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WV PURCHASING
DIVISION



West Virginia
Department of Health and Human Resources

SPECIALIZED MANAGED CARE FOR CHILDREN AND YOUTH

CRFP 0511 BMS 1900000001
Technical Proposal





TITLE PAGE

RFP Subject: Specialized Managed Care for Children and Youth

Number: CRFP 0511 BMS 1900000001

Vendor's Name: The Health Plan

Business Address: 1110 Main Street, Wheeling, WV 26003-2704

Telephone Number: 1.800.624.6961

Fax Number: 740.695.7581

Name of Contact Person: Christy Donohue

Email Address: cdonohue@healthplan.org

Vendor Signature:

Date: August 16, 2019



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.

Christy Donohue
Medicaid Assistant Vice President
141 Summers Street
Charleston, WV 25301
304.720.4923
cdonohue@healthplan.org

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

The Health Plan of West Virginia

(Company)

James M. Pennington

(Authorized Signature) (Representative Name, Title)

James M. Pennington, President and CEO

(Printed Name and Title of Authorized Representative)

8/8/19

(Date)

800.624.6961

740.695.7581

(Phone Number) (Fax Number)



TRANSMITTAL LETTER

August 16, 2019

April Battle
Purchasing Division
2019 Washington Street East
Charleston, WV 25305

Dear Ms. Battle,

Request Number: RFP CRFP 0511 1900000001

The Health Plan of WV (THP) respectfully submits the attached Request for Proposal related to the Specialized Managed Care for Children and Youth. We believe we have provided a document which outlines our approach to this vulnerable population.

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

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

Sincerely,

James M. Pennington
President and CEO



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.

The Health Plan

(Company)

James M. Pennington, President and CEO

(Representative Name, Title)

(tel) 1.800.624.6961 (fax) 740.695.7581

(Contact Phone/Fax Number)

August 16, 2019

(Date)

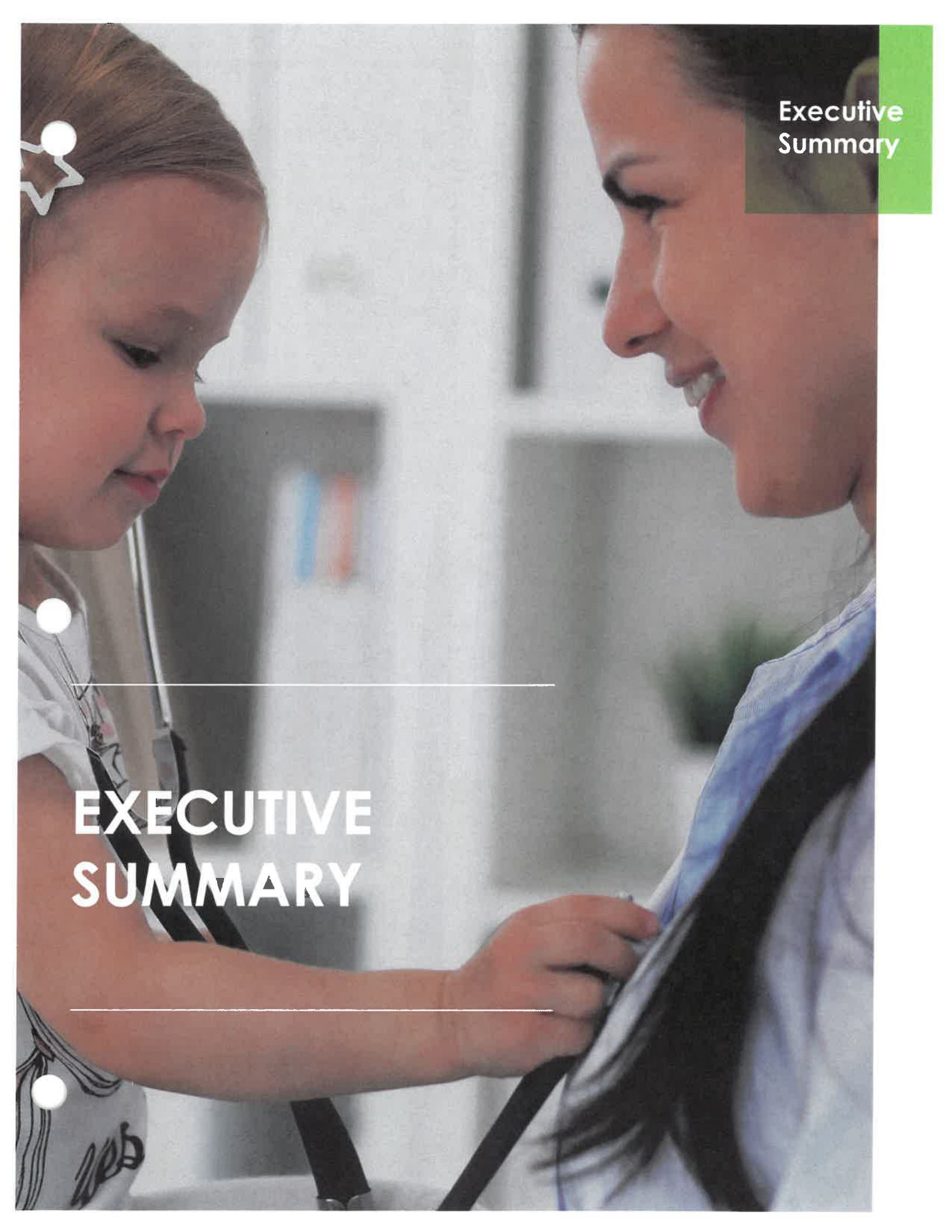
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2. Position Descriptions
3. Relevant THP policies and documents
4. Subcontractor agreement and letters of intent
5. Glossary of Terms
6. Network Analysis

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A close-up photograph of a woman with dark hair, wearing a light blue shirt, smiling warmly at a young child. The child, with light brown hair and a white star-shaped hair clip, is looking down at something the woman is holding. The background is a blurred classroom environment with shelves and books. A green vertical bar is on the right side of the image.

Executive
Summary

EXECUTIVE SUMMARY

Executive Summary

The Health Plan of West Virginia, Inc. (THP) is pleased to respond to The Request for Proposal for Specialized Managed Care for Children and Youth. For over 40 years, THP has been a strong partner throughout the state offering our HMO and PPO Benefit plans to various employers, individual members, Medicaid eligible members, Medicare eligible members, PEIA and other public and private entities.

As The Health Plan has grown, so has our commitment to West Virginia and its residents. Chartered as a not-for-profit 501(c)(4) West Virginia corporation, we have a strong commitment to effective and efficient use of the healthcare resources in our communities. THP, as a community health organization, provides service that is vibrant, personal and energetic. THP delivers a clinically-driven, technology-enhanced, customer-focused platform by developing and implementing products and services that manage and improve the health and well-being of our members. We achieve these results through a team of healthcare professionals and partners across our community.

Our tenure in the marketplace brings significant experience and leadership to meet the needs of the various components of the Foster Care population. Our corporate headquarters is located in Wheeling along with two additional locations in Charleston and Morgantown West Virginia. We are extremely well positioned to expand our capabilities and staff within West Virginia to better manage the care and needs of the West Virginia Foster Care populations and their caregivers/families. As a local organization and the only West Virginia based managed care organization (MCO), The Health Plan is committed to staffing on a local basis. The Health Plan believes that the Foster Care program is best staffed by individuals from our local communities who know and understand the local culture and medical delivery systems.

THP offers significant unique factors which position us to be the best option for our West Virginia Foster Care members:

- As a not-for-profit entity, we ensure that a greater percentage of the premium dollars go directly to patient care and not to shareholders.
- As a local West Virginia company, we not only employ staff from throughout West Virginia, but we retain services from throughout the state such as printing, mail and postal services, marketing services and financial services.
- We have several years of experience as a managed care organization in West Virginia dating to 1979 when THP was founded as a West Virginia Corporation. Beginning as a regional plan our footprint has grown at a steady rate and has successfully grown to a statewide entity within West Virginia.
- As a community partner, we are actively involved in the communities and supportive of initiatives to improve the health and well-being of the residents of WV. We sponsor two

important youth camps in the state that focus on asthma and diabetes and we participate in many different community health fairs and 5K run/walks throughout the State.

- We are invested in the future of the State.
 - Currently, THP provides over \$2 million dollars in scholarships for medical students in the state of West Virginia. These scholarships require a commitment on the part of the students to serve West Virginia after graduation.
 - We have built our NEW corporate headquarters in downtown Wheeling, WV, which allows over 500 people to be employed in West Virginia.
 - We have office locations in both Morgantown, WV and Charleston, WV which will continue to grow in size.
- The Health Plan was originally founded by community providers in West Virginia and we continue to have strong relationships with our WV provider communities. Currently, we partner regularly with various providers in WV, not only as providers, but also as community partners.

Having served the State of West Virginia for many years, the experience of our staff and executive leadership is unrivaled in our industry. Our Executive Management Team has over 200 years of combined experience in not just the healthcare field, but specifically, healthcare in West Virginia.

As you are aware, foster care children represent less than one percent of Medicaid beneficiaries. But, these children command, and deserve, much more than what the math suggests. They are often the victims of neglect and abuse. The Health Plan believes their future can be beneficially impacted through coordinated care.

It is important to understand the population to be served in order to make positive changes. The Health Plan's Model of Care for Foster Children Services rests upon goals for providing access to coordinated care through integrated service components designed to provide improved health outcomes. Our approach will involve care navigators, DHHR caseworkers, clinicians and community resources, all collaborating to provide a transparent network of supportive care for the children. This can be achieved through Interdisciplinary Care Teams (ICT) who are accountable to make support for foster children seamless and effective. Needs can be anticipated and then addressed through individualized care plans.

The Health Plan believes we are in a unique position to provide high-quality cost-effective services for this population members by providing access to a coordinated delivery system designed to provide improved health outcomes. In this RFP, we have proposed an integrated approach which incorporates:

- Enhanced coordination of care and access to services
- Improved communication and training with various stakeholders
- Reduced fragmentation of care
- Delivery of needed support and services at the right place, right time and right cost
- Increased focus on health and social outcomes for this population

- Development and utilization of electronic health records and electronic systems
- Reductions in the number of children removed from the home
- Inclusion of a comprehensive quality approach
- Management of socially necessary services

THP, as West Virginia's only FULLY LOCAL managed care organization, believes we are uniquely positioned to provide the best solution for the foster care population which will capitalize on the care and services available through our in-state system of providers and support services.

Through a collaborative effort with WVU Medicine and KVC of WV as primary partners, THP will leverage the expertise of the largest integrated delivery system in WV and the largest private foster entity in WV. The vast knowledge and experience base provided through the joint efforts of our three organizations, will enable us to establish an integrated holistic approach focused on ensuring that the children in our state receive the care and service they need in a prompt and efficient coordinated manner with improved healthcare outcomes as the ultimate goal.

We believe that moving the responsibility for oversight of medical care needs to managed care is a measure that will save costs, but even more important, will ensure that the children in our state receive the care and service they need in a prompt, efficient and coordinated manner with improved healthcare outcomes as the ultimate goal. The Health Plan believes that through a system of care designed to integrate the medical, behavioral, and pharmaceutical services with attention to the social and educational support mechanisms within our state, the overall health and well-being of our children can be significantly improved.

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A

INTRODUCTION TO THE HEALTH PLAN TEAM

A. Introduction to The Health Plan Team

The attached response is submitted on behalf of The Health Plan of West Virginia (THP) and its key strategic partners for this contract, which include WVU Medicine and KVC West Virginia as primary collaborating partners. Letters of Intent from all of THPs collaborating partners for delivery of Specialized Managed Care for Children and Youth are included in Appendix 3.

The Health Plan

The Health Plan (THP) provides services to a number of different product lines including commercial insured products, self-funded products, Medicare, and Medicaid. The record of service and experience branches out over 40 years. THP is:



- A 501c-4 not-for-profit corporation;
- Medicaid MCO since 1996, managing over 94,000 beneficiaries;
- Medicare MCO since 1982, managing over 24,000 beneficiaries;
- Over 25 years of operating as a licensed third-party administrator; and
- Established and financially secure with over \$165 million in reserves.

THP provides services to over 225,000 covered lives

Commercial

- HMO
- PPO
- POS
- PEIA (MO, PPO)

Self-Funded

- HMO, PPO and POS benefit design platform

Medicaid

- Medicaid Expansion
- TANF
- SSI

Medicare

- Medicare Advantage (HMO, PPO)
- Medicare Supplement
- Dual-Eligible Special Needs (D-SNP)

With 538 total employees, THP is governed by a Board of Directors and overseen on a daily basis by the President and Chief Executive Officer of the organization. Our CEO along with an Executive Management Team (EMT) comprised of nine (9) Senior Vice Presidents bring a wealth of experience and knowledge to the organization. The CEO and EMT are actively involved in the daily oversight and management of the functional areas within the organization which include:

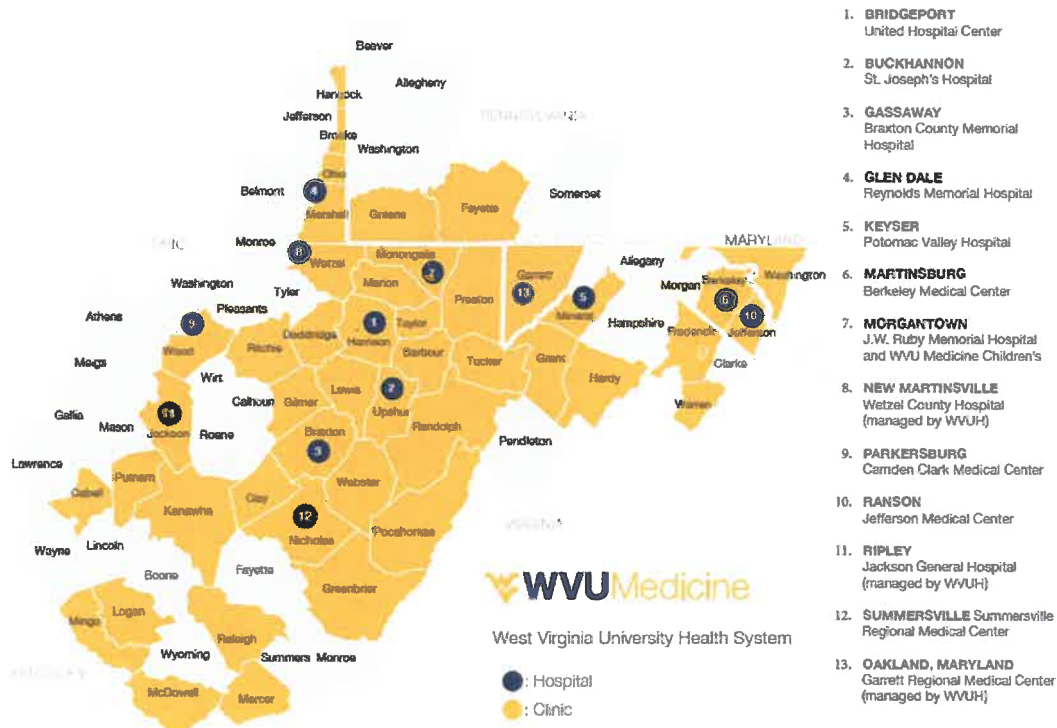
- **Government Programs** represents Medicare and Medicaid programs including product development and implementation, contract management, and general operational responsibilities for all government related business.
- **Clinical Services** is divided into four (4) distinct areas each with a specific clinical focus aimed at appropriate navigation of members through the healthcare systems ensuring **each member receives the right care, at the right place, at the right time and the right cost.** The four areas include:



- **Medical Management** including utilization management, catastrophic case management, disease management, concurrent review, authorizations and preauthorization. Staff in this area include registered nurses, social workers and physicians all with varied clinical backgrounds and expertise.
- **Behavioral Health Services** including utilization management, case management, disease management, authorizations and preauthorization, claims processing, and concurrent review. Staff in this area included registered nurses with behavioral health expertise, social workers and physicians including a psychiatrist.
- **Pharmacy Services** including formulary development and management, preauthorization, drug utilization review and specialty pharmacy management.
- **Clinical Analysis and Research** including clinical reporting, technology research and assessment, predictive modeling, provider profiling, gaps in care analysis and outcomes tracking.
- **Finance** handles all financial functions of the organization including account receivable, accounts payable, fund recovery, billing reconciliation, payroll, financial analysis, actuarial analysis and business intelligence.
- **Administrative Services** includes customer services, claims processing and payment, outreach, enrollment and general operational functions.
- **Payment Integrity and Population Health Management** handles business intelligence reporting functions, quality accreditation, population health, and special investigations unit and compliance functions.
- **Information Systems** handles all information system functions including system development, programming, EDI, telecommunications, network support and Web Design.
- **Provider Delivery Services** handles provider contracting, network support services, provider credentialing, provider payment and pricing, provider education, provider list development and maintenance, development and implementation of alternative payment models and other support services needed to ensure access to network providers.
- **Corporate Services** is comprised of human resources, marketing and general corporate services.
- **Sales and Account Management** handles insured product sales to commercial populations including HMO, PPO, and POS services to fully funded and self-funded clients. Other products handled in this area include health reimbursement accounts (HRAs), Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), VEBA administration, COBRA administration, Stop Loss Coverage and other TPA benefit services.

West Virginia University Medicine

West Virginia University Health System (WVUHS) operates under the brand of WVU Medicine (WVUM), as the largest Integrated healthcare delivery system in the state of West Virginia, will provide THP with significant clinical expertise and access to existing services. Furthermore, They will aid in the development of needed services across the state of West Virginia.



WVUM is comprised of ten (10) hospitals – its flagship academic medical center, West Virginia University Hospitals, including a behavioral and mental health services center known as Chestnut Ridge in Morgantown; Berkeley Medical Center in Martinsburg; Braxton County Memorial Hospital in Gassaway; Camden Clark Medical Center in Parkersburg; Jefferson Medical Center in Ranson; Potomac Valley Hospital in Keyser; Reynolds Memorial Hospital in Glen Dale; St. Joseph's Hospital in Buckhannon; Summersville Regional Medical Center in Summersville; and United Hospital Center in Bridgeport. WVUM also provides management services to Wetzel County Hospital in New Martinsville; Jackson General Hospital in Ripley; Wheeling Hospital in Wheeling; Garrett Regional Medical Center in Oakland, Maryland; and Barnesville Hospital in Barnesville, Ohio. WVUM also includes five institutes – the WVU Cancer Institute, the WVU Critical Care and Trauma Institute, the WVU Eye Institute, the WVU Heart and Vascular Institute, and the WVU Rockefeller Neuroscience Institute.

WVUM broke ground on a new tower to house the pediatric and women's services of WVUM Children's in 2018. The 150-bed, nine-story facility is scheduled to be completed in 2021. WVUM

Children's continues to focus on improving the health of our youngest and most vulnerable population and has opened a Neurodevelopmental Center (NDC) to evaluate and treat children with a wide variety of neurodevelopmental disabilities, including Autism Spectrum Disorder, developmental delay, cerebral palsy, neuromuscular disorders, and Tourette syndrome.

WVUM has over two thousand two hundred (2,200) billing professional providers offering services in thirty-six (36) of West Virginia's fifty-five (55) counties and continues to expand. They build new partnerships with providers across the state to bring high quality care to the people of West Virginia and the surrounding region so that patients do not have to travel great distances or even out of state to receive needed care.

Our partnership with West Virginia University Medicine will provide a unique opportunity for provider/payer collaboration which will enhance and improve the care and services provided to the foster care populations. Some of the key areas of innovation and collaboration for this population include:

- **TELEMEDICINE**—as the leading provider of telemedicine services in the state, WVUM already has several telemedicine projects that will benefit the foster care population. Such programs include:
 - telepsychiatry program providing psychiatric and psychological consultation and crisis assistance.
 - real-time urgent care
 - remote patient monitoring
 - specialist evaluations
 - medication reconciliation
 - Project ECHO resources to provide specialty support for rural communities.
 - Further, WVUM is committed to development of telemedicine capabilities to meet the needs of the foster care population
- **PREDICTIVE MODELING**— In order for WVUM to redesign care WVUM has transitioned to one electronic medication record, EPIC, across the system that has one patient ID, one record and is one unified system of care. Having a unified system allows WVUM to seamlessly coordinate care regardless of clinic or hospital location. In conjunction with the clinical chart data in EPIC, WVUM has the capability to enhance predictive analytics by incorporating external claims data into the EPIC platform. THP and WVUM will collaborate to integrate historical claims and other relevant information to enable WVUM providers to ascertain high risk patients early in the process using predictive analytics. THP is also able to share data from our CAVE system directly with WVUM providers through an electronic interface allowing them a broader "picture" of the child by integrating both the clinical chart data and the plan claims data.
- **SOCIAL SERVICE RESOURCES**—Social determinants of health have a significant impact on the Foster Care population. While THP employs social workers to assist with needed services, Care Managers in the WVUM practices settings have robust resources around the various social services in the various communities. The Care Management program through their healthcare system incorporates a PCMH/Population Health model that evaluates the whole patient and identifies social determinants of health.

- Additionally, WVUM employs social workers who are very knowledgeable on community resources and connects patients to those resources. THP will integrate these resources along with our established resources to capitalize on the broader knowledge base of the delivery system.
- **PCMH CAPABILITIES**—WVUM has significant PCMH resources in many of its practices which are established and integrated into the delivery system. Integration of Population Health information between THP and WVUM PCMH practices will ensure a more coordinated approach to care delivery and will avoid duplication of services across the care continuum.
 - The Foster Care population with significant behavioral health needs, would benefit from a PCMH approach in the comprehensive behavioral health center setting. United Summit Center, a behavioral health center within the WVUM system provides an opportunity for development of a PCMH approach for the foster care population.
 - For those services not delivered through WVUM partner providers, WVUM and THP will work in collaboration with network providers to develop patient care management resources to enable deliver of PCMH care throughout the network. The provider/payer partnership will facilitate the development of a model of care that facilitates effective patient management within the primary care practice as well as in the specialty practice setting when appropriate.
 - WVUM and THP can work jointly with small primary care practices that may have limited resources to deliver a PCMH model of care through varied means and provide support resources.
- **SPECIALTY CARE** - WVUM has significant specialty provider resources available to meet the complex needs of the Foster Care membership. The collaborative partnership will provide for prompt access to needed specialty care in addition to resources for clinical review and evaluation of data to establish best practices.
- **URGENT/EMERGENT RESOURCES**—WVUM will work with THP to establish a statewide network of providers able to provide crisis services to Foster Children when needed.
- **WVU BEHAVIORAL Health** resources are the most comprehensive in the state of West Virginia. The team at WVUM is committed to development of new and needed resources and have vast experience with children including foster care populations.
- **TRAINING RESOURCES**—WVUM will act as a training resource for providers, families, staff, stakeholders with some of the following developed training protocols, not limited to:
 - Trauma Informed Care
 - Mental Health First Aid
 - SANE – Sexual Assault
 - Pressley Ridge Trauma Training
 - Trauma Systems Therapy
 - Life-skills trainings – Vocational services, etc.

KVC West Virginia

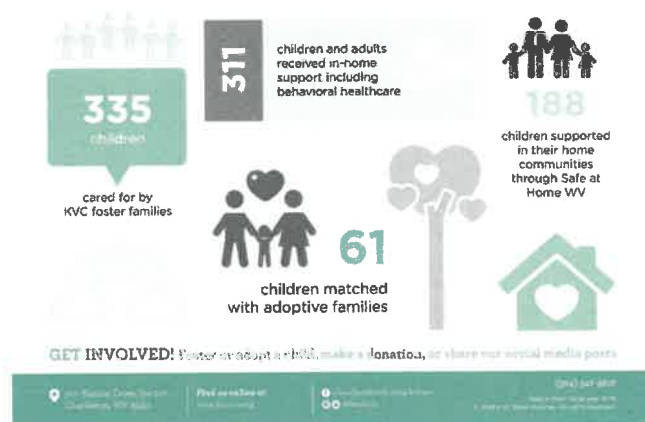
KVC, as the largest private foster Care provider entity in WV, will provide the support that The Health Plan needs to integrate evidence-based guidelines into our management of the foster children in WV. KVC has been an active partner with the state of Kansas since 1996 around privatization of Foster Care Services where they have shown significant improvement in outcomes as a result of the privatization. Some key statistics:

- Foster Children in Group Settings:**
 - In Kansas 30% in 1996 reduced to 5.3% in 2015 with KVC rate at 4%
 - WV current rate is 14.5% based on April 2019 Foster Care Placement Report
- Kansas is now the second safest child welfare system in the country**
 - National Standard 94.6%
 - Kansas 98.5%
 - KVC/Kansas 99.8%
- General Experience of KVC Across Multiple States For Calendar Year 2018:**
 - In Kansas, 12,479 youth and families were served. 9,963 children and families received family preservation services and 1,006 children were reunified with families after participating in foster care.
 - In Nebraska, 817 youth were served in their foster care program and 129 were safely reunified with their families.
 - In Kentucky, over 6,000 children received family preservation services and 97.4% of children served were maintained safely with or were reunified with their families after receiving family preservation or reunification services.
 - In West Virginia, 335 children were served by KVC foster homes and nearly 50% of these youth returned to their families. KVC served 188 families through the Safe at Home program.

KVC West Virginia *people matter*



Over the last year, we helped people in many ways:



THPs partnership with KVC will allow us to utilize their expertise with the following functions:

- Facilitate the involvement of current WV Foster Care providers and community stakeholders in the implementation of THPs Foster Care Program including:
 - Establishment of an advisory committee/group with Foster Care service providers
 - provide guidance and support around community resources relevant to the foster populations
 - act as a liaison with Foster Care provider network and help to establish and implement needed services to improve outcomes
 - Home visits
 - Wrap Around Services

- Identification of resources and capabilities for each county
- Provide resources to assist THP in evaluation of the delivery of Socially Necessary Services
 - evidence based criteria development through collaboration with SNS providers
 - report and monitoring development
- Develop reporting structures for Socially Necessary Services
- Provide a mechanism for to assist with Foster Care crisis intervention services by facilitating 24/7 triage response
 - Model after program in Kansas that facilitated calls and then locates resources
 - Work with Foster organizations to identify organizations serviced by county in WV and facilitate process for after hours
 - Work with THP to identify clinical care after hours resources
- Coordinate with various entities and work on the identification and development of services and providers in West Virginia to service foster children
- Provide educational resources in identified areas of expertise for:
 - Providers
 - Members
 - Staff

As a current provider in West Virginia, KVC is familiar with the foster Care system and the needs of the population. As an integrated partner with THP, we will be able to collaborate to identify obstacles and create innovative solutions. THP will use KVC as an integral resource to bring stakeholders to the table in a meaningful manner. While KVC will continue to act as a provider of socially necessary services and foster care, the strategic partnership with THP shall not impact the delivery of those services nor the ability to obtain those services from the provider of the member's choosing.

