach and for building a greenhouse as part of Stepping Stones' Tiny House Village. Our staff are integrally involved in the Tiny House Village project and we have a seat on the planning committee. Further, we are increasing our support by expanding PH and BH access for youth in residential treatment by looking to establish telemedicine presentation sites at a Stepping Stones location in rural Wayne County. We understand that internet connection is a current barrier to providing access to telemedicine at Stepping Stones, we are exploring the opportunity to locate a mobile router at this site. This will not only allow for telemedicine but will allow youth to access on-line job searches and applications.

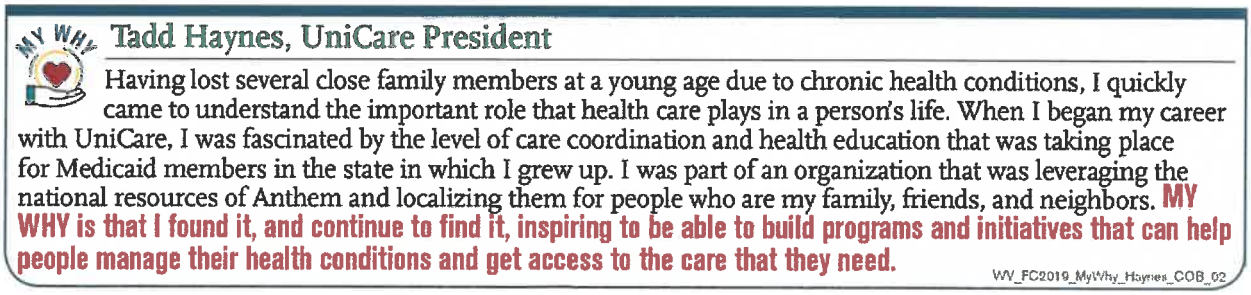
THINK Program Focused on Children and Youth

UniCare provided funding to Mission WV, Inc. (MWV) to implement and support its Teaching Health Instead of Nagging Kids (THINK) program. THINK helps children and youth make better decisions regarding education, substance abuse, sexual activity, and relationships. ***Our funding allowed MWV to add THINK to Putnam County and to continue it in four middle schools in Cabell County, reaching over 400 children.***

Dedicated Partner to Our Members, Providers, and DHHR

Our passion to serve West Virginians, paired with our experience and our knowledge of West Virginia Medicaid goals and challenges, proudly positions us to support DHHR in fulfilling its responsibilities to provide services for children and youth in the foster care system and adoption assistance across the state. We understand serving members, their families, and caregivers requires experience and compassion because every member and family has a unique story. We are best positioned to provide optimal and innovative care, enhance the quality of care, provide services that consider the entire family and caregivers to improve health and social outcomes and improve the services provided, increase appropriate treatment delivered, and reduce the number of children being removed from their homes.

Many of us at UniCare have a personal story that drives the passion we have for working with our members every day. We call this *My Why*, and we want to share with you — first-hand — why our employees come to work every day, why they care so much, and why it matters to West Virginia Medicaid.



It takes an entire community to provide the services needed to support youth displaced from their families of origin. Over the past 16 years serving Medicaid populations in West Virginia, UniCare has shown our commitment to DHHR, community-based organizations, and most importantly, our members and providers.

We are an organization that truly cares for our membership and will drive change and innovation in order to provide the highest-quality programs and services in West Virginia. We learn through experience and collaboration and are humbled by the opportunity to show DHHR we truly are ***stronger together***.

Our technical and cost proposals were prepared simply and economically; DHHR templates were used for our in-line response to the RFP. Should you have any questions regarding our proposal or capability or wish us to provide an electronic copy of the response at any time, please contact me by telephone at (304) 347-2474 or email at Tadd.Haynes@anthem.com.

Sincerely,



Tadd Haynes

We are an organization that truly cares for our membership and will drive change and innovation in order to provide the highest-quality programs and services in West Virginia. We learn through experience and collaboration and are humbled by the opportunity to show DHHR we truly are ***stronger together***.