The heart of KVC's work is helping people. - That's what drives us. The inherent worth of each person defines our purpose, informs our work and guides our culture. Our purpose is to help children, adults and families in all communities and neighborhoods. Families from any background can face struggles or even find themselves in crisis but hope and help can guide a family back to firm -footing.

Our nationwide team of expert professionals and volunteers are here to help.

KVC offers innovative, effective and compassionate care to every individual we serve:

- Innovative because persistent problems can only be solved using new thinking;
- Effective because outcomes matter greatly in child welfare and behavioral healthcare; and
- Compassionate because true caring is both the destination and the means to get there.

The work KVC does is often in people's homes where they are comfortable to experience transformation and repair relationships. The extent of community need is often unknown because this work is unseen, but the changes are visible to those close to it. KVC help families in crisis find the resources that will keep them safely together. KVC helps people overcome addiction to drugs or alcohol through treatment and strengthening supportive relationships. KVC gives adults the practical parenting skills needed to stop the cycles of violence and trauma and create a healthy, loving family. People are the heart of everything KVC does.

KVC Institute



21+ Million - Over 21 million people indirectly impacted by KVC Institute training or consultation

To make real change in communities, KVC works in small ways and big ways, both at the individual level and at the highest organizational levels. Through the KVC Institute for Health Systems Innovation, KVC works to transform the experience of childhood for all children, developing creative solutions to social problems by providing consulting, creating curriculum and online learning, training professionals, and influencing public policy. KVC ensure KVC are doing our best work through our Safe & Connected™ integrated child welfare practice model, guiding practitioners in the application of research into practice and ultimately maximizing human potential.

- Over 1,000 people received direct training or consultation on best practices
- Agencies in 9 U.S. states and 2 countries received child welfare or health-related consultation
- 2 major research projects underway

Foster Care:

6869 children cared for by relative caregivers or foster families

KVC provide 24/7 support to children who have experienced abuse and neglect — giving food, a bed and a caring family to youth going through heartache and separation. Foster care is a necessary intervention so that a family can work to overcome obstacles and challenges and learn parenting and communication skills in order for their child to safely return home. Foster care is meant to be temporary and for as short of a time as safely possible because KVC know that any disruption to a child can negatively affect their development.

That is why KVC look to find relatives, neighbors or other trusted adults that the child knows to become his or her foster caregivers. If KVC are unable to find a known adult to care for the child, KVC have a network of highly trained, loving foster families that become caregivers for the child. These families provide a safe, caring environment for the child to heal from the trauma they have experienced.

In-Home Support:

28,128 children and adults benefited from our in-home services such as family therapy, behavioral healthcare and skill-building

In any neighborhood, individuals and families can struggle with challenges that are hard to overcome without help from caring professionals. Economic hardship, mental illness, abuse or neglect, substance abuse, domestic violence, divorce, incarceration and parenting challenges are some of the primary types of adversity that can affect how a family function.

KVC work to stabilize and strengthen families with in-home supports before the need for foster care arises. Our therapists and social workers support parents and children in their home rather than an office setting because the family setting is where challenges exist and where change must occur. In partnership with the family, KVC create and implement a treatment plan. KVC

also connect them to community resources including jobs, housing, substance use treatment, medical care, psychiatric treatment and parenting education.

Children 'S Psychiatric Hospitals & Residential Treatment

2,869 youth and adults treated at our psychiatric hospitals

Over the past decade, the number of children and teens who have been hospitalized for suicidal ideation has doubled. Unfortunately, it's become a national health crisis and KVC doesn't have to look far to find someone who has been affected by the loss of a friend or family member. Children and teens all across the country are struggling with depression, anxiety, trauma, the effects of stress, mental illness, substance use and other sources and types of psychiatric crisis.

KVC offer a safe place for families who are going through one of most frightening and heartbreaking times in their lives. We're putting Resilience Centers in our hospital locations and in communities to teach kids about brain science and what's happening in their brains when they get angry, scared or sad. KVC teach coping skills and use virtual reality as a highly interactive way of helping children experience safety and healing. Our treatment is trauma-informed which addresses the individual and their experiences but also includes their family and home environment as key contributors to their health and wellness.

- **8,603** individual therapy sessions provided to youth
- **403** therapeutic virtual reality sessions conducted
- **42,128** patient days of care provided, which is more than any previous year

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A photograph of a child in profile, looking up at a sunset over a field of dandelions. The child is in the foreground, slightly out of focus. The background shows a vast field of dandelions and a hazy horizon under a warm, orange sky. The overall mood is peaceful and contemplative.

B

**VENDOR
QUALIFICATIONS
AND EXPERIENCE**

B. Vendor Qualifications and Experience

1. Organization Overview

1.1 Vendor Overview

Table 6: Vendor Overview

Vendor Overview	
Corporate (Legal) Name	The Health Plan of West Virginia, Inc.
Name of Parent Company (if applicable)	Not applicable.
Tax Identification Number	55-0585592
Industry (North American Industry Classification System [NAICS])	524114
Type of Legal Entity	Non-Profit Corporation (501)(c)(4), chartered in West Virginia
Company Ownership (e.g., Private/Public, Joint Venture)	Not applicable.
Number of Full-Time Employees	538
Last Fiscal Year Company Revenue	\$574,821,024
Last Fiscal Year Company Net Income	(\$14,898,183)
% of Revenue from State Government Clients in the United States	57.5%
Number of Years in Business	40
Number of Years Vendor has been Providing the Type of Services Specified in the RFP	Although foster care is a new line of business for The Health Plan, the company enrolled with WV Medicaid in 1996, was certified in all WV counties for Medicaid in 2013 and participated in Medicaid Expansion beginning in 2015.
Number of Employees Providing the Type of Services Specified in the RFP	THP currently has over 100 employees that work on the WV Medicaid line of business.

Vendor Overview	
	These positions range from Claims Analyst, Customer Service Representatives, Registered Nurses, Case and Care Managers, SIU Team, Behavioral Health, Social Workers, Contract Liaison and others.
Headquarters in the United States	Wheeling, WV
Headquarters Mailing Address	The Health Plan 1110 Main Street Wheeling, WV 26003
Street Address	1110 Main Street
Telephone Number	800.624.6961
Fax Number	740.695.7581
Locations in the United States	1110 Main Street Wheeling, WV 26003 48 Donley Street, Suite 502 Morgantown, WV 26501 141 Summers Street Charleston, WV 25301 100 Lillian Gish Boulevard, SW #301 Massillon, OH 44647
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	Not applicable:
Name of Contact Person for Bid	Christy Donohue

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

All 55 West Virginia counties.



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

The Company is incorporated in the State of West Virginia as a community-based entity (i.e. non-stock) with not-for-profit status under IRS 501(c)(4).

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.

The Health Plan currently administers Medicaid within the state of West Virginia. The Health Plan does not provide Medicaid services for other States. As of July 1, 2019, The Health Plan insured 150,482 members, including 94,813 WV Medicaid members, 4,391 WV Medicare members, 3,198 WV DSNP members, 6,668 WV Commercial members, and 14,971 WV PEIA members.

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

Although THP does not have direct experience managing members once they enter into the foster care system, we do have extensive experience in managing those members prior to the transition into the foster care. Over the years, a number of children in our TANF population were in the foster care program before and after their enrollment with THP. Many of the issues they dealt with during the time they were considered a Foster Care enrollee with BMS, continued to exist during the time they were THP members. We actively managed their cases and consequently we have a good awareness of the care needs of the population. Additionally, THP has formed a strategic provider partnership with KVC of West Virginia for this RFP. We will utilize their expertise and experience serving foster population in other states such as Kansas, Nebraska and Kentucky. KVC, as the largest private foster Care provider entity in WV, will provide the support that The Health Plan needs to integrate evidence-based guidelines into our management of the foster children in WV. KVC has been an active partner with the state of Kansas since 1996 around privatization of Foster Care Services where they have shown significant improvement in outcomes as a result of the privatization. Furthermore, THP has experience working with at-risk and medically fragile populations through its Dual Eligible Special Need Plan (D-SNP) line of business.

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.*

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

- The 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.

James Pennington, President & CEO
1110 Main St, Wheeling, WV 26003
(DOB and SSN will be provided if The Health Plan is selected.)

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.

The Health Plan is currently NCQA-accredited, with a Provisional status for the Medicaid line of business. The current accreditation expires on November 28, 2019; however, The Health Plan will be resurveyed beginning August 6, 2019.

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1.2 Subcontractor Overview

Table 7: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Superior Vision Benefit Management, Inc.
Name of Parent Company (If Applicable)	Versant Health, Inc.
Tax Identification Number	22-2512930
Industry (NAICS)	N/A
Type of Legal Entity	For-Profit Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Superior Vision Benefit Management, Inc. is a direct subsidiary of Block Vision Holdings Corporation and an indirect subsidiary of Superior Vision Corporation and Versant Health.
Number of Full-Time Employees	Versant Health currently employs over 1,300 associates.
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	**Proprietary and Confidential** Superior Vision Corporation – 2018 = \$354 MM
Last Fiscal Year Company Net Income	**Proprietary and Confidential** Superior Vision Corporation – 2018 = \$13.8 MM
% of Revenue From State Government Clients in the United States	N/A – 0%
Number of Years in Business	26
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	26
Number of Employees Providing the Type of Services Specified in the RFP	Versant Health currently employs over 1,300 associates. Of that total, approximately 160 employees are dedicated to supporting business on behalf of health plan clients with Medicaid members.
Headquarters in the United States	Yes
Headquarters Mailing Address	939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090
Street Address	939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090

Subcontractor Overview	
Telephone Number	(800) 243-1401
Fax Number	(410) 752-8969
Locations in the United States	11090 White Rock Road, Suite 175 Rancho Cordova, CA 95670 175 East Houston Street San Antonio, TX 78205-2255 713 Troy Schenectady Road Latham, NY 12110 6300 Ridgelea Place, Suite 200 Fort Worth, TX 76116 325 Columbia Turnpike; Suite 307 Florham Park, NJ 07932
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	Same as Above
Name of Contact Person for Bid	David Dunbar, RVP, Health Plan Sales

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

- 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.

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

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

See above.

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

N/A

- 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.

Kirk Rothrock, President and CEO (full information to be disclosed upon request).

Subcontractor Overview	
Corporate (Legal) Name	SKYGEN USA, LLC
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	81-0762694
Industry (NAICS)	524292
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Approximately 600
Last Fiscal Year Company Revenue (from Unaffiliated Parties)	\$95,594,000
Last Fiscal Year Company Net Income	\$6,324,000
% of Revenue From State Government Clients in the United States	3.3%

Subcontractor Overview	
Number of Years in Business	25
Number of Years Subcontractor has been Providing the Type of Services Specified in the RFP	25
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 600
Headquarters in the United States	Yes
Headquarters Mailing Address	SKYGEN USA W140 N8981 Lilly Road Menomonee Falls, WI 53051
Street Address	W140 N8981 Lilly Road Menomonee Falls, WI 53051
Telephone Number	262-946-4400
Fax Number	262-347-3219
Locations in the United States	W140 N8981 Lilly Road Menomonee Falls, WI 53051 10201 N. Port Washington Road Mequon, WI 53092 N92 W14612 Anthony Avenue Menomonee Falls, WI 53051 1000 W. Donges Bay Road Mequon, WI 53092
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (if different from above)	Same as above
Name of Contact Person for Bid	Mark Dasek

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.
 - Grambino Technologies, LLC, 37.5% ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls WI 53051
 - MOA Investments, LLC, 37.5% ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls WI 53051
 - Scion Holdings, Inc., 25% ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls WI 53051
- Tax identification number for a corporation with an ownership or control interest in the Subcontractor or in a subcontractor in which the Subcontractor has a five (5) percent or more interest.
 - Grambino Technologies, LLC, 20-8448188
 - MOA Investments, LLC, 39-01865244
 - 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.

None.
- 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.

None.
- 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.

Title	Name	Address	Birthdate
CEO/President	Craig Robert Kasten	10201 N Port Washington Rd Mequon, WI 53092	6/10/53
CLO/Secretary	Steven Jay Berryman	W140N8981 Lilly Rd Menomonee Falls, WI 53051	7/17/69
CFO/Treasurer	James Patrick Purko	W140N8981 Lilly Rd Menomonee Falls, WI 53051	3/26/73

We will provide the Social Security Numbers directly to the department if the Vendor is selected.

2. Mandatory Qualifications

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	THP is in adherence with the COA requirements with the WV Office of the Insurance Commissioner. Our current COA expires May 31, 2020.
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	The Health Plan is currently NCQA-accredited, with a Provisional status for the Medicaid line of business. The current accreditation expires on November 28, 2019; however, The Health Plan will be resurveyed beginning August 6, 2019.
The Vendor must provide an organizational chart outlining the internal organizational structure for this project.	YES	NO	Organizational charts can be found in Attachment C Project Organization and Staffing Approach.
The Vendor must provide a description of the roles, responsibilities, and skill sets associated with each position outlined in the organizational chart.	YES	NO	Job Descriptions can be found in Appendix 2: Position Descriptions.
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	THP has provided the description and anticipates filling ALL key staff positions with experienced current staff qualified for the roles.
The Vendor must require at least one member of its care coordination team to	YES	NO	As part of the MDT meetings, THP will require and provide staff

Mandatory Qualification Item(s)	Vendor Meets?		Provide a Brief Narrative to Demonstrate Fulfillment of Requirement
participate in all multi-disciplinary team (MDT) meetings, as deemed necessary by the Department caseworker or court system.			from our care coordination team to participate in these meetings.
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	THP has consulting contracts with specialists for assistance in medical review determinations. THP has obtained Letters of Intent from WVUM, KVC, Prestera, Southern Highlands and Westbrook providing resources to assist THP in these areas.
The Vendor must have experience working with children and youth populations requiring specialized care.	YES	NO	THP currently works with the CSHCN program within DHHR. Monthly meetings occur to discuss any issues/concerns regarding these children and youth that require specialized care. Additionally, THP has worked directly with Foster Care youth in our TANF population since 1996.
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	THP currently provides services as an MCO to WV Medicaid, Medicare/Medicaid Dual Eligible (DSNP) and PEIA. THP also provides benefit plans/plan administration for Wheeling Hospital, City of Wheeling, and the City of Charleston.
The Vendor must demonstrate at least five (5) years' experience in Medicaid and Health and Human Services.	YES	NO	THP has been a partner and MCO option with WV Medicaid since 1996.
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	YES	NO	THP has provided 3 references demonstrating our ability to perform the scope of this contract. Those references include PEIA, City of Charleston

Mandatory Qualification Item(s)	Vendor Meets?		Provide a Brief Narrative to Demonstrate Fulfillment of Requirement
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.			and the City of Wheeling.
The approach proposed by the Vendor must have been previously implemented successfully in a State environment.	YES	NO	THP proposed approach is currently implemented with the WV Medicaid contract.
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	THP has been one of the contracted Medicaid MCOs with BMS since 1996. Over the years, THP has successfully implemented additional Medicaid services such as dental and behavioral health, implemented additional membership (SSI and Expansion). With our provider strategic partnerships, we will be able to leverage their experience in other states in implementing this project.

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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.

The Health Plan currently has active business relationships with the following State, States Counties and State's local municipalities:

- WV Medicaid MCO account- since 1997 = 95,281 members
- PEIA HMO account- 14,971 members
- WV Medicare/Medicaid Dual Eligibles: 3,198 members
- City of Charleston Self-funded managed care account- 2600 members
- Marshall County Commission HMO Account – 157 subscribers 401 members.
- Brooke County Commission POS Account- 75 subscribers 190 members.
- City of Moundsville HMO Account- 80 subscribers 208 members.
- City of Benwood HMO Account- 19 subscribers 44 members.
- City of Wheeling HMO Account- 801 members
- Morgantown Utility Board POS Account –285 members

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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.

The Health Plan is subject to an annual audit by Qlarant. There were no findings in the 2017 audit; however, there were minor findings for the 2018 audit, all of which have been remediated. Please see attached report and corrective action plan.

The Health Plan is currently NCQA-accredited, with a Provisional status for the Medicaid line of business. The current accreditation expires on November 28, 2019; however, The Health Plan will be resurveyed beginning August 6, 2019.

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.

None – not applicable.

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5. References

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

Reference #1:

Vendor Information		
Vendor Name: The Health Plan of West Virginia	Contact Name:	Christy Donohue
	Contact Phone:	304.720.4923
Customer Information		
Customer Organization: City of Charleston	Contact Name:	Maria Church
	Contact Title:	Benefits Manager
Customer Address: 501 Virginia Street East, Suite 308, Charleston, WV 25301	Contact Phone:	304-348-8015
	Contact Email:	maria.church@cityofcharleston.org
Project Information		
Total Vendor Staff:	538 employees	
Project Objectives: Provide claims administration, medical management, COBRA services, flexible spending accounts, and premium collections for City of Charleston active employees and their dependents and City of Charleston retirees and their dependents.		
Project Description: In addition to processing claims, THP provides utilization management, case management, and behavioral health management to City of Charleston employees and retirees. THP also manages and maintains healthcare flexible spending accounts and dependent care accounts for the City. THP performs all functions for COBRA administration and collects retiree premium payments on behalf of the City.		
Vendor's Involvement: THP performs all Third-Party Administration services for the customer.		

Project Benefits:

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

Key Personnel

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

Project Measurements

Projected Membership of Vendor's Contract: Employees: 1200 Total Membership: 2600	Actual Membership of Vendor's Contract: Employees: 1200 Total Membership: 2600
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Reason(s) for change in membership:
N/A

Estimated Start & Completion Dates:	From:	1/1/2018	To:	Ongoing
Actual Start & Completion Dates:	From:	1/1/2018	To:	Ongoing

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

If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities:
N/A

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Reference #2

Vendor Information		
Vendor Name: The Health Plan of West Virginia	Contact Name:	Christy Donohue
	Contact Phone:	304.720.4923
Customer Information		
Customer Organization: City of Wheeling	Contact Name:	Robert Herron
	Contact Title:	City Manager
Customer Address: 1500 Chapline St. Wheeling, WV 26003	Contact Phone:	304.234.3819
	Contact Email:	rherron@wheelingwv.gov
Project Information		
Total Vendor Staff:	538 employees	
Project Objectives: Provide MCO services to City of Wheeling Employees who select our benefit package.		
Project Description: THP offers 3 different medical/Rx benefit options to City of Wheeling employees. Two HMO options and one POS option. All three options have medical and prescription benefits including a free Teledoc program.		
Vendor's Involvement: THP provides regular reporting, host meetings for members and prospective members, attend open enrollment meetings and participate in health fairs at the various City locations.		
Project Benefits: THP provides cost effective medical and prescription drug coverage with a Teledoc program. Members can choose between the three benefit plan options.		
Key Personnel		
Name: Bob Tschappat Jr. Account Manager	Role: Day to day contact for the City. Attend Open Enrollment meetings and provide annual renewal rates and regular reporting.	
Name: Ryan Jewell Assistant VP of Sales and Account Management	Role: Supervisor of City of Wheeling account manager. Responsible for all insured accounts at THP.	
Dave Mathieu Sr. Vice President Underwriting	Provides and calculates annual renewal rates and benefit review.	
Project Measurements		
Projected Membership of Vendor's Contract: 357 subscribers; 794 members	Actual Membership of Vendor's Contract: 357 subscribers; 794 members	
Reason(s) for changes in membership: Retirement & moving out of service area.		

Estimated Start & Completion Dates:	From:	November 1980	To:	Ongoing
Actual Start & Completion Dates:	From:	November 1980	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: NA...The City used another carrier in 2010 and enrolled again with THP in 2011 to current.				
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: NA				

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Reference #3

Vendor Information		
Vendor Name: The Health Plan of West Virginia	Contact Name:	Christy Donohue
	Contact Phone:	304.720.4923
Customer Information		
Customer Organization: Public Employees Insurance Agency (PEIA)	Contact Name:	Ted Cheatham
	Contact Title:	PEIA Director
Customer Address: 601 57th St., SE, Suite 2 Charleston, WV 25304-2345	Contact Phone:	304.558.7850 ext. 52634
	Contact Email:	Ted.M.Cheatham@wv.gov
Project Information		
Total Vendor Staff:	538 employees	
Project Objectives: THP provides MCO services as an option to State of WV employees (PEIA) who select one of our benefit options.		
Project Description: THP offers 3 different medical/Rx benefit options to Public Employees. Two HMO options and one POS option. All three options have medical and prescription benefits.		
Vendor's Involvement: THP provides regular reporting, host meetings for members and prospective members, attend Open Enrollment meetings around the State of WV and participate in health fairs at designated locations including the employer worksite.		
Project Benefits: THP provides cost effective medical and prescription drug coverage to our members who select us. Members can choose between three benefit plan options.		
Key Personnel		
Name: Bob Tschappat Jr. Account Manager	Day to day contact for PEIA. Attend Open Enrollment meetings, Finance Board Meetings, Health Fairs & information seminars. Prepare/deliver the annual renewal, etc.	
Name: Ryan Jewell Assistant VP of Sales and Account Management	Supervisor of PEIA account manager. Responsible for all fully insured accounts at THP.	
Dave Mathieu Sr. Vice President Underwriting	Provides and calculates annual renewal rates and benefit review.	
Project Measurements		
Projected Membership of Vendor's Contract: 6724 subscribers; 14,733 members	Actual Membership of Vendor's Contract: 6724 subscribers; 14,733 members	
Reason(s) for changes in membership: THP can lose members each year due to retirement, obtaining Medicare eligibility, premium cost or moving out of our service area.		

Estimated Start & Completion Dates:	From:	1981	To:	Ongoing
Actual Start & Completion Dates:	From:	1981	To:	Ongoing
Reason(s) for difference between Estimated and Actual dates: NA				
If the Vendor performed the work as a Subcontractor, the Vendor should describe the scope of subcontracted activities: NA				

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5.2 Subcontractor References (if applicable)

Table 10: Subcontractor References

Subcontractor Information				
Vendor Name: Versant Health – Superior Vision / Davis Vision	Contact Name:	Kim Roell		
	Contact Phone:	412-544-2153		
Customer Information				
Customer Organization: Highmark HCA	Contact Name:	Jennifer Braverman		
	Contact Title:	Director, Product Management & Development		
Customer Address: 1800 Center Street Camp Hill, PA 17011	Contact Phone:	412-544-3277		
	Contact Email:	Jennifer.braverman@highmark.com		
Project Information				
Total Vendor Staff:	2 dedicated client account management staff			
Project Objectives: Routine Vision services				
Project Description: Provide routine vision services for ACA exchange program.				
Vendor's Involvement: Delegated vision vendor for claims administration for the covered routine vision benefit.				
Project Benefits: Claims administration for routine vision services.				
Key Personnel				
Name: Paul Montuori	Role: RVP, Client Management			
Name: Kim Roell	Role: Senior Client Manager			
Project Measurements				
Projected Membership of Vendor's Contract: 24,196	Actual Membership of Vendor's Contract: 24,196			
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	1/1/2014	To:	Current
Actual Start & Completion Dates:	From:	1/1/2014	To:	On going

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

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

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

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Subcontractor Information				
Vendor Name: Versant Health – Superior Vision / Davis Vision		Contact Name:	Scott Deas	
		Contact Phone:	201-819-7597	
Customer Information				
Customer Organization: Horizon BCBS of NJ		Contact Name:	Terra Swiggett, CHC	
		Contact Title:	Manager, Delegate & Vendor Oversight	
Customer Address: 250 Century Parkway, Mount Laurel, NJ 08054		Contact Phone:	856-638-3377	
		Contact Email:	Terra_Swiggett@horizonNJhealth.com	
Project Information				
Total Vendor Staff:		3 dedicated client account management staff		
Project Objectives: Routine vision and medical optometry services.				
Project Description: Provide routine vision services including eye exams and eyewear. Additional services include medical optometry services which includes diagnostic tests and procedures appropriate for the evaluation, diagnosis and treatment of symptomatic eye conditions.				
Vendor's Involvement: Delegated vision vendor for claims administration, network management, customer service and other areas for the administration of the routine vision and medical optometry services.				
Project Benefits: Provide comprehensive eye care and routine vision services for the health plan and the Medicaid beneficiaries.				
Key Personnel				
Name: Paul Montuori		Role: RVP, Client Management		
Name: Scott Deas		Role: Director, Client Management		
Project Measurements				
Projected Membership of Vendor's Contract: 850,000 Medicaid beneficiaries		Actual Membership of Vendor's Contract: 850,000 Medicaid beneficiaries		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	2003	To:	Current

Actual Start & Completion Dates:	From:	2003	To:	On going
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: The scope of subcontracted activities includes claims administration, provider network management and contracting, customer service for members and providers along with required utilization management services.				

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Subcontractor Information				
Vendor Name: Versant Health – Superior Vision / Davis Vision		Contact Name:	Paul Montuori	
		Contact Phone:	516-827-6792	
Customer Information				
Customer Organization: Healthfirst Health Plan		Contact Name:	Charlene De Saro-Raimondo	
		Contact Title:	AVP, Ancillary/Vendor Engagement	
Customer Address: 100 Church Street NYC, NY 10007		Contact Phone:	212-729-2187	
		Contact Email:	Cdesaro-raimondo@healthfirst.org	
Project Information				
Total Vendor Staff:		3 dedicated client account management staff		
Project Objectives: Routine Vision and medical optometry services.				
Project Description: Provide routine vision services including eye exams and eyewear. Additional services include medical optometry services which includes diagnostic tests and procedures appropriate for the evaluation, diagnosis and treatment of symptomatic eye conditions.				
Vendor's Involvement: Delegated vision vendor for claims administration, network management, customer service and other areas for the administration of the routine vision and medical optometry services.				
Project Benefits: Provide comprehensive eye care and routine vision services for the health plan and the Medicaid, Medicare and ACA Exchange beneficiaries.				
Key Personnel				
Name: Paul Montuori		Role: RVP, Client Management		
Name: Scott Deas		Role: Director, Client Management		
Project Measurements				
Projected Membership of Vendor's Contract: 1.4 million Medicaid, Medicare and ACA Exchange beneficiaries.		Actual Membership of Vendor's Contract: 1.4 million Medicaid, Medicare and ACA Exchange beneficiaries.		
Reason(s) for change in membership: N/A				
Estimated Start & Completion Dates:	From:	2003	To:	Current

Actual Start & Completion Dates:	From:	2003	To:	On going
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities:				
The scope of subcontracted activities includes claims administration, provider network management and contracting, customer service for members and providers along with required utilization management services.				

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Subcontractor Information		
Vendor Name: SKYGEN USA	Contact Name:	Mark Dasek
	Contact Phone:	262.946.4537
Customer Information		
Customer Organization: Horizon Blue Cross Blue Shield New Jersey	Contact Name:	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 NJ Health, including implementation, network development, provider relations, credentialing, member services, member outreach, intensive care management, quality, utilization management, appeals and grievances, and reporting. In addition to our policies and procedures that proactively ensure members receive appropriate services and treatment, we have built sophisticated reporting and analytics into our dental benefits software system, the Enterprise System. Our system allows us to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes. Using this data, we create interventions, outreach initiatives, and educational campaigns as appropriate for Horizon Blue Cross Blue Shield NJ.		
Vendor's Involvement: SKYGEN USA has managed Horizon Blue Cross Blue Shield of New Jersey's Medicaid members since 2012, with a focus on holistic program integrity and stewardship. To address Horizon Blue Cross Blue Shield of New Jersey's most immediate needs, we used a combination of data analytics, fee schedule analysis, and geo-access reporting to analyze costs. We are delegated to perform the following activities for the dental program: Provider recruitment, credentialing, education and retention Authorizations Utilization review and management Claims processing and provider payment Call Center services Reporting Member services Quality assurance		

Complaints, grievances, and appeals
Fraud, waste, and abuse monitoring

Project Benefits:

For Horizon BCBS of NJ, SKYGEN reduced their PMPM costs, resulting in significant saving while achieving over 80% provider satisfaction from 2015 to 2017. We also consulted with Horizon BCBS of NJ to improve their providers' performance and helped protect nearly 1 million members by reducing and preventing fraud, waste, and abuse.

Key Personnel

Name: Mark Dasek	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
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Reason(s) for change in membership: No change in membership

Estimated Start & Completion Dates:	From:	Dec 1, 2012	To:	Present
Actual Start & Completion Dates:	From:	Dec 1, 2012	To:	Present

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

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

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

Subcontractor Information

Vendor Name: SKYGEN USA	Contact Name:	Mark Dasek
	Contact Phone:	262.946.4537

Customer Information

Customer Organization: United Concordia Dental	Contact Name:	Daniel J. Wright
	Contact Title:	SVP Government Business & CFO
Customer Address: 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
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Project Objectives:
SKYGEN USA provides administrative dental services for United Concordia's Medicaid members.

Project Description:
SKYGEN is a dental administrative services organization. We 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 our policies and procedures that proactively ensure members receive appropriate services and treatment, we have built sophisticated reporting and analytics into our dental benefits software system, the Enterprise System. Our system allows us to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes.

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

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

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: No change in membership				
Estimated Start & Completion Dates:	From:	April 1, 2012	To:	Present
Actual Start & Completion Dates:	From:	April 1, 2012	To:	Present
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: All services SKYGEN performs on behalf of United Concordia Dental are performed as a subcontractor. This includes authorizations, claims processing, provider payment, reporting, member services, and quality assurance.				

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Subcontractor Information		
Vendor Name: SKYGEN USA	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 USA provides administrative dental services for Commonwealth Care Alliance's 31,000 Medicaid members.		
Project Description: SKYGEN is a dental administrative services organization. We 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 USA performs the following activities for Commonwealth Care Alliance: Claims processing, provider payment Reporting Call Center Authorizations Quality assurance Complaints, grievances and appeals		
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: No change in membership				
Estimated Start & Completion Dates:	From:	June 1, 2014	To:	Present
Actual Start & Completion Dates:	From:	June 1, 2014	To:	Present
Reason(s) for difference between Estimated and Actual dates: N/A				
If the Subcontractor performed the work as a subcontractor, the Subcontractor should describe the scope of subcontracted activities: All services SKYGEN performs on behalf of 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.				

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6. Financial Stability

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.

As of June 30, 2019, The Health Plan has \$244 million of cash and investments and \$116 million of reserves (equity) to support the requirements of this procurement.

Below is the extract from the D&B ratings.

The screenshot shows a web browser window with the URL <https://dandb.com>. The page title is "View Report: Overview". The left sidebar contains a menu with the following items: Overview (selected), History/Operations, Payments, Banking and Finance, Public Filings, Review Payments, Update Financial Statements, Review Public Filings, and CreditSignal®. The main content area is titled "Business Summary" and displays the following information:

Company Name:	HEALTH PLAN OF WEST VIRGINIA, INC., THE
D-U-N-S #:	09-420-8816
DBA's:	N/A
Address:	1110 Main St
City:	Wheeling
State:	WV
Zip:	26003
Phone:	7406953585
Principal:	JAMES PENNINGTON
Year Started:	1979
Employs:	400 which includes officer(s) and 79 part-time. 260 employed here.
SIC Code(s):	63249903 Health Maintenance Organization (HMO), insurance only 80820000 Home health care services
NAICS Code(s):	524114 Direct Health and Medical Insurance Carriers 621610 Home Health Care Services

At the bottom of the page, the text "Legal Structure: DOMESTIC CORPORATION" is visible.

Officers and Directors

Name	Title
JAMES PENNINGTON	CEO
JAMES NEWTON	CHB
JOHN YEAGER	CFO-TRES
DONALD MOLTER	SEC
JERRY FISHER	DIR
ROLAND HOBBS	DIR

Current Directors

Name
JAMES PENNINGTON
JAMES NEWTON
JOHN YEAGER
DONALD MOLTER
JERRY FISHER
ROLAND HOBBS

Company History

Operates as a hospital or medical insurance plan carrier, specializing in health maintenance organization (HMO) coverage. Provides home health care services.

Terms are on a fee basis from members subscriptions. Sells to general public. Territory : Local Including 25 Counties.

Health Plan Of West Virginia, Inc., ...

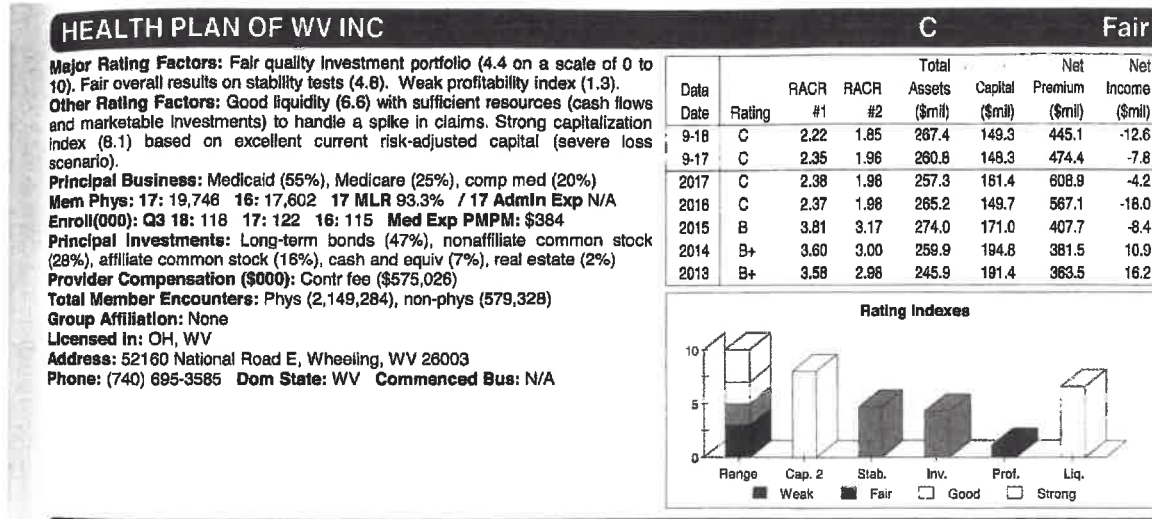
CS CreditSignal

Summary

Company Info	Update Company Info
1110 Main St Wheeling, WV 26003 Phone: (740) 695-3585 URL:	DBA's : HEALTH PLAN

Scores and Ratings		
Score / Rating:	Status	Last Date Changed
PAYDEX®	Fair	03/19/2019
Delinquency Predictor Class	Good	04/02/2019
Financial Stress Class	Fair	05/22/2018
Supplier Evaluation Rating	Good	04/02/2019
D&B Rating	N/A	08/06/2019
D&B Viability Rating	Good	

THP has historically valued the Weiss Rating for our industry. They provide the ratings on virtually all U.S. banks, credit unions and insurance companies and their information is updated quarterly. Below is the most recently published rating report.



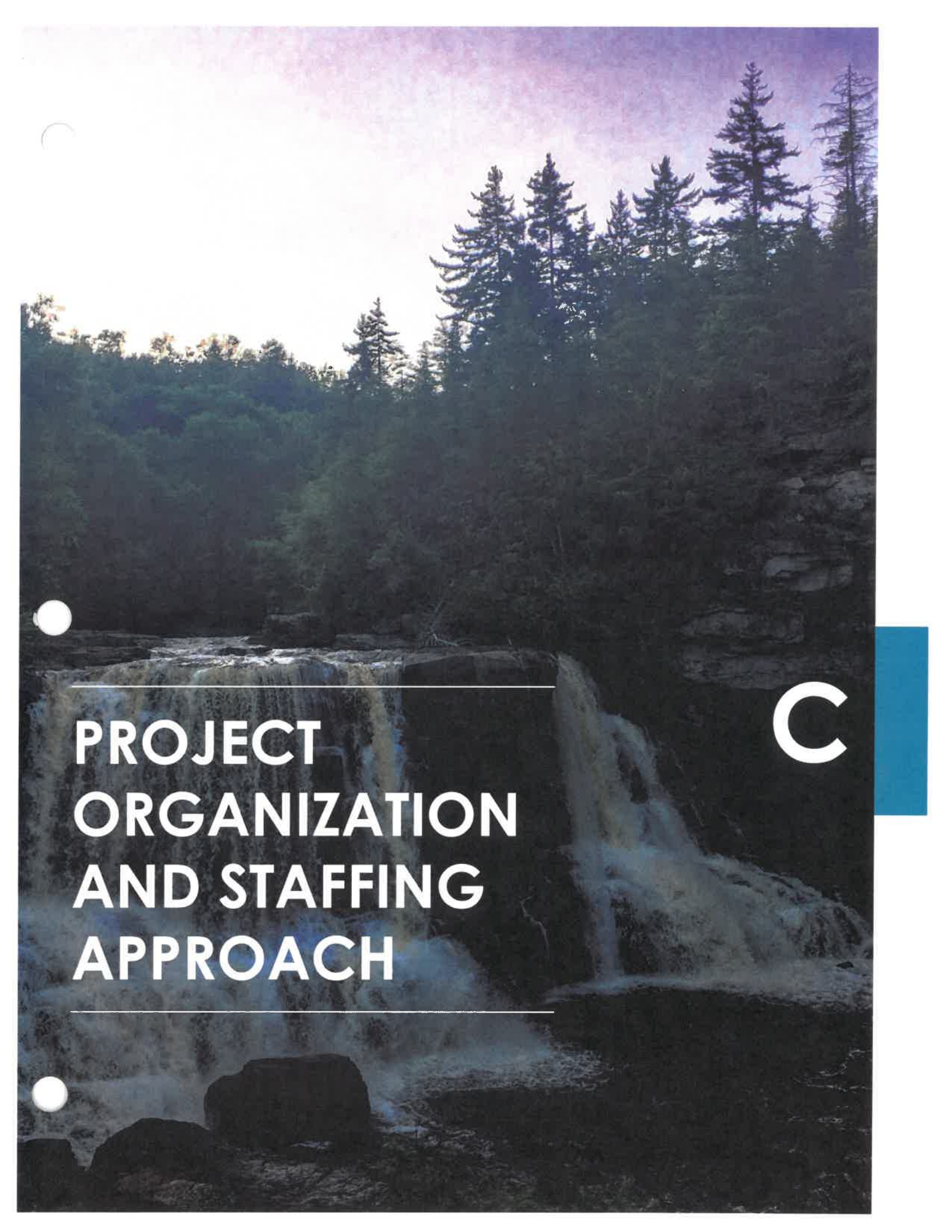
6.2 Financial Capacity

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

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
Liberty Distributors, Inc.	6015 National Road, Triadelphia, WV 26059	800-828-9920
Morgantown Printing	915 Green Bag Road, Morgantown, WV 26508	888-292-0001
Wheeling Office Supply	1420 Market Street, Wheeling, WV 26003	304-233-2810
Erb Electric Company	500 Hall Street, Ste 1, Bridgeport, OH 43912	740-633-5055



PROJECT ORGANIZATION AND STAFFING APPROACH

C

C. Project Organization and Staffing Approach

1. Initial Staffing Plan

THP's Staffing plan includes standards for implementing an effective system of healthcare delivery to members. THP views its relationship with DHHR as a partnership, and will present its staffing plan for review, and approval during the Readiness Assessment and Review period. THP commits to notifying DHHR of all changes to the approved staffing plan within thirty (30) days of the decision to change and will submit a modified plan reflecting all changes if the change results in a decrease in personnel.

- At the implementation of the contract, THP will staff every key position with one or more professionals who meet or exceed the position requirements listed in the response to this solicitation. With sizable operations current in WV, THP anticipates staffing ALL key personnel positions with currently employed and experienced staff already located in WV.
- THP intends to employ all key personnel full-time (minimum of 40 hours per week). These individuals will be located in one of our WV offices, and will hold primary responsibilities for the requirements included under the Contract.
- Below are the names, titles, qualifications, and contact information of THP's designated personnel who have been identified to serve in each key position associated with this response are described in the staffing plan below and listed in section 3.1.

THP will not reassign key personnel or appoint replacements without Informing DHHR. In the event THP must divert or reassign personnel, THP commits to informing DHHR, and refraining from making the final change until it has heard from DHHR's Contract Administrator (CA) and Contracting Officer (CO). . In all instances, THP will submit a justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of Covered Services.

Project Staffing Methodology

THP recognizes the importance of a "complete, expert team!" At the initiation of the contract and throughout the entirety of its implementation, THP commits to adhering to high standards of contract performance. As such, our "Initial Plan" calls for **EVERY KEY PERSONNEL position to be filled on Day One!** THP's history demonstrates its ability to acquire and retain a professional workforce with the knowledge necessary to meet the needs of an MCO.



THP's approach to staffing and recruiting for this project reduces the staff identification and assignment risks shown. Using lessons learned from supporting other user service support contracts, we have developed our approach. It identifies critical skills, capabilities, and offers quick-response capability. It consists of the following components.

- Key staff positions will be filled from THP's current resource pool of qualified and experienced personnel.
- For Key positions for which THP must recruit, THP will pull from its well-defined recruiting process targeting candidates with motivation and credentials that exceed the minimum requirements. Performance oriented professionals demonstrating a record of maintaining the high standards of quality and productivity demanded by THP.
- Categorizing each staffing requirement as normal, surge, or Tiger Team, allowing us to implement effectively.

Recruitment

THP has extensive experience in recruiting. The organization's experienced human resources team includes senior management, generalist, and recruiting specialists. Together they develop recruiting strategies to attract the best candidates. They design and implement formal recruitment and hiring policies. These policies make sure the hiring process uses consistent guidelines and selection criteria. Our streamlined recruitment process uses a variety of sources. Our recruitment process provides qualified candidates in the shortest practical timeframe -- See Exhibit Below.



Planning

THP has a proven process in place to bring on board and retain high quality candidates with the right qualifications.

THP assesses these candidates against position requirements using a rigorous interview and evaluation process. By matching potential employees to available positions, our approach increases employee satisfaction, improves retention, and reduces hiring and training costs.

Internally, we post jobs online. Current staff has the opportunity to apply for positions posted even in new areas (provided they meet the minimum eligibility criteria. This creates career movement opportunity that contributes to low turnover.

Project Organization and Staffing Plan

I. Initial Staffing

Project Team: The project team will consist primarily of the Key Staff positions that will provide the leadership both during the implementation phase of the project as well as post

implementation. The project team will be divided into key areas and additional project team members will be allocated for each area based on the expertise needed to carry out the tasks. The key areas and team members are presented in *Table: Project Team* below with the Asst. VP of Medicaid (Medicaid Administrator), the Medicaid Liaison and the Sr. VP of Government programs involved in all components. Given the tight timeframe for implementation, we believe it is imperative that we have resources on hand ready to begin preparations.

Table: Project Team

Project Team With "tentative" task list	
Component/Tasks	Team Members
OVERALL PROJECT - Interface with DHHR - Establish implementation plan - Monitor readiness for all areas - Oversee subcontractor contracts and oversight functions - Staff Education - Compliance/DHHR Requirements - Readiness Assessment - Policy and Procedure development	- Sr. VP Government Program - Asst. VP Medicaid - Sr. VP Provider Delivery Services - Sr. VP Clinical Services - Sr. VP Administrative Services - VP Operations - Manager Care Management (Foster Care) - Director Medicaid Operations - Medicaid Coordinator - Director Community Engagement - Clinical Psychologist - Social Services Director
Human Resources - Recruiting - Hiring - On Boarding - Training	- Sr. VP Human Resources - Asst. VP of Medicaid - VP of Operations - Director of Medicaid Operations - Director of Medical Management
Operations - Training - New staff - New product and services - Materials Development and Preparation - Benefit set up and testing	- Asst. VP of Medicaid - VP of Operations - Director Medicaid Operations - Manager Medicaid Claims - Manager Medicaid Customer Service - Supervisor Member Advocates (outreach) - Medicaid Coordinator/Member Advocate - Appeals Coordinator - Trainer
Clinical Care—Medical Management - Training - Establish of system for SNS review - Evaluation of SNS criteria - Programming system for SNS - Establishment of Process for evaluation and review of Q RTP services in accordance with contract requirements - Development of process for evaluation of personal care services	- Director Medical Management - Care Management Director/Manager - Social Services Director - Clinical Psychologist - SNS Liaison - SNS referral coordinator - KVC support staff - IT clinical developer

Project Team With "tentative" task list	
Component/Tasks	Team Members
Community Outreach/Network Outreach and Education - Establish collaborative workgroups with community partners - Develop and distribute educational and outreach materials - Establish resource directory for project - Provider education - Community education - Stakeholder meetings and education	- Director Community Engagement - Provider Engagement Managers (Provider Relations Directors*) - Asst. VP Population Health - Director Clinical Quality - SNS Liaison - Social Services Director - Provider Engagement Rep (BH) - Director Education
Network - Network adequacy reporting and testing - Network contracting/ Amendments as needed - Contracting for new services - Q RTP - Personal Care - Value Based Agreement strategy and implementation for project - PCMH strategy and implementation for project - Credentialing of new providers	- Sr. VP Provider Delivery Services - Director Contracting - Director Operations (Provider) - Manager Credentialing - Director Provider Strategic Initiatives
Systems/Connectivity - Develop and implement necessary electronic interfaces - Upgrade internal system to capture "new" data elements - HEART new claim type and referral types - COMET new tracking components, document attachment capabilities and external user interfaces - Provide required reporting and encounter file submission - Connectivity with WVHIN, DHHR various resources, etc.	- Sr. VP Information Systems - Sr. VP Government Programs - Asst VP Medicaid - VP Information Systems - System Analyst - Director Operations

Resource Provision: THP has thoroughly developed the resources that will be required as set forth in the Organizational Charts. The staffing levels were determined based on the following:

1. Productivity Data and Volume data relevant to membership and claims volumes was used to arrive at staffing needs for our Customer Services, Claims and Member Advocate (outreach) areas.
2. Clinical staff was established based on review of types of services provided and membership numbers. We were also able to ascertain types of services and volumes by Medicaid Plan Code allowing us to determine types of clinical support and number of staff

needed in each area. Based on services we did ascertain the need for greater resources for behavioral health services and social services.

3. Data on the socially necessary services provided us with referral volumes and types. We were able to determine the number of coordinators needed based on this information.

The Staffing Worksheet provided in *Table: Foster Care RFP Staffing* highlights the positions to be filled and the timeline for hiring based on a project start date of 1/1/2020. The worksheet indicates positions to be filled by internal staff and the timeline prior to go live for filling of other positions. Our intent would be to hire key staff as soon as the procurement is awarded. We have also noted which positions would be filled through a 50% allocation of existing staff to provide experienced support for the new project.

Table: Foster Care RFP Staffing

Foster Care RFP Staffing Worksheet					
Positions	Department	Identified Staff Candidate(s)	Hire days prior to go live)	50% filled internally	Location
Advocate, Clinical	Clinical		75	Yes	Wheeling, WV
Advocate, Clinical	Clinical		75	Yes	Wheeling, WV
Advocate, Clinical	Clinical		75	Yes	Wheeling, WV
Navigator, RN	Clinical		90	Yes	Wheeling, WV
Navigator, BH	Clinical		90	Yes	Wheeling, WV
Navigator, BH	Clinical		90	Yes	Wheeling, WV
Navigator, MSW	Clinical		90	No	Wheeling, WV
Navigator, MSW	Clinical		90	No	Wheeling, WV
SNS Referral Coordinator	Clinical		75	No	Wheeling, WV
SNS Referral Coordinator	Clinical		75	No	Wheeling, WV
SNS Referral Coordinator	Clinical		75	No	Wheeling, WV
SNS THP Navigator	Clinical		75	No	Wheeling, WV
SNS Liaison	Clinical	Tammy Wright	7	N/a	Wheeling, WV
Care Management Mgr.	Clinical	Bobbi Jo Billiter	7	N/a	Wheeling, WV
Social Work, Lead	Clinical	Dawn McCroskey	7	N/a	Wheeling, WV
Clinical Psychologist	Clinical	Shelia Kelly	7	N/a	Charleston, WV
Navigator-Auth, RN	Clinical		75	Yes	Wheeling, WV
Navigator-Auth, RN	Clinical		75	Yes	Wheeling, WV
Navigator-UM, RN	Clinical		75	Yes	Wheeling, WV
Navigator-UM, RN	Clinical		75	Yes	Wheeling, WV
QI Clinical Coordinator	QI		60	No	Wheeling, WV
QI Data Analyst	QI		30	No	Wheeling, WV
Advocate, Outreach	Operations		60	Yes	Wheeling, WV
Advocate, Outreach	Operations		60	Yes	Wheeling, WV
Advocate, Outreach	Operations		60	yes	Wheeling, WV
Claims Analyst	Operations		30	yes	Charleston, WV
Claims Analyst	Operations		30	yes	Charleston, WV

Foster Care RFP Staffing Worksheet					
Positions	Department	Identified Staff Candidate(s)	Hire days prior to go live)	50% filled internally	Location
Claims Analyst	Operations		30	yes	Charleston, WV
Claims Analyst	Operations		30	yes	Charleston, WV
Claims Analyst	Operations		30	yes	Charleston, WV
Claims Analyst	Operations		30	yes	Charleston, WV
Claims Analyst	Operations		30	yes	Charleston, WV
Claims Analyst	Operations		30	yes	Charleston, WV
Customer Service Rep	Operations		45	yes	Charleston, WV
Customer Service Rep	Operations		45	yes	Charleston, WV
Customer Service Rep	Operations		45	yes	Charleston, WV
Foster Care Liaison	Government		7	n/a	Charleston, WV
Comm Engagement Dir	Government	Joshua Austin	7	n/a	Morgantown, WV

Immediately, upon notification of a vacancy or potential vacancy, the Manager will notify Human Resources of replacement or new position with validation documentation and the timeline for filling the position. HR will complete a "Request for Personnel" form along with a job description to be reviewed and approved by the CEO. Once approved, Human Resources will post position on THP website for internal and external candidates and will also post with outside sources. HR will accept internal bids signed by head of department. The employee completing internal bid will understand that immediate supervisor will be notified of the bid.

When resumes are received at The Health Plan, Human Resources will track applicants and provide a copy of the resume to the hiring Department. The Manager will review resumes and select candidates to be interviewed. All interview appointments will be made through Human Resources and conducted with Human Resources present.

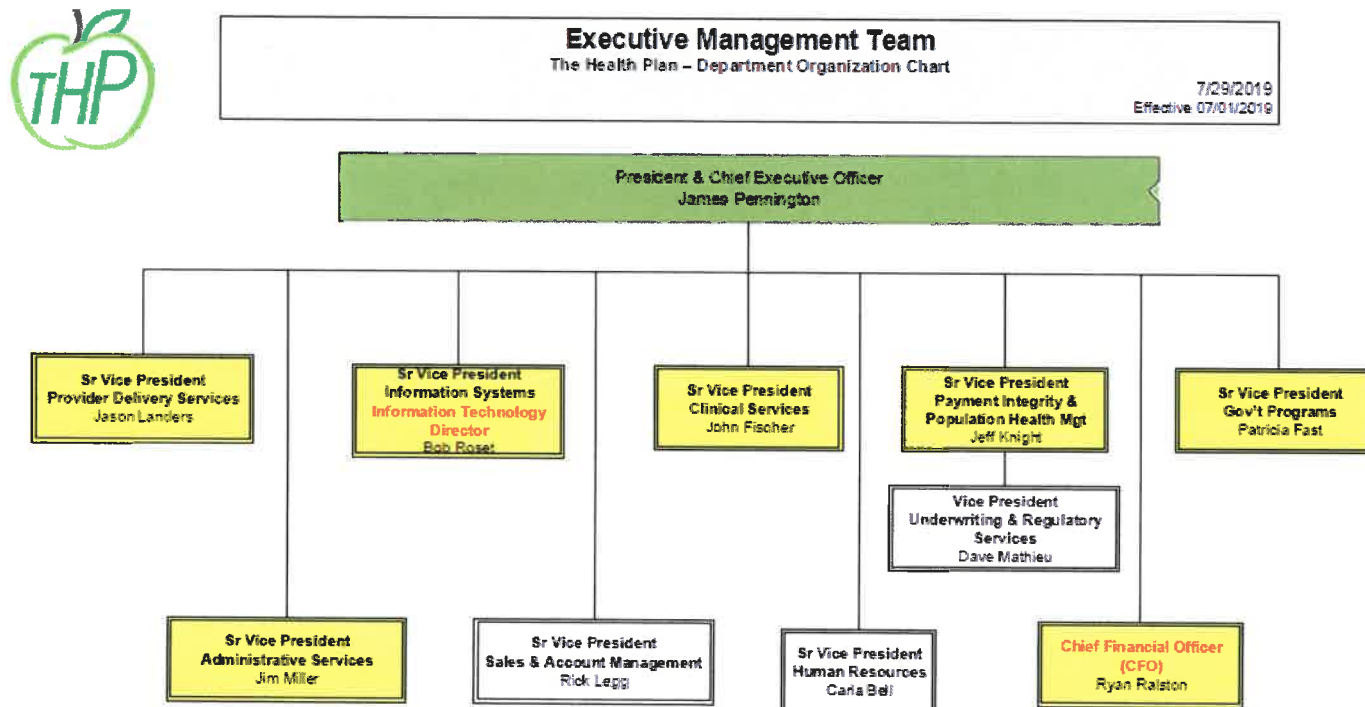
Once a candidate is chosen, the offer is sent to the candidate. When the offer is accepted, Human Resources will schedule drug screening, check the exclusions lists, license (if RN, LPN) and in some instances, a background check. When the drug screening results are received as negative and exclusions lists are clean, new employee will be notified a start date.