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Sincerely,



Tadd Haynes

UniCare. An Anthem Company

Comprehensive Care Plan

Member Name:	Jay Doe	**Date of Birth:**	6/10/2003	**Member/Representative sent/given copy of Care Plan**	☑
Medicaid ID#	11111111			**PCP/Specialist Participation in Care Plan Requested**	☑
Brief Member History	Jay is a 16 year old male who was removed from his home and placed in foster care 3 weeks ago due to parental substance use disorder. Jay has uncontrolled Type 2 Diabetes, and was recently suspended from school for physical aggression. He is struggling with meeting educational goals.			**Copy of CP sent to Physician, Date(s):** Aug 13, 2019	☑
				Facility Name: N/A	
Diagnosis/Health Conditions:	Aggression and Type II Diabetes	**Date of Enrollment**	7/23/2019	**Copy of CP sent/given to Facility Staff, Date(s):**	

My current living arrangement is: ☑ Foster Home ☐ Kinship Home ☐ Independent Living ☐ With Family of Origin ☐ Group Home ☐ Unstable housing/homeless ☐ Other

Permanency Goal is to: ☐ Remain in my current setting ☐ Adoption ☐ Kinship Placement ☑ Reunification ☐ Independent Living

Care Coordination Level: ☐ Connected ☑ Intermediate ☐ Complex

Effective Date	Member agreement w/services	Interventions (from all funding sources formal & informal)	Measurement of Intervention	Barriers to Progress	Amount/Frequency/ Units	Service Provider	Begin Date	End Date
#1 Area of focus: Physical Aggression								
Goal #1: I will manage my anger and avoid physical violence.				**Goal Type:** DHHR Initiated		**Caregiver or Provider Input:** Yes		
8/6/2019	☑ Agree ☐ Disagree	Jay will engage in weekly therapy with Best Counseling who specializes in evidence based practices such as CBT to address changes in behavior	Care Coordinator will follow up with Jay and Provider to ensure attendance and participation	None. Jay has foster parent willing to transport to weekly appointments.	Weekly	Best Counseling	8/6/2019	8/5/2020
8/6/2019	☑ Agree ☐ Disagree	Jay will increase understanding and recognition of situations that trigger escalation and feelings of aggression	Jay will identify and report to counselor 3 triggers that cause him to escalate	None. Jay is engaged and willing to address changes in behavior.	Weekly	Best Counseling	8/6/2019	8/5/2020
8/6/2019	☑ Agree ☐ Disagree	Jay will access Online Well-being program for tools to manage feelings and behaviors, and learn three appropriate ways to cope with frustration.	1. Jay will share with Care Coordinator and Foster Parent a resource or tool he used from the Online Well being program. 2. Foster Parent will verify Jay's use of tool 3. Jay will be able to report three coping mechanics and share about instances when he used these skills.	None. Member is engaged and willing to address changes in behavior.	As Needed	N/A	8/6/2019	8/5/2020
#2 Area of focus: Type II Diabetes, Uncontrolled								
Goal #2: I will increase knowledge of how to care for my diabetes and will show how I can manage the Diabetes.				**Goal Type:** Care Team including Member		**Caregiver or Provider Input:** Yes		
8/6/2019	☑ Agree ☐ Disagree	Jay will meet face-to-face with care coordinator and providers to learn about diabetes and how to successfully manage his life with diabetes	1. Jay will share with Care Coordinator and foster parent 3 ways he can better manage his diabetes following meeting. 2. Jay will attend his appointment with Dr. Jones, Endocrinologist, scheduled for 8/15/2019 and will follow all recommendation 3. Jay will share his plan for nutrition with Care Coordinator and Foster Parent 4. At Dr. Jones' request, Jay will commit to testing blood sugars daily and document his numbers	Jay lacks education about the benefit of proper nutrition and increased exercise and the positive impact it has in controlling his diabetes and improving his overall health .	As Needed	Dr. Jones, Endocrinologist	8/6/2019	8/5/2020
#3 Area of focus: Educational Needs								
Goal #3: I will increase my grades by one full letter so I can continue to stay on my projected track for high school graduation.				**Goal Type: DHHR Caseworker**		**Caregiver or Provider Input: Yes**		
8/6/2019	☑ Agree ☐ Disagree	Socially Necessary Services Tutoring	Jay will show measurable improvement in his school work via review of progress reports and report cards.	Jay reports loving school in the past, but being distracted by the multiple recent changes including his new diagnosis of diabetes, and being removed from his home.	17 units (hours)	A - Z Learning	8/6/2019	11/6/2019