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Organization Charts

Overall Organizational Structure Diagram

Key positions depicted on the Executive Management chart not otherwise reflected on the various departmental charts that have been provided include the following positions.



The organization structure shown in the chart above provides an overview of the corporate organizational structure. As shown on the chart, the key organizational functions relevant to this project (those highlighted in yellow) are all led by key Executive Level Staff reporting directly to the President and Chief Executive officer of The Health Plan.

- **Government Programs**—The Government Programs area of THP will have overall responsibility for the program. The program will be handled through the Medicaid unit of our Government Programs area where our current WV Medicaid MCO business is managed. The responsibilities of this area include:
 - Overall contract delivery and oversight
 - Interface with DHHR
 - Program support including materials development, reporting, community engagement, and contract compliance.
 - Coordination and Integration of all aspects of program
 - Contracting and Oversight of all subcontractor relationships
- **Provider Delivery Services**—through our network team, we will ensure adequate network resources to meet the needs of the population. As an existing MCO in the state of West Virginia, we have in place an experienced staff to recruit and support the needed network resources in West Virginia. Our network team handle the following responsibilities:
 - Recruitment of Medical Providers not already contracted by THP
 - Recruitment of Socially Necessary Providers
 - Recruitment of Residential and Shelter Providers
 - Credentialing Providers
 - Education and Outreach with Providers and Community Resources
 - Coordination and Collaboration with providers including development of value-based agreements
- **Administrative Service**—will handle the daily operational functions which include:
 - Customer Service
 - Claims adjudication and payment
 - Grievances and Appeals
- **Clinical Services**—will handle all aspects of clinical management of the program will be handled by our Clinical Services team including:
 - Care Management
 - Utilization Management and Preauthorization
 - Establishment and Review of Clinical Criteria
 - Social Services Management
- **Payment Integrity and Population Health Management**
 - Quality Management and Clinical Reporting
 - Special Investigation Unit
 - Compliance
 - Financial Analysis and Reporting
 - Facilities management
- **Information Systems**
 - System development and support services
 - EDI functions including eligibility file receipt, encounter file submission and other data exchange functions
 - Web Site and Mobile Site development and support

- **Human Resources**

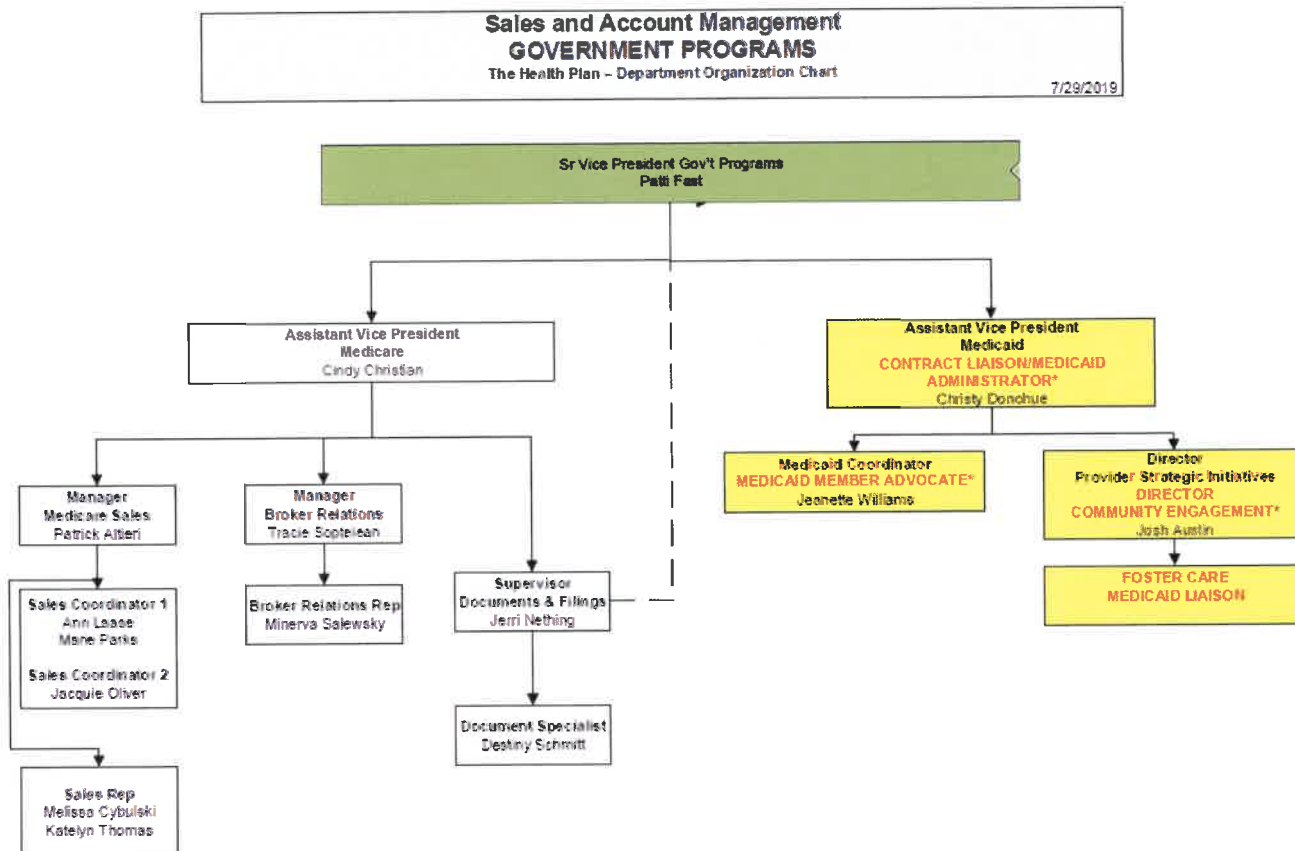
- Hiring and Recruiting
- Employee Education and Training
- Employee credentialing

The Executive Management Team at The Health Plan are all based at the organization's corporate headquarters in Wheeling, WV. ALL positions being added to fulfill the roles required for the RFP will be located in West Virginia at one of our three West Virginia office locations: Wheeling, Charleston and Morgantown. Copies of the organization charts for each area and a description of the roles, positions are below for each of the key areas.

Executive Management Team—Key Position Summary			
Position	Employee Background/ Hiring Plan	Location	Reports To
President and CEO	James Pennington has served as President and CEO of THP since July 2014. Prior to THP, James' career includes a number of executive healthcare positions spanning a career of over 35 years.	Wheeling, WV	THP Board of Directors
Chief Financial Officer (KEY POSITION ROLE: CFO)	Ryan Ralston has been with THP since 2016 and has served in the role of CFO since January 2019. Ryan is a CPA.	Wheeling, WV	President and CEO
Sr. Vice President Information Systems (KEY POSITION ROLE: Director of Information Systems)	Bob Roset has over 30-years of experience leading the Information Systems department at THP.	Wheeling, WV	President and CEO

Government Programs Organizational Chart

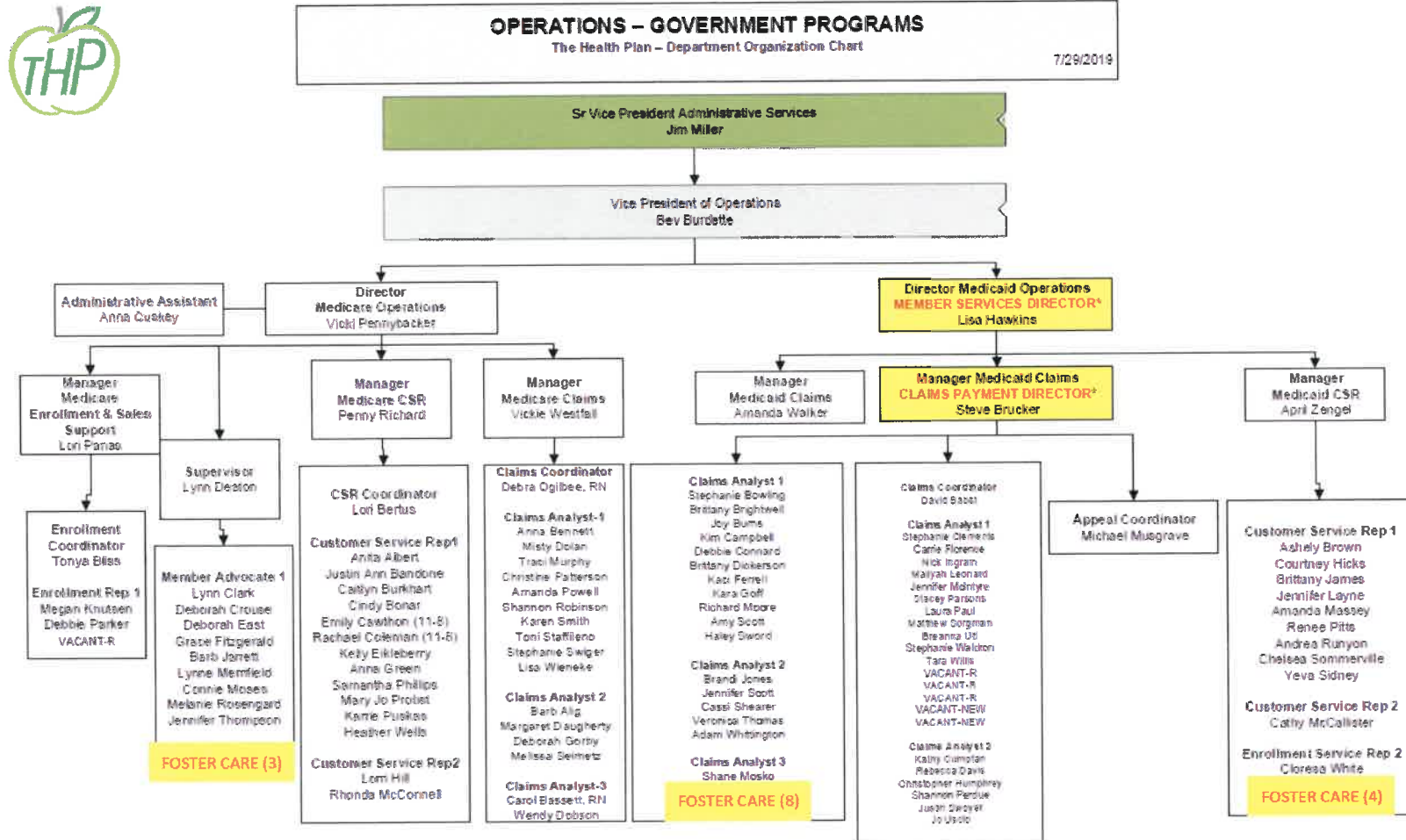
Government Programs Department, which houses the Medicaid area, will serve as the project leadership for the program. As shown on the chart this department includes the following positions relevant to the RFP:



Government Programs—Key Position Summary			
Position	Employee Background/ Hiring Plan	Location	Reports To
Sr. VP of Government Programs	Patricia Fast, the Senior VP of Government Programs has served in an Executive Leadership role at The Health Plan for over 35 years and has vast experience in government programs and operations. Patricia will provide the overall leadership and direction for the program .	Wheeling, WV	President and CEO
Asst. VP Medicaid (KEY POSITION ROLE: Contract Liaison and Medicaid Administrator)	Christy Donohue who has served in the role of Contract Liaison and Medicaid Administrator since February 2015 will continue in this same role for the Foster Care Population as this population will be administered through the same organizational structure as our current MCO products in WV.	Charleston, WV	Sr. VP of Government Programs
Medicaid Coordinator (KEY POSITION ROLE: Medicaid Member Advocate)	Jeanette Williams, who currently holds this role will handle responsibilities of Medicaid Member Advocate. Jeanette joined THP in 2016. Prior to that time, she worked as a Customer Service Representative at HealthSmart.	Charleston, WV	Asst VP Medicaid
Foster Care Director (KEY POSITION ROLE: Community Engagement Director)	Joshua Austin who currently holds the role of Director of Provider Strategic initiatives at THP will move to the role of Community Engagement Director. Joshua joined THP in April of 2019 bringing with him several years of experience in public health projects in WV.	Morgantown, WV	Asst VP Medicaid
Medicaid FOSTER CARE Liaison	THP will be recruiting an individual to serve as the Medicaid Foster Care Liaison.	Charleston, WV	Community Engagement Director

Operations Organizational Chart

Operations Department will handle daily operational responsibilities. As shown on the chart this department includes the following positions relevant to the RFP

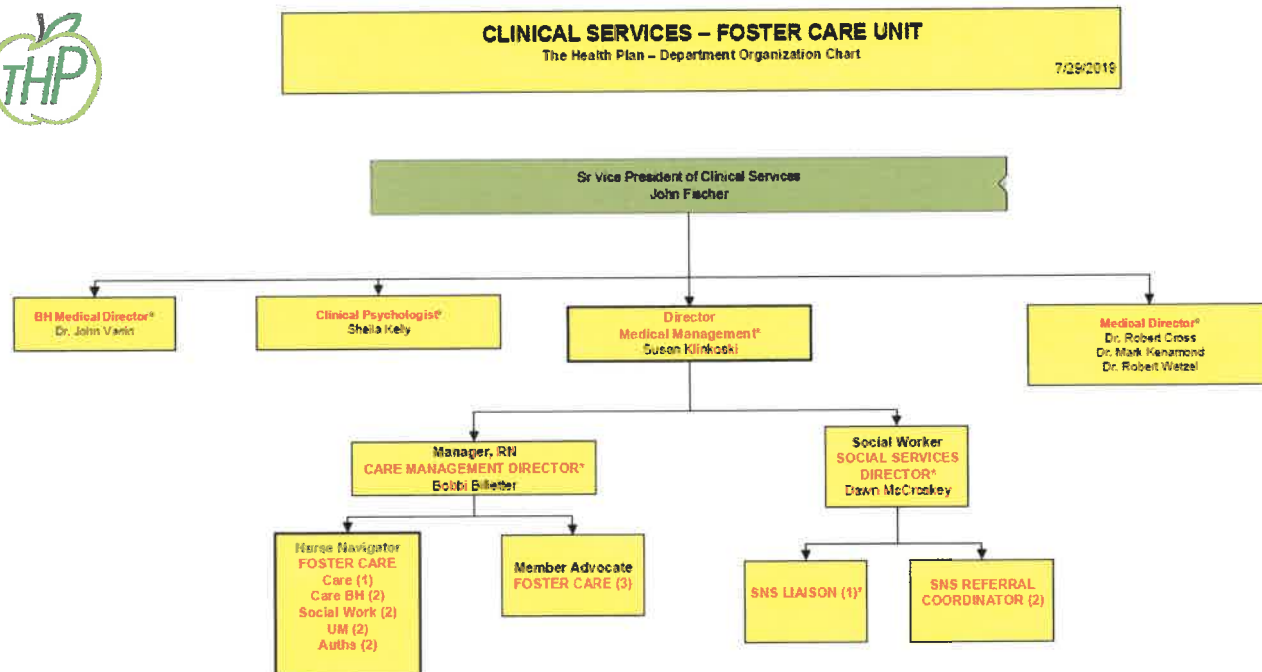


Operations—Key Position Summary			
Position	Employee Background/ Hiring Plan	Location	Reports To
Senior VP of Administrative Services	James Miller, VP of Administrative Services, has been employed by THP since November 2018. Prior to joining The Health Plan in 2018, spent over 25 years in executive leadership roles with various Blue Cross and Blue Shield Plans. Background includes strategic experience and proficiency in Finance, IT, Operations, Clinical, Provider Networks and Contracting. Recognized as revitalizing operations and fostering productive customer relationships.	Wheeling, WV	President and CEO
VP Operations	Beverly Burdette has lead Operations at THP since 2015. Prior to that she was with HealthSmart and Wells Fargo TPA where she held the position of VP of Operations for 20 years. She was in charge of an operations center handling claims payment and customer services for over 400 clients with approximately 500,000 members, serving both commercial and government contracts.	Charleston, WV	Sr. VP of Administrative Services
Director of Medicaid Operations (KEY POSITION ROLE: Member Services Director)	Lisa Hawkins employed with THP since December 2018 and oversees both claims payment and customer service for THPs Medicaid areas. Prior to employment with THP, Lisa worked with HealthSmart and Wells Fargo as a team manager for over 15 years serving both commercial and government contracts.	Charleston, WV	VP Operations
Manager of Medicaid Customer Service	April Zenger was recently hired by THP as manager of Customer services for THPs Medicaid business unit. Prior to employment at THP, April worked for 10 years in Customer Service in Aetna's Medicaid area.	Charleston, WV	Director of Medicaid Operations
Manager of Medicaid Claims (KEY POSITION ROLE: Claims Payment Director)	Steve Brucker has served as Manager of Claims in THPs Medicaid area since November 2016. Prior to employment with THP, Steve served at HealthSmart as a Claims Team Lead where he worked in the claims area for over 10 years.	Charleston, WV	Director of Medicaid Operations
Claims Analyst	THP currently employs 38 Claims analyst for processing, adjudication and payment of claims for it's Medicaid business unit. With the additional volumes generated through the RFP, THP will add 8 additional claims analyst to handle the additional volume of claims. Claims Analyst must have experience in a claims processing or insurance submission role.	Charleston, WV	Manager Medicaid Claims
Customer Service Representative	THP currently employs 12 customer service representatives for handling of customer inquiries for it's Medicaid business unit. With the additional volumes generated through the RFP, THP will add 4 additional Customer Service Representatives to handle the additional volume of calls and correspondence. Representatives are	Charleston, WV	Manager Medicaid Customer Service

	required to have good telephone skills and experience dealing with the public.		
Supervisor Member Advocates (telephonic outreach area)	Lynn Deaton started at THP 15 years ago as a Medicaid Outreach representative and has been managing the department for the past two years.	Wheeling, WV	Director of Operations
Member Advocate (telephonic outreach)	THP currently employs 7 outreach representatives for handling corporate telephonic outreach functions. THP will add 3 additional Member Advocates to handle call volume generated through the RFP.	Wheeling, WV	Supervisor of Member Advocates

Clinical Services Organizational Chart

Clinical Services will handle care management and utilization management functions with a specialized unit of staff dedicated to the Foster Care Populations.

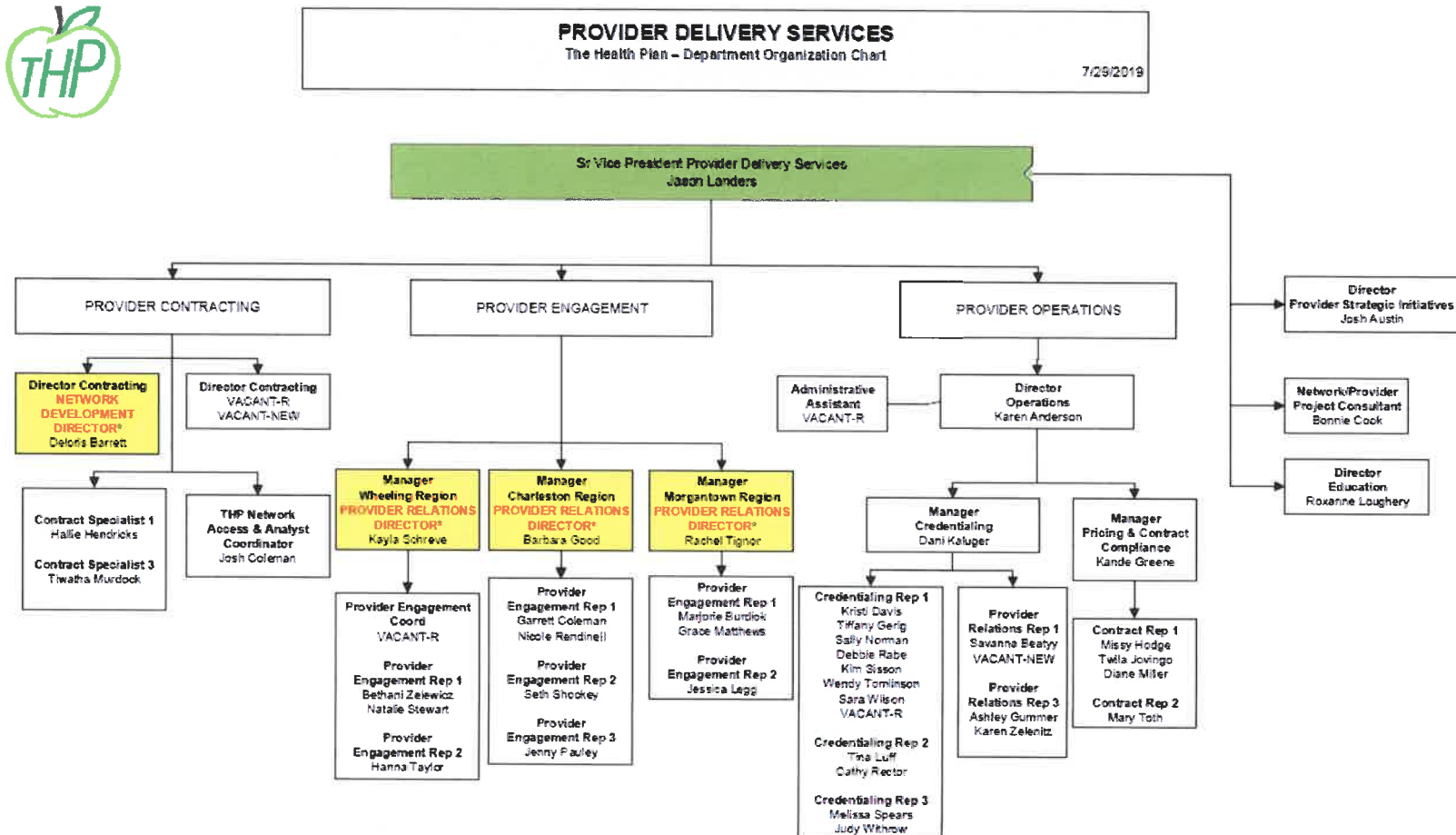


Clinical Services—Key Position Summary			
Position	Employee Background/ Hiring Plan	Location	Reports To
Senior VP of Clinical Services	John Fischer has held the position of Senior VP of Clinical Services since January 2015. A registered nurse in West Virginia, John has served a variety of leadership roles in various managed care capacities in West Virginia for over 35 years.	Wheeling, WV	President and CEO
Medical Directors (KEY POSITIONS ROLE: Medical Director)	THP currently employs three Medical Directors; Dr. Mark Kenamond (radiologist) has served as a full time Medical Director with THP since 2010, Dr. Robert Cross (surgeon) has served as a full time Medical Director with THP since 2015 and Dr. Robert Wetzel (OB/GYN) who has served as a part-time Medical Director at THP since 2015. They are available daily to handle authorizations and inquiries from providers and members. All of our Medical Directors are licensed in WV and Board Certified in their specialty. They provide leadership within our clinical departments, lead our clinical committees and review utilization determinations.	Wheeling, WV	Sr. VP of Clinical Services
BH Medical Director (KEY POSITION ROLE: BH Medical Director)	Dr. John Vanin has served as the Behavioral Health Medical Director at THP since 2015. During his tenure at WVU, he worked in a number of capacities including provision of student mental health at the university. He has also worked as a consulting psychiatrist at various Community Mental Health Centers.	Morgantown, WV	Sr. VP of Clinical Services
Clinical Psychologist	For THP Shelia Kelly serves as a full time Clinical Psychologist. Prior to THP Shelia worked as a Senior Care Manager with Beacon Health where she managed behavioral health benefits for WVFH members. She has over 30 years in clinical practice in WV where much of her work focused on children and youth.	Charleston, WV	Sr. VP of Clinical Services
Director of Medical Management (KEY POSITION ROLE: Director Medical Management)	Susan Klinkoski has been employed in the Care Management area as a Registered Nurse with THP for over seven years. Prior to her employment with THP she worked for over 15 years as a Pediatric and Nursery nurse in the hospital setting.	Wheeling, WV	Sr. VP of Clinical Services
Social Worker III (KEY POSITION ROLE: Director Social Services)	Dawn McCrosky, LGSW, has been a Social Worker with THP for over 20 years. Prior to coming to THP, she worked in the college setting as a student counselor and prior to that she worked in a variety of Pediatric and Newborn capacities.	Wheeling, WV	Director of Medical Management
Manager Care Management Foster	Bobbi Jo Billiter has worked as BH Nurse Manager for THP for the past 4 years. Prior to coming to THP, Bobbi Jo held a number of nursing positions in the	Wheeling, WV	Director of Medical

Care Population (KEY POSITION ROLE: Care Management Director)	region in various behavioral health capacities. She has direct experience with the Foster Care populations giving her a great understanding of the unique challenges of this population.		Management
THP Navigator(s)-RN	1 RN will be hired to fill a new position as a THP Navigator(s). THP requires relevant clinical experience with Care Management experience preferred.	Wheeling, WV	Manager of Care Management Foster Care
THP Navigator(s)-RN BH	2 Behavioral Health RNs will be hired to fill new positions as THP Navigator(s)s. THP requires BH experience with Care Management experience preferred.	Wheeling, WV	Manager of Care Management Foster Care
THP Navigator(s)-MSW	2 Licensed Social Workers will be hired to fill new positions as THP Navigator(s)s. THP requires relevant experience with Case Management experience preferred.	Wheeling, WV	Social Worker III
Clinical Support Advocate	3 advocates will be hired to support the THP Navigator(s)s in the Clinical areas. The Advocates will be responsible for coordination of activities with the members for the clinical team. THP requires advocates in the clinical area to have worked in a patient care or member outreach.	Wheeling, WV	Manager Care Management
SNS Liaison	Tammy Wright serve in the position to SNS Liaison. She has worked as Autism Advocate for THP for the past 2.5 years. She is also a part-time Child Developmental Specialist with the Birth to Three program in West Virginia. Throughout her 30-year career, Tammy has worked extensively with at risk children and their families.	Wheeling, WV	Manager of Care Management
SNS Referral Coordinator	3 referral coordinators will be hired to handle SNS authorizations. THP requires relevant experience in a patient care or social services environment.	Wheeling, WV	SNS Liaison
The following additional staffing will be added to the existing centralized clinical unit to handle additional authorization volumes and utilization management departments to handle authorization requests and concurrent utilization review functions. These functions have been centralized to facilitate single point access by network providers to resources.			
THP Navigator(s)-UM	2 RNs will be hired to fill a new position as UM Navigators. THP requires relevant clinical experience in a facility setting. These positions will be integrated with a team of navigators handling all of THP's patient populations.	Wheeling, WV	Director of Medical Management
THP Navigator(s)-Authorizations	2 RNs will be hired to fill new positions as Authorization/ Referral Navigators. THP requires relevant clinical experience in a facility or physician practice environment. These positions will be integrated with a team of navigators handling all of THP's patient populations	Wheeling, WV	Director of Medical Management

PROVIDER DELIVERY SERVICES ORGANIZATIONAL CHART

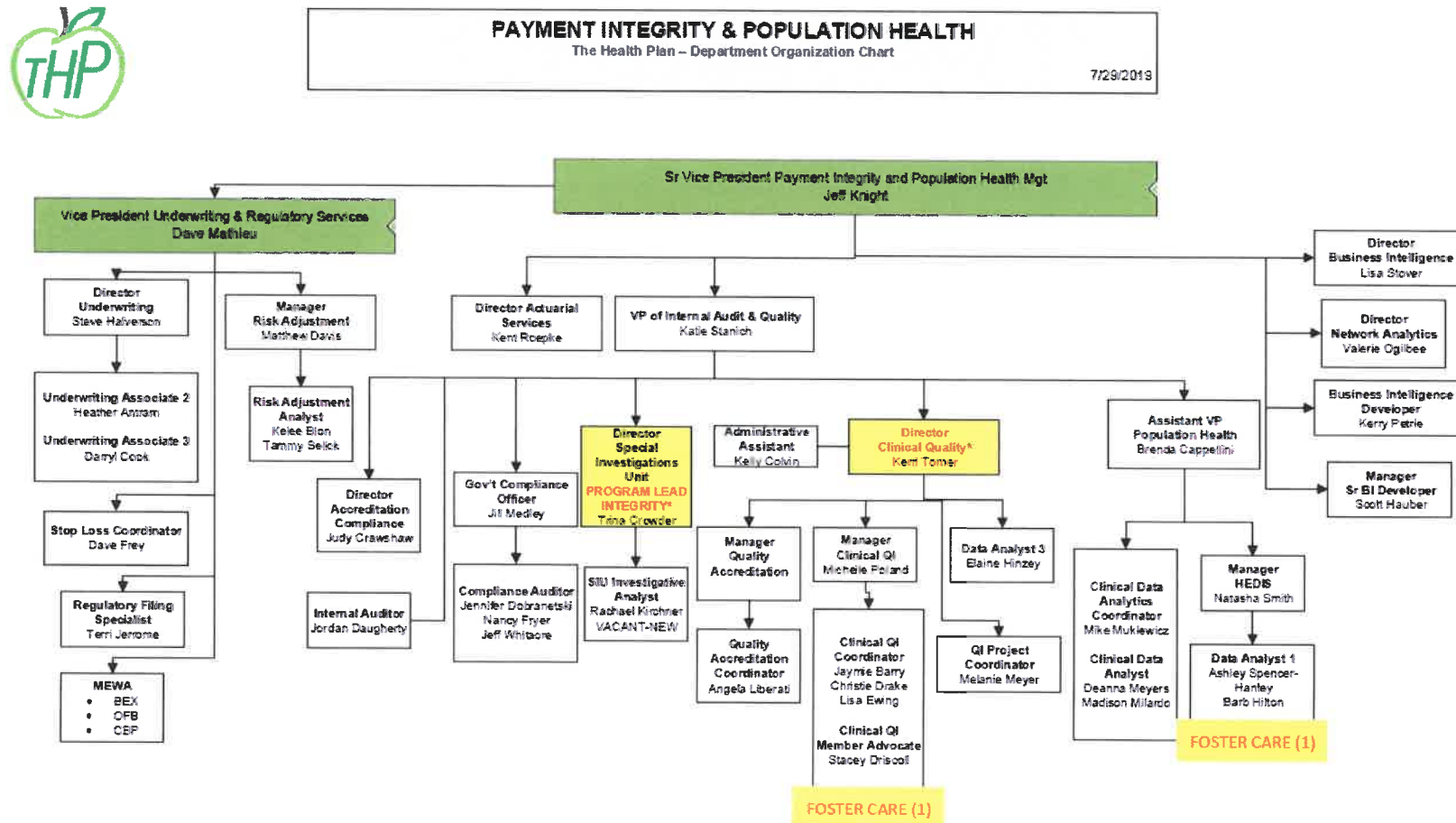
The Provider Delivery Services Department handles all aspects of providing recruiting, contracting, education, credentialing and service. As shown on the chart this department includes the following positions relevant to the RFP:



Provider Delivery Services—Key Position Summary			
Position	Employee Background/ Hiring Plan	Location	Reports To
Senior VP of Provider Delivery Systems	Jason Landers, Senior VP of Provider Delivery Systems, has been employed by THP since May 2018. Prior to his employment at THP, Jason served as the President of WV Family Health for 4 years. Jason played a key role in the acquisition of this Medicaid MCO for Highmark WV. Jason Landers served in other roles with Highmark including leading its value based contracting efforts in WV. Jason has over 25 years of healthcare experience in West Virginia in the managed care arena and as an employee of a regional medical center.	Wheeling, WV	President and CEO
Director of Contracting (KEY POSITION ROLE: Network Development Director)	Deloris Barrett has worked in provider network management for over 24 years. She came to THP over a year ago from Aetna/Coventry in WV where she worked in the network capacity for over 12 years.	Charleston, WV	Senior VP Network
Manager Provider Engagement (KEY POSITION ROLE: Provider Relations Director)	Three individual fill the role of Manager of Provider Engagement in order to allow THP to provide regionalized support of the provider community. The three managers, Kayla Schreve, Barbara Good and Rachel Tignor all provide significant experience dealing with provider issues.	Wheeling, WV Charleston, WV Morgantown, WV	Director Provider Engagement and Quality Initiatives

Payment Integrity & Population Health Organizational Chart

Payment Integrity and Population Health Areas of THP house the quality, data analytics, compliance and Program Integrity functions of the organization. As shown on the chart this department includes the following positions relevant to the RFP:



Payment Integrity and Population Health—Key Position Summary			
Position	Employee Background/ Hiring Plan	Location	Reports To
Senior VP of Payment Integrity and Population Health	Jeff Knight has been a leader in the finance area of THP for over 20 years, serving as CFO and now as Sr. VP Payment Integrity and Population Health. Jeff is a CPA.	Wheeling, WV	President and CEO
VP Internal Audit & Quality	Katie Stanich has lead the Internal Audit, Compliance and Quality areas of THP for the past 4 years. Prior to coming to THP she worked in a similar capacity for Highmark in Pittsburgh.	Wheeling, WV	Senior VP Payment Integrity and Population Health
Director of Special Investigations Unit (KEY POSITION ROLE: Program Lead Integrity)	Trina Crowder, new to THP in March of 2019, is a Certified Fraud Examiner with over 20 years' experience including 12 years with the OIG Medicaid Fraud Control Unit, and approximately 1 year with The Lewin Group as a healthcare fraud subject matter expert advising BMS on strengthening managed care program integrity efforts.	Wheeling, WV	VP Internal Audit and Quality
Director of Clinical Quality (KEY POSITION ROLE: Quality Director)	Kerri Tomer has worked the past 6 years directing THPs quality improvement initiatives. In her 25 years of nursing, she has been responsible for a wide array of quality initiatives.	Wheeling, WV	VP Internal Audit and Quality
Asst. VP Population Health	Brenda Cappellini has worked in various clinical roles at THP for over 20 years. As a Register Nurse with extensive data analytical skills, she brings a creative approach to our population health initiatives.	Wheeling, WV	VP Internal Audit and Quality
Clinical QI Coordinator	1 RN will be hired to fill a new position as a Clinical QI Coordinator responsible for quality projects related to the RFP. THP requires relevant clinical experience with clinical quality experience preferred.	Wheeling, WV	Manager Clinical Quality
Data Analyst	1 data analyst will be hired to fill a new position created to address data requirements of the RFP. THP requires a bachelor's degree in a business or math field with experience using analytical data tools.	Wheeling, WV	Asst. VP Population Health

SUBCONTRACTOR MANAGEMENT

THP's management team has a history of successfully overseeing MCO contracts. In the execution of these successful contracts, THP's management capabilities have developed and improved to meet and satisfy the most rigorous client needs, deadlines and quality control standards. The principles underlying THP's management structure and its approach to delivering the highest quality project results involve:

- Selecting the most qualified personnel available for each technical position;
- Organizing each technical team in a hierarchy that enforces quality control at each level;
- Establishing clear professional performance standards to meet contract requirements;
- Regularly measuring individuals' performance against requirements; and
- Establishing and maintaining direct lines of communication with our subcontractors.

THP's experience and track record of success as an MCO prepares it to internally perform all key functions addressed in the Statement of Work. For this contract, THP has already forged strategic partnerships and relationships with key subcontractors to enhance our capabilities and capacities with resources and/or specialization to staff certain positions non-key personnel. Each subcontractor selected has been selected for specific skill sets and the qualifications of the professionals needed to fulfill the requirements of this contract. The long-standing track record of the organization's team, as well as the specific examples of the organization's performance demonstrates that THP has a team of subcontractors that reflects the competency that THP brings to the DHHR requirements and the MCO services needed.

- When THP does utilize the services of subcontractors, the process will be managed from a single point of contact through a senior member of THP's Management Team. Ms. Christy Donohue will be responsible for the oversight of all subcontractor firms and their compliance with all DHHR standards and WV laws. THP's department leaders will be responsible for all daily subcontracting activities and ensure that all reporting and compliance measures are met.
- THP will select from subcontractor's qualified staff by position available to complete the work assigned and has no "conflict-of-interests". THP has reserved the right to approve each subcontractor staff person submitted to determine skills and experiences meet the position categories.
- Once integrated into the team assembled to accomplish specific areas of responsibility, subcontractor staff will take their direction from the THP department lead. Deliverables or milestones, uniquely the responsibility of subcontractor staff, are given the same scrutiny as from THP employees.
- Our THP Team will prepare and publish an official data specification and file transfer requirement memorandum to all subcontractors who will be responsible for uniform submission of any required third-party reports and following data security protocols. The data specification and file transfer memorandum will also specify uniform invoicing and

billing requirements and the necessary backup procedures required to assure DHHR of accuracy for all invoices.

- THP will require all subcontractors to affirm their understanding, commitment and compliance with all requirements related to the protection of personally identifiable information ("PII"). In addition, all contract documents will include language addressing these Critical PII requirements.
- An example of a redacted subcontractor contract is available in Appendix 4.

THP has expended significant time and resources in the vetting, qualification and selection of each subcontractor. In the following section you will find more detailed information on these companies that will be utilized as part of our subcontracting plan.

THP will utilize our existing partnerships with Superior Vision and Skygen Dental as our subcontractors for this procurement. Both firms are unrelated third-party vendor to THP. They will be performing the below functions for our members under the age of 21.

	Skygen Dental	Superior Vision
Claims Processing	✓	✓
Customer Service- Member and Provider	✓	✓
Member Appeals	✓	
Member Grievances	✓	✓
Provider Credentialing and Contracting	✓	✓
Utilization Management	✓	✓

Currently, these two subcontractors provide an array of monthly, quarterly and annually reports to THP. Some of the reports provided are as followed:

- Provider Network
- Call and claim volume
- Appeals and grievances
- Provider credentialing
- Credible allegation of fraud
- Utilization Management
- Third Party recovery
- Fraud Waste and Abuse
- Financial Reporting

THP will continue to require the existing reporting requirements and structure in addition to any other reports that would be beneficial to this procurement. Examples of reports:

Member and Provider Appeals/Complaints/Grievances Report:

Member Appeals/Complaints/Grievances	
Number of Member Complaints/Grievances Received:	0
Number of Member Authorization Denials	191
Number of Member Clinical Appeals:	2
Member Clinical Appeal Resolution Time:	8.00
Member Clinical Appeal Rate:	1.05%
Member Clinical Appeal Upheld:	0%
Member Clinical Appeal Overturned:	100%

Provider Appeals/Complaints/Grievances	
Number of Provider Complaints/Grievances Received:	0
Complaint Turnaround Time (days):	N/A
Number of Provider Clinical Appeals:	4
Provider Appeal Resolution Time:	8.33
Provider Appeal Rate:	2.1%
Provider Appeal Upheld:	100.0%
Provider Appeal Overturned:	0.0%

Clamis Summary Report:

Insurer: The Health Plan of WV

	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD
Claims Inventory Total Claims	0	0	0	0	0	134	134
Queue Name: Entered							
Queue Total	0	0	0	0	0	118	118
Average Age of Claims in Queue	0.00	0.00	0.00	0.00	0.00	4.35	0.73
Queue Name: Rejected							
Queue Total	0	0	0	0	0	0	0
Average Age of Claims in Queue	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Queue Name: Ready to be Processed							
Queue Total	0	0	0	0	0	0	0
Average Age of Claims in Queue	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Queue Name: Ready to Edit							
Queue Total	0	0	0	0	0	0	0
Average Age of Claims in Queue	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Queue Name: B	JUNE SUPERIOR VISION EXECUTIVE OVERVIEW	
Queue Tr		
Average	PHONE METRICS - MEMBER	
Queue Name: R	TOTAL CALL VOLUME	8,209
Queue Tr	AVERAGE SPEED OF ANSWER (IN SECONDS)	35
Average	ABANDONMENT RATE	2.33%
Queue Name: B	TOTAL CALL VOLUME (INCLUDING ABANDONED)	8,498
Queue Tr	AVERAGE HOLD TIME	23
Average	NUMBER OF STAFF TAKING CALLS	50
Queue Name: B	MEMBERSHIP	
Queue Tr	THE HEALTH PLAN OF WV	31,952
Average	CLAIMS PROCESSING	
Claims Aging L	TOTAL NUMBER OF CLAIMS PROCESSED	533
Claims Aging 3	TOTAL NUMBER OF CLAIMS PAID	23
Greater than 45	TOTAL NUMBER OF CLAIMS DENIED	510
Adjustment Pay	# OF CLAIMS 0-30 DAYS	510
	# OF CLAIMS 31-60 DAYS	0
	# OF CLAIMS >60 DAYS	0
	COMPLAINTS	
	NUMBER OF MEMBER COMPLAINTS	0
	DENIED CREDENTIALING	
	DENIED CREDENTIALING	0

THP will continue to monitor our subcontractor's performance on an ongoing basis. Currently, we meet with our subcontractors on a monthly basis to discuss any identified issue and performance. On a quarterly basis, both subcontractors and THP complete a Joint Operating Committee (JOC) meeting. This meeting is to summarize the performance of the subcontractor for the previous quarter. If a determination is made that one of our subcontractors are not performing, THP will work with the subcontractor to mitigate the concern. If needed, THP can and would place the subcontractor on a corrective action plan (CAP). During the CAP process, THP would work very closely with the subcontractor to ensure the required milestones are being met within the CAP.

In the event a termination would be issued for one of our subcontractors, THP would work to either identify another vendor where the services can be transitioned to or would handle the services in house. THP currently has the capabilities to process both dental and vision claims within our claims processing system and has the ability to contract with the applicable providers. With either solution, THP would ensure our members would still have access to the required services.

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2. Use of Department Staff

THP anticipates a negligible amount of time from DHHR business and technical resources associated with "The Transition." However, we do believe that an efficient and effective transition to Managed Care will require some collaboration with DHHR. Therefore, we believe these support elements would provide the most "Effective Transition", however, they are not anticipated for THPs operational performance.

The nature and extent of Department support required, in terms of staff roles and percentage of time available components that we anticipate requiring some level of collaboration include:

- Department resources to support effective integration with data available through the FACTS system: THP anticipates needing to collaborate with IT professionals in the department capable of providing electronic file formats and data to provide electronic transmission of FACTS system data to THP on an as-required basis.
 - We anticipate 40-60 hours of IT time for implementation after which we believe the process could be automated and any needs to resolve changes and/or issues.
- Department resources to supply detailed information needed for the implementation of the residential and shelter components of the RFP which includes data on providers and payment mechanisms, clarification on process and approval process, and joint development of needed reporting and data feeds.
 - We believe approximately 40 hours of staff time at manager level will be helpful along with an additional 20-40 hours of IT resources for data. On-going we would anticipate 4-8 hours a month for meetings, report reviews and project management input.
- Department resources to provide education on requirements of Socially Necessary Services ASO arrangement including resources to explain established authorization process, to collaborate on potential changes to process, to evaluate reporting and to establish necessary interfaces for on-going communications.
 - We believe approximately 40 hours of staff time at manager level will be needed with an additional 10-20 hours of IT resources for data exchange set up and testing. On-going we anticipate 4-8 hours a month for meetings, report reviews and project input.
- Department resources to supply standard MCO data needed for project implementation include eligibility information, claims history data, authorization files and other standard components typically delivered with an MCO transition.
 - Since this has been provided in the past for other lines of business, we anticipate 10 hours of IT resources will be required.

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3. Key Staff and Resumes

The Key staff resumes have been included in this section below. This staff will serve the key role and provide the leadership within THP for the Specialized Managed Care for Children and Youth Project. THP is fortunate to be able to fill ALL of these positions with in house, experience staff. This is optimal for several reasons:

- **NO NEED TO RECRUIT:** THP will not need to spend time and resources to recruit expertise needed for the project
- **TRAINED ON THP SYSTEMS:** Key staff are already trained on THP systems, Medicaid benefits and other project requirements allowing them to quickly transition to their new roles and responsibilities
- **INTIMATELY FAMILIAR WITH PROJECT SCOPE:** Key staff have been actively involved in RFP preparation and response, so they are fully aware of project plan and requirements
- **WEST VIRGINIA RESIDENCE AND WORK HISTORY:** Key Staff ALL have work history in West Virginia and are personally committed to the State and impact that THP will be able to have toward the improvement of the lives of children and youth in OUR communities.

3.1 Resumes

Table 12: Resumes for Proposed Key Staff

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Christy Donohue	Contract Liaison/Medicaid Administrator	27 years	Yes
Ryan Ralston	Chief Financial Officer	14 years	Yes
Mark Kenamond MD	Medical Director	34 years	Yes
Robert Cross MD	Medical Director	38 years	Yes
Robert Wetzel MD	Medical Director	26 years	Yes
Susan Klinkoski RN	Medical Management Director	20 years	Yes
Bobbi Jo Billetter RN	Care Management Director	20 years	Yes
John Vanin MD	Behavioral Health Medical Director	38 years	Yes
Sheila Kelly, MA	Behavioral Health Medical Director	40 years	Yes
Dawn McCroskey	Social Services Director	27 years	Yes

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Tammy Wright	SNS Liaison	30 years	Yes
Kerri Tomer	Quality Director	25 years	Yes
Lisa Hawkins	Member Services Director	25 years	Yes
Steve Brucker	Claims Payment Director	13 years	Yes
Deloris Barrett	Network Development Director	24 years	Yes
Barbara Good	Provider Relations Director	24 years	Yes
Kayla Shreve	Provider Relations Director	5 years	Yes
Rachel Waybright Tignor	Provider Relations Director	10 years	Yes
Trina Crowder	Program Integrity Lead	20 years	Yes
Bob Roset	Information Technology Director	32 years	Yes
Joshua Austin	Community Engagement Director	5 years	Yes
Diane Palletta D.D.S	Dental Director	35 years	Yes
Jeanette Williams	Medicaid Member Advocate	9 years	Yes

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CHRISTY DONOHUE

CONTRACT LIAISON/MEDICAID ADMINISTRATOR

PROFILE

Ms. Christy Donohue is an experienced project manager with over twenty-five years of demonstrated project operations experience. Her expertise is comprised of a hands-on direct approach in every aspect of managing a project. For several multi-million dollar contracts, she has been responsible for one-hundred-plus person teams in every arena of the system's scope of work ranging from client, provider, EDI, member, change management/problem management, developing policies and procedures and operations including budgets, service level agreement, quality control, and organizational strategic objectives. Further, she has extensive experience with implementing changes within an organization, ranging from new policies, root cause analysis, adding additional lines of business or in changes within the scope of the contract. Throughout her career, she has been responsible for communication with large healthcare providers, government agencies, staff and clients and has led several successful audits which were completed with no findings. Her leadership abilities are utilized on a day-to-day basis with clients and staff and she possesses excellent communication and organizational skills.

EDUCATION AND TRAINING

- A.A., Applied Science; West Virginia State College, Institute, WV; 1994
- B.A., Organizational Leadership; University of Charleston/ Mountain State University, Beckley, WV

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia **Assistant Vice President Medicaid**

February 2015 – Present

Oversees and manages the Medicaid line of business within The Health Plan. As the AVP, executes the contract with BMS, which encompasses operations, medical, behavioral health and regulatory. She is also the primary contact for the contract with WV Medicaid. Additional duties include investigating and resolving access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations and beneficiaries. Monitors formal and informal grievances with the grievance personnel to look at trends or major areas of concern and discuss these reports with community advocates. Ms. Donohue functions as a primary contact for beneficiary advocacy groups and work with these groups to identify and correct beneficiary access barriers. Analyze systems functions through meetings with staff and organizes and provides training and educational materials for MCO staff and providers to enhance their understanding of the values and practices of all cultures with which the MCOs interact.

CNSI, Gaithersburg, MD **Operations Manager**

December 2011 – Present

Worked on several projects since joining CNSI. Currently, Ms. Donohue is responsible for the Data Service Hub Project. This project is associated with the Health Information Exchange as it relates to the Affordable Care Act (ACA). As the manager of this project, Responsible for overseeing the EDI implementation and operations. Previously, as the operations project manager, was responsible for providing oversight and management support for the operations implementation project for the state of Louisiana. Within her role as the operations project manager, was responsible for ensuring the subcontractor on the project was executing and meeting all the requirements stated in the contract. She worked closely with the subcontractor and client in developing policies and procedures related to the implementation of the project and completed root cause analysis on issues that arose within the project. In addition to her project role, supported multiple MMIS proposal submissions for CNSI with emphasis on recruitment of staff and documenting operations procedures.

Molina Medicaid Solutions/Unisys Corp.

July 2005 – December 2011

Charleston, WV - Deputy Account/Project Manager

As the deputy account manager, was directly responsible for the MMIS fiscal agent system day-to-day operations, including the areas of claims, mailroom, provider relations, pharmacy, quality assurance, and other contract-specific functions. In the absence of the account manager, was also the primary point of contact for BMS as it related to operations. served as the fiscal agent representative in the Medicaid Services Advisory Council. She ensured that contractual requirements, including SLAs, were fully executed and fulfilled. She developed budgets and acted as the internal liaison with each of the MMIS units, facilitating communications in order to prepare operations reports for the mandatory meetings in which she served as the site representative.

With Ms. Donohue' oversight, the annual SAS70/SSAE 16 audit was successfully completed for three years with no findings or qualifications. In 2006, Ms. Donohue participated in the certification process of the existing MMIS system and was hands-on in the overall management of the scope of the \$25 million project, as well as in the leadership and direction of the 100+ employees on a daily basis. Worked in collaboration with BMS to define processes and procedures related to the new ARRA guidelines. These processes and procedures allowed BMS to obtain their additional FFP match on specified claims. Was also responsible for developing and managing the weekly flash report which outlines weekly operation statistics. In conjunction with the executive account manager, she worked to establish annual performance goals with the department managers so that department goals supported the overall account-level objectives. As an ongoing quality assurance measure, she facilitated the weekly management review process of key operations to include performance measurements, goal achievement and initiative progress status reports.

Led the implementation of the Bureau of Health and Health Facilities (BHHF) onto the MMIS system and participated in the requirement sessions for the upcoming implementation for the U.S. Virgin Islands. Under her direction, Molina successfully implemented their provider incentive payment system in 2011.

Carelink Health Plans, Charleston, WV

January 2001 - July 2005

Senior Provider Relations Representative

As the senior provider relations representative, Ms. Donohue assessed, recruited, and organized vendors for the Medicaid, HMO and PPO provider networks. Ms. Donohue was the primary contact for a number of specific provider groups within the state of West Virginia, spearheaded annual workshops throughout the state, and investigated claims issues for providers. She negotiated complex contracts with physicians, ancillary, and hospital providers and acted in an advisory capacity to the legal department with regard to the financial and legal impact of provider contracts. She managed and oversaw the quality of the customer service given to the provider practice by resolving problems and advising and documenting on new protocols, policies and procedures. Ms. Donohue was responsible for overseeing compliance of Network Management for the applicable accrediting body (URAC). Further, she was responsible for contracting with large hospitals and PHOs within West Virginia regarding Commercial and Medicaid business and investigated claims issues for providers.

PrimeONE, Charleston WV

April 1996 - June 2000

Customer Service Supervisor

As the customer service supervisor she was responsible for the hiring and training of all new customer, provider, and grievance coordinator representatives. She developed and implemented the quality and production incentive program for employees. Was responsible for the quality and output of the provider and member call centers; specifically, she maintained and managed over 60 employer groups.

RYAN RALSTON

CHIEF FINANCIAL OFFICER

PROFILE

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

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV

August 2016 – Present

Chief Financial Officer, Director of Finance

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

Aladdin Food Management Services, LLC, Wheeling, WV

September 2012 – July 2016

Vice President of Finance, Controller

As the vice president of finance, Mr. Ralston was responsible for all aspects of the financial management, month-end close and financial reporting, and budgeting functions for four businesses with combined revenues of \$140MM and 2,500 employees. He supervised and managed an accounting and finance team consisting of ten team members. Mr. Ralston served as a strategic partner to the Company's president with responsibility for analyzing the current state of the business, identifying financial and operational areas of improvement, and setting the strategic and financial directions of the business. Mr. Ralston evaluated all new business opportunities from both a strategic and financial perspective to ensure the opportunities aligned with the Company's strategic and financial goals. He also evaluated and approved all capital expenditures, including developing financial models to ensure all investment hurdles were achieved. Mr. Ralston was selected to be a part of the Elor North America (Aladdin's parent company) CEO's leadership and mentoring council. The council was established to further develop high-performing employees with the potential for significant advancement in the organization; six individuals were selected to the council out of over 10,000 employees.

RTI International Metals, Inc., Pittsburgh, PA

July 2011 - September 2012

Manager of Operational Finance

As the manager of operational finance, Mr. Ralston led the integration of all domestic and international acquisitions from a finance and accounting perspective, including all purchase accounting and post-acquisition accounting. The acquisitions ranged in size from \$40MM to \$185MM. He served as the interim controller of a \$70MM manufacturing facility; his responsibilities included the daily oversight and execution of all accounting and finance activities, including the implementation of internal controls as required by the Sarbanes-Oxley Act. He developed and prepared valuation and strategic models to evaluate the financial and strategic fit of subsidiaries and presented significant findings to executive management so they could evaluate potential divestitures. Mr. Ralston also analyzed financial and

operational performance to prepare monthly and quarterly financial reporting and analysis for executive management, the Board of Directors, and SEC regulatory filings. He developed a process for systematically evaluating the financial merits of the Company's research and development activities. Mr. Ralston drove reductions in net working capital by implementing policies and procedures related to sales discounts and aged inventory.