8/6/2019	☑ Agree ☐ Disagree	Additional support from In-Home tutoring Value-Added Service	1. Once Jay has completed his 17 hours of tutoring through the SNS provider, reevaluate Jay's progress through verification of current grades via progress reports and report cards. If the SNS service continues to be needed, reauthorization of units will be considered to allow the maximum of 34 hours per year. 2. If additional support is needed for educational needs, Care Coordinator will refer Jay for In-Home tutoring. 3. Care Coordinator to review progress reports from In-Home tutor, Foster Parents and Jay, to ensure grades and comprehension of materials taught are increasing 4. If Jay continues to experience educational needs, Care Coordinator to contact DHHR worker to discuss establishing an Individual Education Plan (IEP)	Jay reports loving school in the past, but being distracted by the multiple recent changes including his new diagnosis of diabetes, and being removed from his home.	Up to 24 hours	A - Z Learning	8/6/2019	8/5/2020
8/6/2019	☑ Agree ☐ Disagree	Jay will receive information about Jump Start (the online education and job training platform) where he will advance his skills in financial literacy.	Jay will provide Care Coordinator with information he learned using the online learning platform and he will share his certificates upon course completion	None	As Needed	N/A	8/6/2019	8/5/2020
#4 Area of focus: Independence/Transportation								
Goal #4: I want to feel independent and own my own car.				**Goal Type: Member Initiated**		**Caregiver or Provider Input: Yes**		
8/6/2019	☑ Agree ☐ Disagree	Jay will learn about all options for transportation and what is required to own a car.	1. Jay will participate in a face to face meeting with his care coordinator to discuss his desire for independence and car ownership and jointly create a plan to explore all options 2. Jay will research and report to care coordinator cost of reliable used cars 3. Jay and ICM team o discuss requirements for parental/caregiver permissions that may be required for car purchase or insurance policy 4. Jay will research and obtain three quotes for car insurance. 5. Jay will research and share his findings about the cost and location of driver's education classes.	Jay needs education on the legalities of car ownership and insurance and the need to obtain parental or caregiver consent for someone less than 18 years old. Car ownership may be a longer term goal but there are many ways Jay can achieve milestones towards independence.	N/A	N/A	8/6/2019	8/5/2019
8/6/2019	☑ Agree ☐ Disagree	To further independence, Jay will learn about the Independent Living Program and other applicable community resources that will help him plan to be independent regardless of his current case plan of reunification.	1. Jay will work with his DHHR worker to create a Learning/Transition Plan 2. Jay will work with his DHHR worker and obtain support from his care coordinator to complete the Ansell Casey Life Skills assessment tool to identify which domains Jay will need to focus on while progressing towards adulthood. 3. Care Coordinator will refer Jay to the It's My Move webpage (itsmymove.org) where he can download and complete the Readily-At-Hand online application which provides him with a list of documents and experiences he will need to successfully transition to adulthood. 4. Jay's care coordinator will be supported by the dedicated Fostering Independence Coordinator to give referrals for educational and employment needs as appropriate. 5. Jay will be referred to MODIFY to learn what tuition and educational assistance he may be eligible for if he remains in foster care until or beyond his 18th birthday.	None	As Needed	MODIFY	8/6/2019	8/5/2020

Care Plan Review Dates:	Type of Review	Care Manager Name:	Care Manager Signature	Care Plan Review Dates:	Type of Review	Care Manager Name:	Care Manager Signature

I have received and read the Plan of Care. I understand that I have the right to file an appeal or fair hearing if my services have been denied, reduced, terminated or suspended.

Date	Member/Authorized Representatives Signature	Date	Member/Authorized Representatives Signature	Date	Member/Authorized Representatives Signature

Type of Review Key: Initial= Initial Care Plan AN=Annual QT=Quarterly MO = Monthly CHG =Significant Change

Figure C.1-1. UniCare's West Virginia Program Organizational Chart