KPMG LLP, Columbus, OH

September 2005 - July 2010

Audit Manager, Senior Associate, Associate

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

MARK C. KENAMOND, M.D.

MEDICAL DIRECTOR

PROFILE

Dr. Kenamond has served as Medical Director for The Health Plan for the past 9 years. Dr. Kenamond is a Board Certified Radiologist with 25 years' experience in Diagnostic Radiology prior to joining The Health Plan. As Medical Director, Dr. Kenamond provides physician oversight for activities related to Utilization Management, Disease Management, and Quality Management programs ensuring compliance with NCQA, Medicare, Medicaid, and other regulatory entities

BOARD CERTIFICATION AND LICENSURE

- Board Certified, American Board of Radiology, June 1989 – Present
- West Virginia Board of Medicine, License Number: [REDACTED] Current
- State Medical Board of Ohio, License Number: [REDACTED] Current

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan **Medical Director**

2010 - Present

Dr. Kenamond has been employed at The Health Plan since 2010 as a Medical Director.

Wetzel County Hospital **Staff Radiologist**

2003 – 2006

While employed at Wetzel County Hospital, Dr. Kenamond practiced diagnostic radiology, interpreting X-Ray, MRI, PET, CT and Ultrasound studies, among others

Ohio Valley Medical Center, Wheeling, WV **Staff Radiologist**

1990 - 2010

While at Ohio Valley Medical Center, Dr. Kenamond practiced diagnostic radiology, interpreting X-Ray, MRI, PET, CT and Ultrasound studies, among others. He was also a preceptor for medical students, interns, and residents from 1989 – 2010. Dr. Kenamond was Chairman of the Department of Radiology from 1999 – 2003 and President of the Medical and Dental Staff 2000 – 2002.

East Ohio Regional Hospital **Staff Radiologist**

1990 - 2010

Dr. Kenamond worked at EORH for 20 years where he practiced diagnostic radiology, interpreting X-Ray, MRI, PET, CT and Ultrasound studies, among others.

Wheeling Clinic **Radiologist**

1990 – 1999

Dr. Kenamond practiced diagnostic radiology, interpreting X-Ray, MRI, PET, CT and Ultrasound studies, among others.

Bellaire City Hospital **Staff Radiologist**

1990 - 1999

Dr. Kenamond started his career at Bellaire City Hospital as a diagnostic radiologist, interpreting X-Ray, MRI, PET, CT and Ultrasound studies, among others.

ROBERT L. CROSS, M.D., F.A.C.S.

MEDICAL DIRECTOR

PROFILE

Dr. Cross has 38 years' experience as a general surgeon. In 2015 Dr. Cross came to The Health Plan as a medical director and has served in this capacity for the past 4 years. As Medical Director at The Health Plan Dr. Cross is required to maintain an active physician license without restriction in Ohio and West Virginia, as well as being board certified. He must meet all THP credentialing requirements, have at least 3 years managed care experience and a minimum of 5 years post graduate clinical experience. Dr. Cross provides physician oversight for activities related to the company's Utilization Management, Disease Management and Quality Management programs ensuring compliance with NCQA, Medicare, Medicaid, Ohio BWC and other regulatory entities. As a medical director, he also works with Network Development staff to develop and coordinate effective provider education/intervention programs including providing input into provider training and education programs, review of provider manuals and direct contact with providers as needed.

EDUCATION AND TRAINING

- National Board of Medical Examiners, 7977
- American Board of Surgery, 1983, Recertified in 1991, 2001, 2011
- Licensed in Ohio and West Virginia, 1981 - Present

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan **Medical Director**

2015 – Present

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

East Ohio Regional Hospital **Chief of Surgery**

1981 - 2015

Dr. Cross started his career in general surgery at East Ohio Regional Hospital in 1981. During his time there he worked his way from a General Surgeon to Chief of Surgery (1986). Dr. Cross also held the President Elect (1987) and President (1988, 2003 and 2004) of the medical staff positions. Dr. Cross was the Trauma Medical Director from 2003 to 2015 and the Chairman of Quality Improvement from 2000-2012.

Ohio Valley Medical Center, Wheeling, WV **Chief of Surgery**

1981 - 2015

Dr. Cross also started at Ohio Valley Medical Center at the same time as its affiliate East Ohio Regional Hospital. Dr. Cross was also a general surgeon at OVMC from 1981 until he became Chief of Surgery in 1986. From 1988-1990 Dr. Cross was the Vice Chairman of the Department of Surgery, 1991-1996 he was the Chairman of the Department of Surgery and 2012 to 2015 he was the Chairman of the Breast Committee.

Wheeling Hospital, Wheeling, WV **General Surgeon**

1984 – 2015

Dr. Cross was employed as a Board Certified Surgeon at Wheeling Hospital for 31 years. During his time at Wheeling Hospital Dr. Cross performed various surgical procedures.

PROFESSIONAL AFFILIATIONS

American Society Breast Surgeons

Fellow American College of Surgeons

Pittsburgh Surgical Society

Eastern Association for the Surgery of Trauma

Ohio County Medical Society

Ohio Committee on Trauma

Belmont County Medical Society

WV State Medical Association

Ohio State Medical Association

ATLS Certified/ Course Director and Instructor

Certified in Stereotactic Breast Biopsy by the American Society of Breast Surgeons in February 2013

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

MEDICAL DIRECTOR

PROFILE

Dr. Wetzel has 26 years' experience as an Obstetrician and Gynecologist. In 2015 he came to The Health Plan as a part time medical director and has served in this capacity for the past 4 years. Dr. Wetzel still maintains his own practice and sees patients part time, as well as teaching one and a half days a week. As Medical Director at The Health Plan he is required to maintain an active physician license without restriction in Ohio and West Virginia, as well as being board certified. He must meet all THP credentialing requirements, have at least 3 years managed care experience and a minimum of 5 years post graduate clinical experience. He provides physician oversight for activities related to the company's Utilization Management, Disease Management and Quality Management programs ensuring compliance with NCQA, Medicare, Medicaid, Ohio BWC and other regulatory entities. As a medical director, he also works with Network Development staff to develop and coordinate effective provider education/intervention programs including providing input into provider training and education programs, review of provider manuals and direct contact with providers as needed.

CERTIFICATIONS AND LICENSURE

- Fellow American College of Obstetrics and Gynecology (Armed Forces District)
- Diplomatic, Board of Obstetrics and Gynecology [REDACTED]
- State of West Virginia Board of Medicine [REDACTED]
- State Medical Board of Ohio # [REDACTED]

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan

2015 - Present

Medical Director – Part Time

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

West Liberty University, West Liberty, WV

2013 - Present

Teaching Staff

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

East Ohio Regional Hospital, Martins Ferry, OH

1998 - Present

Obstetrics and Gynecology

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

Keesler Medical Center, Keesler Air Force Base, Mississippi

1995 - 1998

Director of Gynecology

Returned to Keesler Medical Center in August 1995, and became part of the teaching staff and Director of Quality Assurance until June 1996. Also during part of this time period, Dr. Wetzel was working as a Medical Law Case Reviewer to the Surgeon General from December 1995 – June 1998. Dr. Wetzel became the Director of Obstetrics and Gynecology and maintained this status from June 1996 – June 1998 when he relocated to the Ohio Valley.

Robbins Medical Center, Robins Air Force Base, Georgia

1993 - 1995

Chief of Obstetrics and Gynecology

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

Keesler Medical Center, Keesler Air Force Base, Mississippi

1989 – 1993

Residency

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

PROFESSIONAL ORGANIZATIONS AND AWARDS

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

SUSAN KLINKOSKI, BSN, RN, CCM

MEDICAL MANAGEMENT DIRECTOR

PROFILE

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

EDUCATION AND TRAINING

- Certified Case Manager 2014 to present by the Commission for Case Manager Certification
- Active RN Licensure in Ohio, West Virginia, Pennsylvania and Kentucky

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV

2012 - Present

Director of Medical and Behavioral Management

Began THP career as a Case Manager with oversight of a member caseload of approximately 200 medically complex members across all lines of business. Developed electronic medical record to meet and maintain NCQA standards. Developed and integrated related case management reports for reinsurance for ASO/TPA clients. Onboarded new case managers. Developed and implemented quality and productivity monitoring for clinical staff. Served as Supervisor of Case Management prior to being promoted Manager of Medicaid Clinical Services in 2017. Oversight of all aspects of preauthorization for Medicaid including appeals process up to and including state fair hearings. Developed/wrote policy and procedure including the THP coverage guideline for private duty nursing as well as clinical workflows. Participated in weekly MCO meetings in Charleston as clinical representation and had daily interaction with BMS staff including interaction with Children with Special Healthcare Needs. Developed and wrote the workflow for all MCO case management interaction with CSHCN. In 2018 promoted to Assistant Director of Medical Management where my responsibility returned to program and staff oversight for all lines of business. Participate in Medical Director Oversight Committee, Transplant and Technology Committee, STARS, Medicaid Operations, Securecare Operations, Continuous Quality Improvement, NCQA Preparation and HEDIS Task Force for direction of policy. In charge of all medical managerial staff. Maintained responsibility for analysis of unit quality, productivity and staffing. Promoted to Director of Medical Management in the Fall of 2018. Continues to sit on all committees mentioned above, serves as liaison to community organizations and providers. Coordinates and presents talks to hospital facilities describing THP programs and how to access them, Transplant Integration and support sales for the TPA/ASO lines of business as needed. Writes policy and procedure, provider manual updates, provider and member newsletter articles as well as request for proposals and/or information. In 2019 additionally assumed responsibility for integration of THP Behavioral Health Unit into a unified Clinical Service model assimilating an additional 27 direct care behavioral health professionals and 2 behavioral health RN managers into a holistic, person centered, care focused unit.

Ohio Valley Medical Center, Wheeling, WV

1998-2012

Staff Nurse and Charge Nurse Pediatrics and Newborn Nursery

Full time staff RN and charge nurse with rotating shifts in level 2 nursery and community hospital pediatric unit. Performed patient care, order entry, unit budgeting/supply maintenance and oversaw unit staffing schedule. Maintained Pediatric Advanced Life Support, Neonatal Resuscitation Protocol Certification and Pediatric Trauma Certification. Taught hospital based community classes for parenting, childbirth and lactation.

Interim Home Health, Bridgeport, OH

2000-2003

Per Diem Private Duty Nurse

Registered Nurse provided skilled visits on a case by case basis for complex pediatric cases in the home setting. Drew labs, performed family teaching, hung hyperalimentation, provided IV therapy, assessed/documented, coordinated admits from home.

Fox Run Hospital, St. Clairsville, Ohio

1996-1998

Evening Shift RN House Supervisor

Registered Nurse House Supervisor responsible for after-hours emergent intake assessments for behavioral health inpatient acute unit. Reported directly to Director of Nursing and called intake assessment results to staff psychiatrists for inpatient certification. Coordinated all after- hours emergent medical and behavioral care. Oversaw all clinical staff on 3-11pm shift for both acute and residential pediatric units including RN, LPN and Mental Health Technicians. Performed regular staff in-services and trainings including CPR and first aid. Audited group therapy sessions conducted by RN nursing staff and performed RN clinical quality and productivity evaluations.

Heinzerling Foundation, Columbus, OH

1994-1996

Staff Nurse and Relief House Supervisor ICF/MRDD

Full time RN/Relief House Supervisor for an intermediate care facility in Central Ohio with 2 buildings serving 110 adults and 110 children with severe to profound mental retardation and developmental disabilities. Provided daily care as a staff nurse for severe behavioral unit in the pediatric facility. Participated on the habilitation team, attended specialist appointments and interacted with providers, families and staff therapists to support member care and habilitation goals. Performed evening shift House Supervisor Duties supervising staff, responding to emergencies and supervising on-site dental clinic for residents which operated during evening hours.

BOBBI JO BILLETTER RN, BC, BS, CMCN

CARE MANAGEMENT DIRECTOR

PROFILE

A registered nurse with board certification in mental health nursing. She has over 20 years of experience in the mental health field. The majority of her experience has been in providing services to children and adolescents who have been diagnosed with mood disorders, impulse control and addiction disorders, personality disorders, anxiety disorders, psychosis, and co-occurring or dual diagnosis disorders. She has had oversight in the structured services provided to children and adolescents to decrease disruptive behaviors and to address maladaptive thought processes in adolescents who are court ordered for services related to conduct disorders and oppositional defiant disorder. She has worked closely with children's services and the court system in cases of abuse and neglect, foster placement, and reunification services. She has experience in acute and emergent admissions, residential placement, and outpatient services. She is knowledgeable of process implementation as well as transitional services in the managed care organization.

EDUCATION AND TRAINING

- Registered nurse
- Board Certified in Mental Health Nursing - American Nurses Credentialing Center
- Bachelor of Science degree in Healthcare Management- Franklin University in Columbus, Ohio
- Certified Managed Care Nurse

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, West Virginia
Manager of Behavioral Health Services

2015-present

Developed the Behavioral Health Transitional program for the social security population. Responsible for Care Management services for all lines of business, all Utilization Management Services, Hospital Review, Authorizations, and Prior Authorizations. Implemented transitional process for Substance Abuse Waiver Program.

Forest Hills Retirement Center, Saint Clairsville, Ohio
Registered Nurse

2015-2015

As a registered nurse, provided skilled nursing services to a diverse population. Participated in the nursing process by assessing, planning, implementation, and evaluation of services provided.

Country Club Retirement Center, Bellaire, Ohio
Director of Nursing

2014-2015

As the Director of Nursing, was responsible for all clinical services provided to the patients in a 100-bed skilled facility which included Assisted Living and Independent Living services.

Weirton Medical Center, Weirton, West Virginia
Director of Clinical Services

2012-2014

Responsible for the coordination of services for the geropsych population on a 12 bed secure unit. She coordinated, planned, and managed all nursing activities, formulated nursing program goals and objectives, and managed the nursing budget.

Barnesville Healthcare Center, Barnesville, Ohio
Director of Clinical Services

2011-2012

Responsible for the clinical services provided to patients in a 100-bed skilled nursing facility.

Northpoint Consulting, Saint Clairsville, Ohio
Nursing Supervisor

2010-2011

Provided nursing services to clients with mental health and substance abuse disorders. She worked closely with foster care agencies as well as the court system in providing outpatient services to children and adolescents who had been removed from the home and those who were court ordered into treatment. She provided oversight to the case managers who provided socially necessary services and in-home support to clients.

Pomegranate Health Systems, Cambridge, Ohio

2019-2010

Chief Operations Officer/Director of Clinical Services

Responsible for the operation of a 54-bed psychiatric facility and a 70-bed residential facility. Successfully developed and implemented the addition of a 10-bed acute unit to serve adolescents directly involved in the court system. Obtain a dual licensure through the Department of Mental Health and the Department of Alcohol and Drug Addiction Services. Secured Joint Commission accreditation upon the initial survey. As a trained trauma informed care nurse, worked directly with abused and neglected children and their families in collaboration with Franklin County Children's services in Columbus, Ohio.

Wheeling Hospital, Wheeling, West Virginia

2008-2009

Joint Commission Coordinator

Successfully established compliance with regulatory agencies for services that included cardiovascular, intensive care, surgical, trauma, and the visiting nurses association.

Appalachian Behavioral Healthcare, Cambridge, Ohio

2002-2008

Psychiatric Nursing Supervisor

She worked directly with the judicial system in court appointed treatment for a variety of issues which included reunification plans. She was involved in the interface between the legal system and children's services. She was a trainer for the State of Ohio for Emerging Best Practices in Mental Health. She served on state wide committees which included Nursing Standards of Care, Pharmacy and Therapeutics, and the Electronic Medical Records steering committee.

Fox Run Hospital, Saint Clairsville, Ohio

1991-2002

Nurse Manager of the Acute Unit

Responsible for assessing children and adolescents experiencing difficulty associated with trauma and other mental health related issues. Her approach in helping children who have experienced sexual, physical, and emotional abuse was individualized and personalized to the child. She worked with children who had severe behavioral problems, self-esteem issues, thought disorders, adjustment disorders, self-injurious behaviors, ineffective coping skills, abuse and neglect. She also worked with children and adolescents with developmental disabilities and co-occurring mental illness. She played a significant role in a multi-disciplinary approach to the treatment of medical, psychiatric, social, and academic needs. Her focus was on the provision of services in a safe and structured setting. Her experience in the discharge planning process included coordination social service agencies, juvenile probation officers, and other mental health professionals to establish a plan that provides ongoing support of the family at discharge.

JOHN R. VANIN, MD, DLFAPA

PSYCHIATRIC CONSULTANT- BEHAVIORAL HEALTH MEDICAL DIRECTOR

PROFILE

Dr. John Vanin is a board certified psychiatrist with over 38 years of clinical, teaching and administrative experience. He serves as the Behavioral Health Medical Director for The Health Plan, working with the behavioral health and medical staff. Duties include reviewing in-patient censuses, psychological/neuropsychological testing requests, and urine drug testing requests. Dr. Vanin serves on THP Quality Improvement Committee, THP Physician Advisory Board, and THP Medical Director Oversight Committee. Dr. Vanin was the Director for Mental Health/Health Education at the WVU Student Health Service for over 25 years, overseeing clinical, educational and administrative areas of student mental health. He was Professor of Behavioral Medicine and Psychiatry/Family Medicine at WVU, supervising and teaching psychiatric residents. He is currently Professor Emeritus of Behavioral Medicine and Psychiatry. After obtaining his M.D. degree, and completing residencies in both Psychiatry and Family Practice, Dr. Vanin was a USAF Psychiatrist and served as Chief of Mental Health and as an Attending Psychiatrist/Resident Supervisor. He achieved the rank of Major, received the USAF Commendation Medal for Meritorious Service and is proud to have served as a medical officer in the U.S. military. He is a Distinguished Life Fellow of the American Psychiatric Association and a Past-President of the WV Psychiatric Association. Dr. Vanin served as a psychiatric consultant during his career, working as a pension and compensation examiner at a Veterans Administration Medical Center and cared for patients at various Community Mental Health Centers. Dr. Vanin has given numerous local, state and national presentations and has published widely on clinical aspects of anxiety disorders, depression, adult ADHD, and psychiatric medications. In addition, he is a co-editor/author of a book titled Anxiety Disorders – A Pocket Guide for Primary Care and also a co-author of NCAA Guidelines for the Treatment of Athletes with ADHD. Dr. Vanin is a long-time member of the WV Drug Utilization Review Board, a DHHR board responsible for the establishment of standards and criteria for drug utilization.

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan

2014 -Current

Psychiatric Consultant/ BH Medical Director

Dr. Vanin has served as Behavioral Health Medical Director for The Health Plan for the past 5 years. He carries out a variety of functions such as utilization and quality reviews of psychiatric/psychologic services, substance use disorder treatment programs and behavioral health crisis facility stays. He is also active in all other Medical Director functions including committees (MDOC, T&T, etc.) and Grand Rounds (Internal/External Complex case reviews).

Community Mental Health Centers

2011-2012

Psychiatric Consultant/Staff Psychiatrist

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

Louis A. Johnson VA Medical Center Clarksburg, WV

2011-2014

Psychiatric Consultant (Compensation & Pension Exams)

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

WVU Student Health Service

1985-2011

Director, Mental Health/Health Education

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

WVU School of Medicine

1985-2011

Professor, Behavioral Medicine & Psychiatry/Family Medicine

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

WVU Department Behavioral Medicine and Psychiatry

as of 2011

Professor Emeritus

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

HONORS AND AWARDS

USAF Commendation Medal

Diplomat, American Board of Psychiatry and Neurology

Distinguished Life Fellow, American Psychiatric Association

Past-President/Member, WV Psychiatric Association

SHEILA EMERSON KELLY, MA, NCSP

BEHAVIORAL HEALTH MEDICAL DIRECTOR

PROFILE

Sheila Kelly is a licensed psychologist, certified school psychologist and retired nationally certified school psychologist. She has a broad range of clinical and leadership experience, having lived and practiced in West Virginia for over 40 years. As a private practice psychologist, she performed psychological assessments on literally thousands of children and adults, spending two years or more as a consulting psychologist with KVC services evaluating at risk children and families. As a government employee and director for Behavioral Health Services for OHFLAC, she was personally responsible for convening large groups of stakeholders in order to review and revise numerous state rules regarding behavioral health, most relevantly the children's residential treatment rule, which has remained in place, with amendments, since approximately 2005. She excels in working with groups of diverse stakeholders in order to reach consensus regarding a road forward. Her last efforts in this arena resulted in the most recently enacted rule for Behavioral Health Services. She is intimately familiar with Medicaid policies and practices, having served on multiple Medicaid committees during her tenure with BHMF and the Hartley Court Monitor's Office. She has served as president of the West Virginia Psychological Association, the West Virginia Association of Professional Psychologists, and the West Virginia Behavioral Health Provider's Association, as well as serving on their executive committees for several years. She spent the last three years as the Market Clinical Liaison for Beacon Health Options and acquired broad knowledge of Case Management and Utilization Management practices as applied in the MCO environment. Her contacts and relationships across the behavioral health system in West Virginia are diverse and warmly personal.

EDUCATION AND TRAINING

- Clinical Psychology [REDACTED]
- Independent School Psychology Practitioner [REDACTED]
- Nationally Certified School Psychologist

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan

July 2019 to Present

Licensed Psychologist

Beacon Health Options

January 19, 2016 to July 2019

Market Clinical Liaison/Senior Care Manager

As a care manager Ms. Kelly was responsible for the linkage to behavioral health services of 60,000 West Virginia Family Health Plan (Medicaid Managed Care) Members. This involves working with consumers and providers, as well as key partners in West Virginia DHHR. Much of her work was performed by telephone at home, however, she traveled across the state to visit providers, including hospitals and community mental health agencies, to attempt to address systems issues that impair access to services for consumers. The position required considerable data maintenance using the Beacon system and use of Outlook/email systems. She serves as the clinical coordinator for the West Virginia plan.

Starlight Mental Health Clinic

December 1, 2013 to January 16, 2016

Clinical Director

Ms. Kelly was responsible for management of the staff and operations of two mental health clinics for children and adults with over 1000 patient contacts per month, an Assertive Community Treatment Team, a suboxone program providing care for 70 plus patients and grant writing and program development in a multi-county area. The position required negotiation and contract management of four managed care contract as well as numerous commercial insurers and Medicare. Ms. Kelly also served as a member of QI Council of West Virginia Family Health Plan. In addition the clinic director provided a certain amount of direct service including intake assessment, psychological testing and psychotherapy.

**Office of the Hartley Court Monitor
Special Assistant**

November 1, 2009 to December 1, 2013

Ms. Kelly was responsible for tracking and analysis of civil commitments across the state and for preparing formal reports to the Court. In addition, as Special Assistant Ms. Kelly volunteered to coordinate development of a new behavioral health regulation for the state, amendment of Chapter 27 of the West Virginia Code, and preparation of policy for investigations of abuse and neglect in licensed behavioral health facilities. She additionally served as the Office's representative on a variety of DHHR committees and project groups.

**WV Healthcare Authority
Healthcare Policy Authority**

October 1, 2008 to November 1, 2009

Ms. Kelly was responsible for analysis of proposed general healthcare services including fiscal projections, utilization projections and quality, accessibility and value of services as well as preparation of legal decisions of the Healthcare Authority. Other special projects included staffing the Quality Obstetrics Collaborative and the Healthcare Associated Infection Control Advisory Panel.

**Private Practice, Part Time
Clinical Psychologist**

July 1987 to August 2012

Ms. Kelly was responsible for assessment and psychological testing of full range of adults and children for a variety of reasons –forensic, clinical, academic. Ms. Kelly has a history of over two year's consultation with Action Youth Care on clinical issues of provision of care (to some degree supervision of clinical staff). She has had contractual employment with numerous Boards of Education for school intellectual and academic evaluations. She also has several years of contracting with Dept. of Corrections for personnel evaluation of Corrections Officers in all state facilities.

DAWN L. MCCROSKEY, LGSW

SOCIAL WORKER

PROFILE

Ms. McCroskey has been a Social Worker for 27 years. Throughout her career, she has had the pleasure of holding a variety of rewarding positions that has given her a considerable knowledge and expertise. Her past expertise continues to benefit clients with whom she encounters in her current position. She is a compassionate professional which aids her in career choice as she feels that everyone should be shown compassion at their time of need. She is affective at utilizing community resources to assist her clients in needs as presented to her. She is an integral part of The Health Plan and works very well with her co-workers. She feels that a multi-disciplinary approach is very beneficial to clients and leads to most successful outcome.

EDUCATION AND TRAINING

- BSW, West Virginia University, Morgantown, WV May 1991
- MSW, West Virginia University, August 1992
- LGSW, West Virginia Board of Social Work – Last renewed in November 2018

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV **Social Worker**

February 2008 - Present

Ms. McCroskey has been employed as a licensed social worker for this health insurance company for over 11 years. The Health Plan offers coverage across many lines of business including commercial, self-funded, as well as Medicare and Medicaid. Ms. McCroskey receives referral from multiple departments within the organization and has also been called upon from outside agencies. Some frequent needs that she has to address are typically outside of health insurance benefits and include problems affording copayments and coinsurance on prescription and medical care, housing problems, needing assistance in the home to continue to live independently. She also provides supportive services to members needing counseling, education, and encouragement to maintain an overall healthy life.

West Liberty State University, West Liberty, WV **Retention Specialist/Counselor (full-time)** **Adjunct Instructor (part-time)**

August 2006 - February 2008
November 2008-Dec. 2014

As counseling/retention specialist, Ms. McCroskey provided supportive and counseling services to students needing guidance to maintain success in their education and life responsibilities. She assisted students struggling with adjusting to college, family and peer relationships, finances, D&A, as well as behavioral health issues, especially anxiety and depression. In her role as instructor, she affectively taught health courses covering many issues such as drugs/alcohol, sexuality, behavioral health, issues in the news including healthcare and violence.

Children's Hospital of Pittsburgh, Pittsburgh, PA **Social Worker**

November 2003-August 2006

Ms. McCroskey was a medical social worker at this world class hospital. Her responsibilities were to provide social work services to families caring for children at home on mechanical ventilation (birth – 21). She assisted with respite coverage, shift nursing, financial concerns and community resources. It was also Ms. McCroskey's goal to provide supportive counseling and guidance to parents coping with their child's special healthcare needs. She also participated in palliative care services when needed.

Penn State Hershey Medical Center – Hershey, PA **Medical Social Worker**

April 1998-October 2003

As a medical social worker in this facility, Ms. McCroskey was responsible for social service coverage for the NICU, maternity, newborn nursery, outpatient obstetrics. She assisted patients in obtaining WIC,

Medicaid, Social Security, Early Intervention and many other community resources. Ms. McCroskey was responsible for assisting in the discharge of patients that needed home health, hospice, IV services, and DME. She worked with the entire team of physicians, nurses, as well as other professionals to meet the needs of the patients being served.

Schreiber Center for Pediatric Development, Lancaster, PA

September 1993- April 1998

Social Worker

This facility provides rehabilitation, preschool, and recreational programs for children with disabilities. As a social worker, Ms. McCroskey provided I&R, accepted community and physician authorizations, completed intake reports, and provided supportive services to children and families. She participated in and at times facilitated IEP meetings. Ms. McCroskey also assisted families in applying for Medicaid and SSI for their children.

Easter Seals Rehabilitation Center, Wheeling, WV

September 1992-August 1993

Social Worker

This facility provides rehabilitation, preschool, and recreational programs for children with disabilities. As a social worker, Ms. McCroskey provided I&R services, accepted community and physician authorizations, completed intake reports, and provided supportive services to children and families. She participated in and also facilitated IEP meetings. Ms. McCroskey was helpful in helping families obtain Medicaid and SSI for their children.

TAMMY WRIGHT

SNS LIAISON

PROFILE

Ms. Wright is a seasoned early childhood professional with near to 30 years experience in the field of education/social services. Out of these years of practice, she has over 20 years of experience in working with children with disabilities and at-risk children and their families. Ms. Wright is a trained and skilled early interventionist, parent educator, trainer, motivational interviewer and advocate. She is a past Early Head Start & Parents as Teachers Parent Educator who possesses skills in coaching and educating families on evidence-based practices such as the Strengthening Families Framework/Protective Factors. In addition, Ms. Wright has extensive experience in community collaboration. She is a current member of the Family Ways Community Collaborative & Foster Care Subcommittee, and the Ohio County Family Resource Network General Networking and Disabilities Committees. She has provided behavioral health consultation services to young children and their families in the past as a Developmental Healthcare Consultant for The Children's Hospital of Pittsburgh. Ms. Wright has worked for the state of West Virginia as a Resource and Referral Trainer & as a Family Partnership Coordinator and Child Development Specialist for West Virginia Birth to Three. She is currently employed as a part-time Child Development Specialist with West Virginia Birth to three, in addition to her position as The Autism Advocate with The Health Plan. Throughout her career, Ms. Wright has obtained direct experience in working with foster care and adoptive families.

EDUCATION AND TRAINING

- B.A., Double Major in Early Childhood Education and Psychology; Carlow University; Pittsburgh, PA
- Certified Early Intervention Specialist; Office of Maternal, Child & Family Health; WV Department of Health & Human Resources; 5/5/14-5/5/19 & 2005-2008.
- West Virginia Stars Career Pathway, Level VII [REDACTED]

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV **Autism Advocate**

January 2017-present

Providing individualized consultation & support to families who have a child with autism; conducting intake assessments & providing case management; providing evidence-based information & linking families to community resources; providing technical assistance and coaching to families; collaborating with local service providers & community agencies; completing pre-authorizations; assisting families to find providers & developing and evaluating program.

West Virginia Birth to Three, Charleston, WV **Child Developmental Specialist**

April 2014-present

Independent contractor including: assessing the development of children from birth to the age of 3; preparing reports and completing documentation; providing direct early intervention services to children and families; participating in teaming activities and development and updates of IFSPs; ongoing-assessment of children; collaborating with family/child service providers; organizing and marketing of business.

Marshall County Family Resource Network, Moundsville, WV **Parent Educator, Parents as Teachers**

April – November 2015

Provided home-based educational and family support services (including service coordination & case management) to families with children (prenatal to age 5); Implemented Parents As Teachers curriculum, collaborated with community agencies and family/child service providers; planned and facilitated monthly group social experiences for families; completed assessments, reports and documentation.

Northern Panhandle Head Start, Wheeling, WV

February 2012-May 2013

Parent Educator, Early Head Start

Provided home-based educational and family support services (including service coordination & case management) to families with children (prenatal to age 3); Implemented Creative Curriculum; collaborated with community agencies; planned and facilitated group social experiences for families; participated in planning & facilitating Family Activity Nights; completed assessments, reports and documentation.

Children's Hospital of Pittsburgh, University of Pgh

Early Childhood Partnerships, Pittsburgh, PA

September 2005-February 2010

HealthyCHILD Coordinator/

Developmental Healthcare Consultant

Lead team member responsible for implementation of behavioral health consultation services to staff, children & families of Northern Panhandle Head Start. Summary of services provided include: Preschool and Early Head Start classroom consultation; Individual child/family consultation along with service coordination & case management; Support to disabilities, educational & early head start services; Collaboration with local and regional behavioral health service providers and community partners; Coordination and administration of program as well as supervision of WV team members; evidence-based training to head start staff; program development & evaluation.

West Virginia Birth to Three/Catholic Community Services, Wheeling, WV

6/2004 - 2/2005

Family Partnership Coordinator

Provided advocacy services including: technical assistance, information/resources and support to families with children enrolled in the WV Birth to Three System ; Compiled and maintained a central directory of resources for children and families; Represented WVBTT on local community and early childhood committees; Collaborated with the local school systems and Tadpole committees; provided public relations opportunities ; provided family- to- family support through planned trainings, family advocacy support groups and events in Region #1.

KERRI TOMER, RN

QUALITY DIRECTOR

PROFILE

Ms. Kerri Tomer is a Registered Nurse with over 25 years of experience in clinical hospital setting and managed care organization setting. Ms. Tomer has over 15 years of management and project management experience. Her expertise is comprised of a hands-on direct approach in every aspect of managing a project. Ms. Tomer is responsible for the direction and coordination of the development of ongoing systematic processes for collecting, aggregating and reporting data in a format that quantitatively trends medical events and identifies recurring utilization issues. She has experience in overseeing and guiding the process of analyzing, qualifying and summarizing data pertaining to quality clinical indicators. Ms. Tomer has been responsible for quality initiatives in the acute care setting and managed care setting. She has several years of experience in root cause analyses that result in data driven initiatives to improve outcomes. Ms. Tomer has an extensive background in quality accreditation in the acute setting and managed care setting with the ability to identify target areas and implement projects as a result. She has used this background as a platform to implement policy and procedure changes within the organization.

Throughout her career, Ms. Tomer has been responsible for coordinating the implementation of quality management programs for continuous monitoring, evaluation and improvement of health and services provided to our members. She has overseen the operations in an effort to close gaps in care and improve HEDIS ® and CAHPS survey scores. Ms. Tomer has impeccable communication skills with the ability to persevere with a positive attitude. Her leadership abilities are utilized on a day-to-day basis with clients and staff. Ms. Tomer's performance is evident of her multitasking capabilities and demonstrates her ability to proactively plan, prioritize and manage objectives under tough constraints.

EDUCATION AND TRAINING

- Associate Degree in Applied Science, Registered Nursing 1994

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, WV

April 2013 – Present

Clinical Quality Improvement Director

Ms. Tomer has worked on several projects since joining The Health Plan. Currently, Ms. Tomer is responsible for the all quality improvement and performance improvement projects. These projects are associated with HEDIS, NCQA and BMS requirements. She oversees the HEDIS data analysts and all HEDIS, CAHPS, HOS and Medicare Star Ratings operations. She is also responsible for the direct oversight of The Health Plan's NCQA accreditation. In this role, she is responsible for the coordination of strategic development and all projects and activities related to enhancing organizational compliance with NCQA, CMS, BMS, and Qlarant. She conducts mock audits and shares the findings with appropriate stakeholders to develop initiatives or corrective action plans as a result. Ms. Tomer collaborates with internal departments, delegated entities and vendors to enhance compliance with accrediting/regulator bodies.

Tri-State Pediatric Ophthalmology, OH

February 2011-April 2013

Office Manager

As the office manager, Ms. Tomer was directly responsible for overseeing the daily operations of the practice, including but not limited to staff scheduling, patient scheduling, coordination of supplies, care coordination with providers, and office billing. She developed policies and procedures for the practice as well as documented workflows that were non-existent prior to her employment there. In her length of time there, Ms. Tomer also developed a medical library of staff training material and patient education material. She worked with parents and school nurses to assure continuity and coordination of care was in place for the wellbeing of the child. She assisted with office budgets and worked with multiple payers

for authorizations and claim encounters. She coordinated required documentation for hospital and payer credentialing/recredentialing for the physician.

East Ohio Regional Hospital, OH

July 2001 – February 2011

Pre-operative and Recovery Room Manager

As the manager, Ms. Tomer was responsible for overseeing the daily operations of the pre-operative testing and recovery room areas. She was responsible for staffing, departmental budgets, implementation of policies and procedures. Ms. Tomer was responsible for assuring ASPAN standards with followed in all aspects of care delivered to the patients to promote safety, efficacy and optimal patient outcomes. Ms. Tomer performed monthly medical record audits, surgeon monthly audits for quality indicators and overall compliance audits. She was responsible for tracking and trending surgical data to implement quality improvement initiatives. Ms. Tomer served on multiple committees related to accreditation, morbidity and mortality, quality improvement strategies and JCAHO workgroups.

LISA HAWKINS

MEMBER SERVICES DIRECTOR

PROFILE

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

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

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

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan

December 2018 – Present

Director, Medicaid Operations

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

Health Smart Benefit Solutions, Charleston, WV

January 2012- November 2018

Team Manager

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

In the Team Manager role, Ms. Hawkins participated in interviewing, selecting, training and developing new employees, was responsible for development of policies and procedures related to the Operations functions, and monitored accuracy pertaining to claims pricing methodologies for her team. Multiple pricing methodologies were in use and Ms. Hawkins team was responsible for monitoring the periodic updates of RBRVs fees, DRGs, APCs, and other direct contracts fee loads to ensure accuracy of claims payments to providers.

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

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

Wells Fargo Benefit Services, Charleston, WV
Team Manager, Team Leader, Claims Examiner

September 2001-December 2011

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

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

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

STEVE BRUCKER

CLAIMS PAYMENT DIRECTOR

PROFILE

Mr. Steve Brucker is an experienced claims manager with over 6 years of demonstrated claims supervisory experience. He has a total of 13 years of experience in health insurance administration across various positions. He has served as an internal auditor, quality assurance analyst, and claims examiner and his experience includes both Medicaid and self-funded lines of business. Mr. Brucker has very strong leadership and communication skills and serves as a point of contact for internal and external parties.

EDUCATION AND TRAINING

- B.S.B.A, Accounting; West Virginia University/West Virginia State University; in progress

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Charleston, WV Manager, Medicaid Claims

December 2016 – Present

Mr. Brucker is responsible for managing the Medicaid claims team consisting of 33 claims analysts, a claims coordinator and an appeals coordinator. He is heavily involved in oversight of all claims processing, including behavioral health and medical claims. He closely monitors the claim inventory to ensure that all claims are processed in a timely manner. Mr. Brucker is also the owner of the processing manual by which Medicaid analysts process claims to maintain accurate claims processing procedures. He works closely with the customer service department to ensure that correct information is relayed to providers and members.

Along with his Medicaid responsibilities, Mr. Brucker is also certified as an editor of The Health Plan's code editing software maintains the primary responsibility for implementing rule changes across all lines of business of The Health Plan. This product is a claims payment and editing software put in place to improve payment accuracy, apply correct coding and reduce overpayments. Mr. Brucker has excellent problem solving skills and is very detail oriented. He is involved in quality testing for system changes in The Health Plan's processing platform before the changes are rolled into the production environment.

HealthSmart Benefit Solutions/Wells Fargo TPA/Acordia National, Charleston, WV Claims Team Leader, Internal Auditor, Quality Assurance Analyst, Claims Examiner

2/2006- 12/2016

Mr. Brucker served in a variety of roles at HealthSmart Benefit Solutions which is a third party administrator formerly known as Wells Fargo TPA and Acordia National. Most recently he served as a claims team leader from January 2013 through December 2016. In this supervisory position he managed between 15 and 25 claims examiners to ensure operational objectives were met. He was familiar with multiple processing platforms and was responsible for handling multiple client accounts.

Prior to being a supervisor, Mr. Brucker began as a claims examiner and processed claims on the West Virginia PEIA account as well as the AlaskaCare state insurance plan. He was responsible for processing various types of claims including physician and hospital claims. He then transitioned into a position in the quality assurance department as a quality assurance analyst. There, he spent approximately two years auditing claims processed by the claims staff to ensure quality standards were being met. With his education and previous accounting related experience, he then transitioned to an internal audit position. He had sole responsibility for the monthly internal audit which monitored internal controls for compliance. His review included the system, staff, building security as well as financial documents. He maintained the position for about a year before deciding to return to a role in operations.

DELORIS BARRETT

NETWORK DEVELOPMENT DIRECTOR

PROFILE

Deloris Barrett has 24 years of experience in provider network development and network management to include strategic planning, contract negotiations and Value-based Contracting. Recognized as a strong and effective leader, she is results oriented with good analytical skills. She has excellent project planning and implementation skills. Twenty-one years of her experience has been contracting West Virginia hospitals and practitioners. She has developed a competitively accessible network of physicians, hospitals and affiliates in West Virginia initially for Mid Atlantic Medical Services, Inc. (MAMSI), then United, Coventry Healthcare, Aetna Better Health of West Virginia and now for The Health Plan. She has been recognized for her leadership during mergers and acquisitions. She has recently completed Value Based Medicaid contracts with 2 of West Virginia's largest healthcare systems. She developed a comprehensive behavioral health network for Aetna Better Health in West Virginia. She is responsible for overall network development and network management for The Health Plan in West Virginia which includes behavioral health and Value Based contracting.

EDUCATION AND TRAINING

- West Virginia State University – Business Administration
- Numerous programs, conferences and seminars including Integrity and Compliance,
- Diversity, Mediation/Negotiation, Conflict Management
- Six Sigma – white belt and yellow belt training completed 9/2017

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Charleston, WV

April 2018-present

Director of Contracting

Responsible for network development/management, primarily in West Virginia, with an emphasis on government programs to include Value Based and Behavioral Health contracting. Monitors and reports network adequacy for Medicare and Medicaid services. In conjunction with senior leadership, develops provider contracting strategies, identifying those specialties and geographic locations for purposes of establishing a sufficient network of participating providers to serve the healthcare needs of members and to meet the access standards and requirements set forth by the State.

Aetna Better Health of West Virginia (Coventry acquired by Aetna)

May 2013 – March 2018

Sr. Director, Network Management

Vice President, Network Development and Management

March 2009 – May 2013

Coventry Healthcare, Charleston, WV

Responsible for the day-to-day functions of Network Management for West Virginia; Successfully renegotiated hospital agreements resulting in fixed pricing and/or reduced rates while supporting all Coventry products for the WV market (Commercial, **Medicaid**, Coventry National, Rental, Workers Compensation, Auto); Responsible for oversight of Credentialing and making sure access to care was within the standards.

Coventry Healthcare, Chicago, Illinois

Nov. 2006 – March 2009

Director of Network Development

Began building the network from the ground up (hospitals and practitioners) in the Chicago market (Cook County and five collar counties); Added 32 hospitals and over 10,000 physicians to the network.

United Healthcare Mid-Atlantic Medical Services, Inc. (MAMSI) Charleston, WV

July 1994 – March 2006

Sr. Director, Network Development/Management



Deloris was the first MAMSI employee in West Virginia. Built MAMSI's network from the ground up to include all products. In less than one year the network was adequate enough for MAMSI to open an office and begin marketing its HMO/PPO product. After a short time, MAMSI expanded to offer Medicaid and Medicare products.

Washington Hospital Center, Emergency Department and MedStar Trauma Unit, Washington, DC

Business Manager

4/1989 – 4/1994

MedStar Trauma Unit; Prepared capital, operating and staffing budgets; Negotiated contracts with various insurance companies; Developed and implemented business plan for "Express Care" (new ambulatory care clinic); Directed all patient accounting functions of both Departments; Managed staff of 40.

BARBARA GOOD

PROVIDER RELATIONS DIRECTOR

PROFILE

Ms. Barbara Good is a seasoned professional who has experience in a variety of areas of healthcare. She is responsible for overseeing provider education, training and guidance for the provider network, including having knowledge of contract language and payment methodology. She currently manages the activities of all regional provider education, services, and The Health Plan's community outreach opportunities. Her regional relationships and expertise in the provider delivery system are well known throughout West Virginia. Ms. Good is also knowledgeable about details of provider contracts, payment methodologies, and provider networks, as well as quality initiatives

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

West Virginia State Medical Association **Physician Practice Advocate**

August 2006 – March 2018

As Physician Practice Advocate, Ms. Good served as a liaison between West Virginia physician practices and insurance payers. She provided advocacy for physicians in all areas of practice management, working directly with upper level management and medical directors of insurance companies, both government and commercial. Ms. Good also provided continuous educational opportunities for physicians and staffs, enabling over 500 physicians and staff members to obtain national professional certifications. She produced an online newsletter for physicians and served as a columnist for the WV Medical Journal. She has won national awards and recognition for her advocacy work, and her contacts enabled her to bring in nationally recognized speakers for physician practice events and conferences. In her role at WVSMA, she worked closely (and continues to work) with the WV Medical Group Management Association, the Office Managers Association, the Healthcare Financial Managers Association and other groups, speaking often and knowledgeably for these groups. She was appointed by then State Senator Evan Jenkins to represent the WVSMA on the WV Uniform Credentialing Committee, the WV Medical Services Fund and also Palmetto GBA's Contractor Advisory Committee.

Fresenius Dialysis Services **Charleston, WV Area Manager**

July 2005 – August 2006

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

First Physicians Network Charleston, WV **Executive Director**

June 2001- May 2005

In this position, Ms. Good served as the liaison for physicians with insurance payers and managed care plans. She also conducted the network's messenger model contracting. She helped physicians as they started new practices or joined other practices. Ms. Good ensured that all member physician practices

were kept current of payer issues and also provided monthly educational offerings for physicians/staff. She worked closely with the Board of Directors to ensure quality services for network physicians.

Carelink Health Plans, Charleston WV

June 1995 – June 2001

Provider Relations Supervisor

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

Syntex Laboratories, Charleston, WV

October 1986 – June 1995

Professional Medical Representative

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

KAYLA SHREVE

PROVIDER RELATIONS DIRECTOR

PROFILE

Ms. Kayla Shreve has an extensive knowledge of the provider relations field from her years of experience in the physician practice arena and now in the insurance arena. Ms. Shreve managed a primary care network in her career consisting of 17 physicians, 11 advanced practical providers and over 50 full-time equivalent employees. She has worked in conjunction with many departments within and outside of healthcare systems including clinical departments, human resources, materials management, financial services, patient experience, contracting, credentialing, quality, community stakeholders and MCO relations. She recently transitioned her career into the insurance sector where she works in conjunction with providers to ensure they are meeting patient care standards in addition to quality standards. Ms. Shreve also spends her time engaging with community organizations to provide resources to our providers and the members of our plans.

EDUCATION AND TRAINING

- Certified Medical Insurance Specialist, Practice Management Institute, Wheeling, WV
- B.S., Health Services Administration; Ohio University, Athens, OH

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV

April 2018 – Present

Regional Manager of Provider Engagement

As the regional manager of provider relations, Ms. Shreve is responsible for the following: conducting training and education across our provider network on multiple initiatives, managing and overseeing the provider engagement representatives for the Wheeling region, providing quality information to providers to ensure they are closing all gaps in care and monitoring provider and member complaints. During her time at THP, Ms. Shreve has worked on multiple projects including developing a new provider packet for providers that includes information on how to access our provider manual, quality measures, product matrix information and information regarding our provider portal. In addition, she has worked on the Palladian Health implementation team where she collaborated with Palladian Health to provide education and training to our providers on specific disease management and has monitored the progression of this project. Ms. Shreve has also spent time in the community with stakeholders and organizations to better our members and providers. Ms. Shreve regularly attends family resource network meetings across her region and keeps up to date with events and initiatives. Her most recent project at hand is the foster care initiative where she will develop training for the provider network of THP in relation to the requirements of this initiative.

Trinity Health System, Steubenville, OH

September 2014- April 2018

Physician Practice Manager

During her time as physician practice manager, Ms. Shreve worked to plan, coordinate, direct and supervise various elements of the medical facility. In addition, she worked in partnership with the physicians and staff to ensure compliance with regulatory agencies such as JCAHO. Ms. Shreve worked very closely with the providers she managed to have an understanding of the needs of the practice and of the physicians while supporting the mission and values of the organization as a whole. Ms. Shreve worked closely with the contracting department at Trinity to develop quality incentives and competitive compensation models for the physicians the health system acquired. She also served as site coordinator for the telemedicine project for the management service organization where she worked hand in hand with the software vendor to provide training to physicians and staff. Ms. Shreve served on the start-up committees for Trinity's transitional care clinic, vein center and express clinics. Throughout her career at

Trinity, Ms. Shreve maintained a broad understanding of the principles of financial management and used cost-benefit thinking to set priorities. Ms. Shreve managed all relations with MCO's during her time with the health system and worked directly with providers to ensure all HEDIS and STAR measures were met in addition to MACRA and Meaningful Use measures. Lastly, Ms. Shreve served on the recruiting committee with Trinity where she sought out physicians of various specialties and coordinated facility tours and acted as their liaison with the VP of physician services.

RACHEL WAYBRIGHT TIGNOR

PROVIDER RELATIONS DIRECTOR

PROFILE

Ms. Rachel Waybright Tignor is an experienced administrator with over 10 years of demonstrated physician office management experience. Her expertise is comprised of skills and abilities related to administrative oversight and leadership, financial management, quality assurance and accreditation, and data collection for strategic planning and development. She utilizes her knowledge and experience from for-profit private medical practice to lead a team of three Provider Engagement Representatives serving in-network providers and facilities throughout a twenty county territory. Winchester Medical System and WVU Medicine are two of the larger health systems located in her region.

In addition to physician practice management experience, she also has experience as an administrator negotiating contracts and budgets for clinical research trials. In order to adhere with study guidelines and requirements, Ms. Waybright Tignor was required to demonstrate a thorough understanding of contract language and the ability to implement workflow protocols and management strategies for multiple office locations, clinical research coordinators, participants and study sponsors. She also has served as an Adjunct Professor for Pierpont Community and Technical College. Her course instruction has focused on business management and principles in both the public and private sectors.

EDUCATION AND TRAINING

- M.P.A., Public Administration (Specialization Certificate in Healthcare Administration); West Virginia University, Morgantown, WV; 2009
- B.A., Secondary Education; West Virginia Wesleyan College, Buckhannon, WV; 2002
- B.A., English; West Virginia Wesleyan College, Buckhannon, WV; 2002

SUMMARY OF RELEVANT EXPERIENCE

Dermatology Center for Skin Health, Morgantown, WV **Practice Administrator**

June 2008 – October 2019

Ms. Waybright Tignor was responsible for all facets of management and oversight in this private physician practice. During the course of her tenure, the practice grew from a solo physician owner to a three-provider practice servicing cosmetic and medical dermatology patients. Ms. Waybright Tignor selected and implemented electronic practice management (EPM) and electronic medical records (EMR) systems from AdvancedMD and Modernizing Medicine. This required strategic coordination of transition from a previous vendor (NextGen). She also maintained all quality reporting for PQRS, Meaningful Use, MACRA and MIPS government incentive programs. Ms. Waybright Tignor ensured compliance with applicable government regulations and licensure boards including OSHA and the WV Board of Medicine. Ms. Waybright Tignor managed all practice relationships related to patient care including accounts receivable, negotiations with third party payers, provider credentialing, and human resources. In addition, Ms. Waybright Tignor served as the author and editor for patient education materials, marketing, and internal policy/procedure protocols. During Ms. Waybright Tignor's last year and half with the practice she was the primary point of contact for a contracted external marketing team. This required a thorough understanding of the patient services, products and initiatives to create target market strategies to expand specific patient populations.

West Virginia Research Institute, PLLC, Morgantown, WV **Administrator**

October 2016 – May 2019

As the administrator, Ms. Waybright Tignor was directly responsible for all business administration responsibilities including maintenance of appropriate insurance policies, human resource management, financial management, and study contract and budget negotiation processes. Once enrolled in a

clinical trial, Ms. Waybright Tignor managed all invoicing, subject stipends, and payment reconciliations. Communication with pharmaceutical study sponsors and contracted vendors played a key role in facilitation of West Virginia Research Institute's day to day functions. Study participation included clinical drug trials for rheumatology and dermatology pharmaceuticals.

Pierpont Community & Technical College, Fairmont, WV**January 2018 – Present****Adjunct Professor**

Ms. Waybright Tignor has served as the course instructor for Principles of Management (MGMT 2209). The emphasis in this course is on the modern approach to the field of management. Theoretical and practical approaches are presented, along with analytical techniques that are applicable in the various management and production areas.

TRINA CROWDER

PROGRAM INTEGRITY LEAD

PROFILE

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

EDUCATION AND TRAINING

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

SKILLS

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

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Charleston, WV

March 2019 – Present

Director of SIU

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

The Lewin Group, Falls Church, VA

April 2018 – March 2019

Senior Consultant/Medicaid Program Integrity Analyst

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

DHHR, OIG, Medicaid Fraud Control Unit, Charleston, WV

April 2006 – March 2018

Investigator (2006-2007); Chief Investigator (2007-2011); Director (2011-2018)

Ms. Crowder joined the MFCU as an investigator responsible for conducting criminal and civil investigations of Medicaid fraud. Responsibilities included obtaining, analyzing and synthesizing

evidence; identifying, locating, and interviewing witnesses; interviewing and interrogating suspects; conducting undercover operations including covert surveillance; and training new investigators. As Chief Investigator and Director, she was responsible for directing and evaluating the work of investigators, auditors, nurses, and attorneys, which included reviewing and approving plans of investigation, operations plans, and reports of investigation. She developed training curricula, policies, procedures, and internal controls, and ensured compliance with all state and federal regulations.

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

Ms. Crowder conducted recipient fraud investigations for over 60 public assistance programs, including Medicaid. She also investigated allegations of employee misconduct, both administrative and criminal, in an agency with over 5000 employees.

ROBERT JAMES ROSET

INFORMATION TECHNOLOGY DIRECTOR

PROFILE

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

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV

Sr. VP, Information Systems

Director MIS

System Manager

Programmer

Computer Operator

2004 – Present

1992 – 2003

1990 – 1991

1988 – 1990

1986 – 1988

Mr. Roset advanced to Senior VP IS leadership for the MCO while helping the company grow to over \$800 Million in yearly revenue through in-house developed core business systems. The Health Plan has grown from a small regional MCO, to covering lives in over 45 states with 4 office locations. Mr. Roset continues to design & code key business critical modules to ensure coding skills are fresh and deadlines are met. Mr. Roset manages large-scale enterprise migration projects, systems conversions and performance tuning and monitoring of applications/systems. Mr. Roset is responsible for setting long-range technical direction and capacity plans.

Information Imaging, Wheeling, WV

1995 – 2003

Owner, Programmer

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

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

Security National Bank & Trust, Wheeling, WV

1986

Computer Operator

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

JOSHUA L. AUSTIN

COMMUNITY ENGAGEMENT DIRECTOR

PROFILE

Mr. Austin is the Director of Provider Strategic Initiatives at The Health Plan, a West Virginia-based, not-for-profit health insurer. In this role, he grows relationships with strategic provider groups to advance value-based healthcare. Mr. Austin previously served as a Program Manager at the West Virginia University (WVU) School of Public Health. In various positions at the School, he coordinated the Centers for Medicare & Medicaid Services' State Innovation Model grant for the State of West Virginia and assisted the West Virginia Healthcare Authority in developing a state health plan. He also worked with providers, insurers and a charitable foundation to establish and sustain the West Virginia Partnership for Health Innovation, an organization committed to moving the state toward value-based healthcare.

EDUCATION AND TRAINING

- **BA**, Political Science; West Virginia University, Morgantown, WV; 2008
- **BSJ**, News-Editorial; West Virginia University, Morgantown, WV; 2008
- **MSc**, International Politics; University of Glasgow, Glasgow, United Kingdom; 2009
- **MA**, Political Science; West Virginia University, Morgantown, WV; 2010
- **Jonas Salk Fellowship**; Jewish Healthcare Foundation, Pittsburgh, PA; 2017, build a case for action, shape winning strategies and advocate effectively for value-based healthcare

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Morgantown/Wheeling, WV **Director of Provider Strategic Initiatives**

April 2019 – Present

In this newly created role, Mr. Austin develops and grows positive, long-term relationships with physicians, providers and healthcare systems to support and improve financial and quality performance of The Health Plan. He is the primary liaison between strategic provider groups and The Health Plan and plays a key part in assisting in the contracting and leading the implementation of The Health Plan's value-based provider contracts. These value-based contracts cover approximately 20% of The Health Plan's Medicaid managed care line of business in West Virginia.

WVU School of Public Health, Morgantown, WV **Program Manager**

July 2017 – April 2019

Mr. Austin promoted the strategic priorities of the WVU Health Sciences Center related to population health improvement by providing support and guidance to the Dean of the WVU School of Public Health and by furthering the mission of the West Virginia Partnership for Health Innovation (WVPHI), an organization dedicated to advancing value-based healthcare in the state. He provided technical assistance and analytic/policy support to the West Virginia Department of Health and Human Resources (DHHR). Mr. Austin drafted a series of briefing papers for DHHR on Section 1115 waiver proposals, including work requirements, health savings accounts/premiums and tobacco premium surcharges, and aided the Bureau for Medical Services in creating a five-year strategic plan. He also assisted the Bureau for Behavioral Health in allocating and developing projects related to provider/prescriber training and professional development under the SAMHSA State Opioid Response grant.

WVU Research Corporation/School of Public Health, Charleston, WV **Project Coordinator**

July 2015 - June 2017

From August 2016 to June 2017, Mr. Austin served as the lead, on-the-ground asset for drafting and developing the State Health Plan for the West Virginia Healthcare Authority; the plan is a statutory requirement that forms the legal basis for certificate of need programs and serves as the state's overall

healthcare strategy. He also oversaw special projects for the WVU Health Sciences Center, including: 1. developing alternative payment models and programs for insurers and providers; 2. planning and coordinating an interdisciplinary team of WVU faculty/staff to hold a major summit on children's health policy featuring former U.S. Senator Jay Rockefeller (D-WV) and former U.S. Department of Health and Human Services Secretary Sylvia Mathews Burwell and 3. establishing the WVPHI. Moreover, he wrote a successful \$25,000 grant application to the Claude Worthington Benedum Foundation that funded the summit and created an issue brief on children's health policy with West Virginia KIDS Count, as well as an insurance guide for parents that was distributed statewide.

From July 2015 to July 2016, Mr. Austin was the primary liaison to the DHHR Cabinet Secretary's Office regarding functional and policy aspects of the SIM grant, which focused on developing a plan to transform the state's healthcare delivery and payment system. He arranged, coordinated and staffed all specialized workgroup meetings for various components of the grant, as well as organized, coordinated and staffed the SIM Task Force, a representative C-level executive group of the state's major insurers, providers and consumer representatives tasked with drafting the final plan for the SIM grant.

Variety the Children's Charity, Morgantown, WV
Manager, "My Bike" West Virginia

Dec 2013 – Jan 2015

Mr. Austin established and ran a program to raise, through personal, foundation and corporate sponsors, more than \$100,000 to award 82 individually customized adaptive bicycles to children with disabilities. He created grassroots partnerships with community members, corporate leaders, healthcare providers and politicians as a means for outreach, identifying children eligible for the program and fundraising cultivation. In this role, he planned and coordinated multiple adaptive bicycle presentations including federal, state and local politicians, community partners and children with disabilities and their family members.

Governor's Office, Health Enhancement & Lifestyle Planning, Charleston, WV
Policy Analyst

Nov 2010 – Feb 2012

Mr. Austin functioned as the primary analyst for tracking state healthcare legislation for the Governor's Office and state's senior healthcare leadership team; he updated this tracking list by providing a report and gathering intelligence on bill statuses during monthly arranged meetings led by the agency director. He frequently prepared policy briefs on pressing healthcare issues, including accountable care organizations, health information technology, provider-sponsored networks and other topics as directed.

DIANE PALETTA, D.D.S.

ROLE

PROFILE

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

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

SKYGEN USA, Menomonee Falls, WI **Consultant, WV Dental Director**

October 2013 – Present

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

West Virginia Board of Dentistry, Crab Orchard, WV **Clinical Advisor**

2007 – 2014

West Virginia University Tech, Division of Dental Hygiene, Charleston, WV **Professor of Pharmacology and Periodontology**

2006 – 2007

Private Practice of Dentistry, Charleston WV **Dentist**

1983 – 2005

Dr. Joseph Bowles, Charleston, WV **Dental Hygienist**

1978 – 1979

JEANETTE WILLIAMS

MEDICAID MEMBER ADVOCATE

PROFILE

Mrs. Williams has the experience of assisting a variety of families, and clients over the course of 9 years. Mrs. Williams started with THP in 2016, and while she was in a role of customer service. Mrs. Williams showed determination and goal oriented, and she was promoted within a year of service to Medicaid Coordinator.

EDUCATION AND TRAINING

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

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Charleston, WV **Medicaid Coordinator**

December 2016 – Present

Responsible for the day to day tasks that are assigned to her. She is responsible for the monthly reports and communicates with the Bureau for various reasons. Mrs. Williams also helps out with our operations department to find out on pricing on certain procedure codes. Assist with the CS team on any eligibility issues. She assists the Asst. Vice President and President of Medicaid with their day to day tasks.

HealthSmart Benefit Solutions, Charleston, WV **Senior Customer Service Rep**

August 2012 – December 2016

Effectively managed a high-volume of inbound and outbound calls. She answers a constant flow of customer calls and assist with supervisor calls and problem solving. Maintains a professional attitude towards daily work and environment situations. She addresses and resolve customer product complaints with empathy and professionally. She accurately document, research and resolve customer service issues, and mastery of customer service management systems and databases. She oversaw call center employees to ensure customer satisfaction goals were consistently met.

US Airways, Charleston **Cross-trained Agent**

April 2010 – April 2014

Was a cross-trained agent that held several responsibilities. She assists with day-to-day operations in ensuring that passengers were checked in, and on their flight to their destination. Held an additional role as a GSC (Ground Security Coordinator) that would assist if any immediate danger that would arise with the plane or passengers. As a cross-trained agent there are times that she would work on the ramp, and that would consist of parking planes, loading/unloading luggage.

David's Bridal, Charleston, WV **Wedding Consultant**

June 2012 – August 2012

Mrs. Williams made sure that each bride that enter the door that they were the only ones that was around. Mrs. Williams shows empathy and concern that the brides will be stressed, and they are there to find a perfect dress for their perfect day. She would assist the bridal party in making sure they were all taking care of as well, and part of the process.



MANDATORY REQUIREMENTS

D

D. Mandatory Requirements

See the attached Microsoft Excel file titled, "**Mandatory Requirements.**"

Narrative Response

Req ID #	Requirement Text	Response
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.	The Health Plan will comply with all the applicable requirements outlined in this requirement.
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.	THP will accept the actuarially sound rates established by the State on a per member per month basis for this population.
MR003	The Vendor must have all requirements operational, as agreed upon with the Department, by January 1, 2020.	THP will have all agreed upon requirements operational by the go live date of this procurement.
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.	THP will comply with the W.Va. Code §9-5-27 requirements. We will establish a voluntary advisory group of foster, adoptive and kinship parents to assist in managing the foster care program. THP has three West Virginia office locations, Wheeling, Charleston and Morgantown. Combined these offices make up 487 out of a total of 538 employees. The majority of our Medicaid business is conducted out of our Charleston office and new employees hired for this procurement will be hired in

Req ID #	Requirement Text	Response
		WV
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.	THP will adhere to the case management decisions of the Department caseworker, MDT or court. THP will facilitate the MDT meeting and will incorporate the recommendations from the meeting and the court order into the case management plan. All stakeholders will be expected to provide input and recommendations that will benefit the member. The goals, objectives, and interventions will be identified. Target dates will be documented, and reviews will be updated and revised per scheduled follow up meetings and any revised court requirement. THP case manager will coordinate meetings are required to ensure that the objectives are followed. The THP Navigator will make recommendations as needed to DHHR, the court, and other stakeholders to ensure that the child is receiving the appropriate care and services in a timely manner. The THP navigator will coordinate and ensure that any reports are completed and submitted timely and with accurate and complete information. The THP navigator will document the MDT meeting and the recommendations for case management for the child. Meetings will be documented and tracked to include recommendations, who attended, and next scheduled meeting.
MR006	The Vendor must comply with requirements for qualified residential treatment program (Q RTP) placements as described in the Service Provider Agreement (SPA).	THP will comply with requirements for Q RTP placements and described in the SPA. Children placed in residential treatment programs will be reviewed for medical necessity. The nurse reviewer will receive clinical information indicating need for the child to be placed in this highly restrictive environment and that no other appropriate placement is available. After review and the determination of medical necessity, the nurse reviewer will

Req ID #	Requirement Text	Response
		receive concurrent reviews to determine that continued stay is appropriate. Any questionable criteria will be reviewed with the medical director. The decision for the authorization or denial will be communicated to the case worker. Residential placements are considered planned admits and require prior authorization. The nurse will ensure that the appropriate assessments have been completed prior to placement. Children will be placed in state unless there are no other options available. If the child is considered for out of state placement, the proper consents will be obtained.
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.	THP currently has an established provider network throughout WV and surrounding states. Our network is comprised of physical and behavioral health providers. We will follow the access requirements that are within the SPA and will serve all counties in the state.
MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).	The Health Plan is currently NCQA-accredited, with a Provisional status for the Medicaid line of business. The current accreditation expires on November 28, 2019; however, The Health Plan will be resurveyed beginning August 6, 2019
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.	THP will provide all requested documentation upon notification of the award.
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.	THP will attempt to contract with all providers that are enrolled in the fee for service plan. For those providers which we are not successful in contracting with, THP will provide evidence of our efforts in trying to obtain a contract with the provider.

Req ID #	Requirement Text	Response
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.	The Health Plan Credentialing Team formulates descriptive credentialing policies and procedures that are reviewed annually to assure compliance with NCQA, Medicare and Medicaid as well as any state, federal or regulatory agency requirements. These Credentialing/Recredentialing policies and procedures include, (but are not limited to): the application process, site survey for WV Medicaid programs, Medicare and Medicaid sanction and reinstatement reports via the National Provider Data Bank, the Office of Inspector General and SAM as well as reports from various state and federal regulatory entities. Various provider enrollment reports regarding participation status in WV Medicaid programs, Credentials Committee. All practitioners wishing to participate with The Health Plan must be fully credentialed prior to providing services to plan members, with the exception of those providers who provide patient care services only within the hospital-based inpatient and/or the ancillary facility-based setting (i.e. radiologists, pathologists, etc.). Behavioral health providers who are staff members of an organization providing traditional outpatient/residential/intensive outpatient services and the organization holds an accreditation, designation of a behavioral healthcare clinic, no further credentialing of staff members providing services is required. Potential practitioners must meet defined requirements for education, licensure, etc. to ensure that potential providers satisfy THP's Standards of Participation that can be found in the Practitioner Procedure Manual available on the THP website. Practitioners are directed to view the Practitioner Procedural Manual including the Standards of Participation upon the request to join the THP Network on the Website, through the Provider Focus Newsletters, attendance at seminars, by our Provider Engagement Representatives during on-site visits,

Req ID #	Requirement Text	Response
		during site surveys and on the Provider section of the THP website.
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).	THP will ensure compliance with EPSDT program requirements as outline in the SPA. THP requires that PCP's and pediatricians complete Health Check exams (EPSDT). THP monitors compliance with this program by sending a reminder notice to the PCP and the member that the screening is due. The PCP is asked to return the notice indicating if the exam was or was not performed. This information is entered into the HEART system tracking tool. The file is auto updated in HEART and tracks the next scheduled exam date based on the periodicity schedule.
MR013	The Vendor must comply with post-stabilization care per applicable federal and State requirements, as defined by the Department.	THP will comply with post-stabilization care per requirements as defined by the Department. We incorporate those requirements into our review of Emergent and Urgent care as follows: Emergency Medical Condition—A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. Urgently Needed Services – Are covered services that: • Are not emergency services as defined or emergency medical conditions but are medically necessary and

Req ID #	Requirement Text	Response
		immediately required as a result of an unforeseen illness, injury or condition; • Are provided when the enrollee is temporarily absent from The Health Plan's service area, or under unusual and extraordinary circumstances, when the member is in the service area and network practitioners are temporarily unavailable or inaccessible; and • It was not reasonable given the circumstances to want to obtain the services through The Health Plan network. 1. The Health Plan is notified telephonically by the admitting practitioners/providers of the member's admission, usually within one working day when feasible. 2. Demographic information is obtained and entered into the system for admission census by utilization management support or pre-authorization of services by referral representatives. 3. All pertinent clinical information is obtained by the THP Navigator(s), including circumstances of the admission or requested service and reason for being out of the area (vacation, business/work related). Medicare members may be out of the service network for up to six months. 4. Continued care needs are discussed with the primary care practitioner, attending practitioners, and member/family, and a plan of care is developed. When appropriate, the behavioral health or medical THP Navigator(s) arranges transport back to the area for continued care and services. 5. Emergency medical condition status is not affected if a later medical review found no actual emergency

Req ID #	Requirement Text	Response
		present. 6. Complex cases may be referred to a nurse care/complex case navigator for further coordination. 7. No pre-authorization for emergency or urgently needed services or services prior to the member's stabilization is required. 8. The Health Plan is responsible to cover emergency services/urgently needed services: a. Regardless of whether services are obtained within or outside The Health Plan's service area; b. Regardless of whether there is pre-authorization for the services; c. If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis; and d. Whenever a practitioner of The Health Plan whom has a written contract to furnish plan covered services to its members or other plan representative instructs a member to seek emergency services within or outside The Health Plan. 9. The Health Plan is not responsible for the care provided for an unrelated non-emergency problem during the treatment for an emergency situation. 10. The practitioner treating the member must decide when the member may be considered stabilized for transfer or discharge and that decision is binding on The Health Plan. 11. Post-stabilization care services are covered services that

Req ID #	Requirement Text	Response
		are: a. Related to an emergency medical condition; b. Provided after a member is stabilized; and c. Provided to maintain the stabilized condition or under certain circumstances (see #12) to improve or resolve the member's condition. 12. The Health Plan is financially responsible for post-stabilization care services obtained within or outside of The Health Plan that: a. Are pre-approved by The Health Plan practitioners or other plan representative; b. Although not pre-approved by a plan practitioner of The Health Plan or other plan representative, are administered to maintain the member's stabilized condition within one hour of a request to The Health Plan for pre-approval of further post-stabilization care; or c. Although not pre-approved by a plan practitioner or other plan representative, are administered to maintain, improve, or resolve the member's stabilized condition when: i. The Health Plan does not respond to a request for pre-approval within one hour; ii. The Health Plan cannot be contacted; or iii. The Health Plan representative and the treating practitioner cannot reach an agreement concerning the member's care, and a plan practitioner is not available for consultation in this situation, The Health Plan must give the treating

Req ID #	Requirement Text	Response
		practitioner the opportunity to consult with a plan practitioner. The treating practitioner may continue with the member's care until a plan practitioner is reached or one of the post stabilization criteria is met (see #13). 13. The Health Plan's financial responsibility for post-stabilization care services it has not pre-approved ends when: a. A plan practitioner with privileges at the treating hospital assumes responsibility for the member's care; b. A plan practitioner assumes responsibility for the member's care through transfer; c. A plan representative and the treating practitioner reach an agreement concerning the member's care; or The member is discharged.
MR014	The Vendor must provide 24-hour access to a provider or service in emergency situations.	THP provider contracts require PCPs availability 24 hours for emergency situations. Additionally, THP Nurses are available 24 hours a day, 7 days a week by calling the nurse information line directly or during business hours by calling the nurse information line, customer service or the Medical Department/Behavioral Health Services. Member materials provide instructions for contacting the PCP and/or the THP Nurse information line for assistance. 1. The nurse may perform the following functions: a. Assist with urgent and emergent levels of care. b. Assist with out-of-area urgent or emergent care needs. c. Assist members with contacting primary care practitioner.

Req ID #	Requirement Text	Response
		d. Assist members with names of practitioners/ providers for services. e. Arrange appointments with practitioners/providers. f. Serve as communication liaison. g. Assist with access to pharmacy benefits. h. Assist with access to behavioral health benefits. i. Provide information about authorization of care. j. Assist practitioners/providers with contacting the medical director. 2. Website inquiries for health information line functions are received in the Customer Service Department and the Nurse Information Line email. Best efforts are made to respond to web inquires within 24 hours. 3. Interpretation services are available through a vendor arrangement. 4. Nurse Information Line calls are documented in ER contacts as part of the member's history which links to previous contacts. 5. Members may be referred to medical management programs for social service, pharmacy, behavioral health, care/complex case, or chronic disease navigation programs according to established indicators via COMET. 6. Telephone and website statistics are tracked monthly with member use of the Nurse Information Line quarterly. 7. Satisfaction is monitored via complaints, second reviews and appeal analysis and random monthly calls to members. 8. Monitoring of calls is performed periodically. Missed calls are recorded by the nurse on the ER contact summary form and are calculated on monthly beeper report. Average speed of

Req ID #	Requirement Text	Response
		answer is monitored monthly by random calls to the Nurse Information Line. 9. Opportunities for improvement are identified through a qualitative and quantitative analysis. Reasonable and appropriate safeguards are used to ensure confidentiality. The nurse line on the website is secure.
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.	The Health Plan maintains sufficient numbers and types of primary care, behavioral healthcare and specialty care practitioners in its network through the analyses of member cultural, ethnic, racial and linguistic needs and adjusts the availability of its practitioners within the network as needed. Procedure: - The Health Plan Provider Network conducts an analysis to determine any unmet needs to our members through use of the following data: - Member complaints - Member surveys - US Census data within The Health Plan service area - Member enrollment data - Network practitioner languages and ethnic background - A quantitative and qualitative analysis is performed against the results of member complaints, member surveys, US Census data, member enrollment data and practitioner language and ethnic background to determine any unmet needs of our members. - US Census data is analyzed for member linguistic, racial, and ethnic needs.

Req ID #	Requirement Text	Response
		• Customer Service and Marketing language translation requests along with any other available member enrollment data are used to meet the language needs of members. • CAHPS survey data and US Census data are analyzed to meet the ethnic needs of members. • Member complaints at a minimum are used to analyze member cultural needs. • The data is analyzed annually to determine network adequacy. Adjustments to the practitioner network are made as necessary based on the analysis. • These adjustments may include any of the following: • Recruit, credential and contract with practitioners who speak a language to meet linguistic needs. • Recruit, credential and contract with practitioners with similar cultural and ethnic background as identified in analysis. • Cultural competency training for practitioners based on racial/ethnic composition of member population. The analysis will be reported to The Health Plan's Continuous Quality Improvement Committee (CQI), and Executive Management Team (EMT) with actions taken to maintain and meet the needs of our members. The Health Plan identifies specialists that are high volume and high impact and sets standards for availability that are realistic for the community and the delivery system. The Health Plan maintains adequate availability of practitioners providing specialty care to members through established standards of the number of each practitioner providing

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		specialty care and the geographic distribution of each type providing specialty care. Procedure: • The Health Plan identifies high impact and high-volume providers based on data analysis. At a minimum, high volume includes OB/GYN and high impact includes oncologists. • High volume specialists are identified through encounter data or an expected high-volume geographic location. • High impact specialists are identified through encounter data with those conditions that have high mortality and morbidity rates. • The Health Plan has measurable standards for the number of each type of high-volume specialist and high impact specialist and establishes measurable standards for the geographic distribution of each type of specialist. • Standards are analyzed based on acceptable driving time to the practitioner's office from the member's home and actual distance to the practitioner's office. • At least 90% of all Commercial and Medicare members must have access to high volume specialists and high impact specialists within 45 miles of their residence. • At least 90% of Medicaid members must have access to high volume specialists and high impact specialists within 25 miles (30 minutes travel time) of their residence. • The overall ratio of all Commercial and Medicare members to high volume specialists and high impact specialists is no great than 2000:1. • The overall ratio of all Medicaid members to high volume

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		specialists and high impact specialists is no great than 2000:1. The Health Plan will conduct a quantitative and qualitative analysis against the defined standards for the number of each type of practitioner providing specialty care and the geographic distribution of each type of practitioner providing specialty care. Data analysis will be performed annually and as needed. The analysis will be reported to The Health Plan's Continuous Quality Improvement Committee (CQI) and Executive Management Team (EMT) with actions taken to maintain and meet the needs of our members. The Health Plan strives to maintain adequate network availability of high-volume behavioral healthcare practitioners within the network. The Health Plan identifies high volume behavioral healthcare practitioners and sets standards for availability that are realistic for the community and the delivery system. Policy: The Health Plan maintains adequate availability of practitioners providing behavioral healthcare to members through established standards of the number of each practitioner providing behavioral healthcare and the geographic distribution of each type providing behavioral healthcare. Behavioral healthcare practitioners are defined as psychiatrists, clinical psychologists, and behavioral

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		healthcare counselors/therapists. • The Health Plan has measurable standards for the number of high-volume behavioral healthcare practitioners and establishes measurable standards for the geographic distribution of each high-volume behavioral healthcare practitioner. • High volume behavioral healthcare practitioners are identified through encounter data or an expected high-volume geographic location. • At least 90% of all Commercial and Medicare members must have access to high volume behavioral healthcare practitioners within 45 miles of their residence. • At least 90% of Medicaid members must have access to high volume behavioral healthcare practitioners within 25 miles (30 minutes travel time) of their residence. • The overall ratio of members to behavioral healthcare practitioners is no greater than 2000:1. The Health Plan will conduct a quantitative and qualitative analysis against the defined standards for the number of each type of practitioner providing behavioral healthcare and the geographic distribution of each type of practitioner providing behavioral healthcare. Data analysis will be performed annually and as needed. The analysis will be reported to The Health Plan's Continuous Quality Improvement Committee (CQI) and Executive Management Team (EMT) with actions taken to maintain and meet the needs of our members.

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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.	THP has policies in place to ensure that individuals in applicable populations who have specialists as PCPs are receiving primary care services on an ongoing basis. It is the policy of The Health Plan to facilitate specialist care and coordination of the benefit for appropriate members. This would apply when the primary care practitioner, in consultation with a specialist practitioner, identifies the need for specialty care for a condition that is not life-threatening, degenerative, or disabling. For Behavioral Health Services, members have direct access to behavioral health practitioners/providers. Treatment plans will be submitted by behavioral health practitioners/providers after the initial evaluation is completed. 1. The primary care practitioner or treating practitioner is responsible for initiating the specialist practitioner coordination referral and supplying appropriate member history. A treatment plan is formulated by both practitioner and the member. The plan of care (referral request) is subject to review by the Medical Department. Behavioral health practitioners/providers will send plan of care for review by Behavioral Health Services personnel. 2. Short-term specialist care (6 month or less) is requested upon a specialist referral form ('SR' referral type), if required by the enrollee's group. Ongoing care over an extended period of time, is requested on a standing referral ('SG' referral type), the number of visits shall be based upon the treatment plan and shall be limited to a one-year period of time. 3. Upon approval of the specialist practitioner coordination referral, the specialist practitioner is authorized to provide and refer for healthcare services in the manner of the primary care practitioner, providing the care is relevant to

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		the expertise of the specialist. 4. In order to ensure appropriate coordination of care, the specialist practitioner shall provide the primary care practitioner or treating practitioner with regular reports on the care provided to the member. 5. For the specialist to continue to coordinate care, the primary care practitioner or treating practitioner is required to request an extension of the specialist practitioner coordination referral every year and to provide updated reports and treatment plans to support medical appropriateness. Not applicable to Behavioral Health Services. Medicaid enrollees must have access to certified pediatric or family nurse practitioners and certified nurse midwives, and may designate as them as their Primary Care Practitioner.
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.	THP monitors PCP panels for compliance with BMS limit on members assigned per PCP. The Health Plan has measurable standards for the number of each practitioner type providing primary care. For internal review, the Network Department will conduct analysis against the defined standards for the number of each type of primary care practitioner to monitor PCP to member ratio. Any deficiencies identified as a result of this analysis will be documented and a plan for improvement will be created. Other account specific reviews may be conducted as necessary to meet the requirements of contracts (i.e. CMS, BMS). This data analysis will be performed annually or as needed according to contracts or per improvement plans aimed at maintaining a network that meets the needs of our members.

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MR018	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).	THP will provide our network standards documentation and geo maps as indicated in the contract. Based upon the data provided in the RFP, THP was able to complete a network analysis located in Appendix 6
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.	It is the policy of The Health Plan to screen employees, providers, outside committee members, agents/brokers and other workforce members through federal exclusion databases to prevent hiring or contracting with individuals excluded from participation in federal healthcare programs. Federal law prohibits the payment by Medicare, Medicaid or any other federal healthcare program for an item or service furnished by a person or entity excluded from participation in these federal programs. The Health Plan, its First Tier, Downstream and Related Entities (FDRs) and providers are prohibited from contracting with, or doing business with, any person or entity that has been excluded from participation in these federal programs. Prior to hire and/or contract date, and monthly thereafter, a check must be performed to confirm all persons employed/contracted to perform administrative or healthcare services for The Health Plan's Medicare or Medicaid lines of business are not excluded from participation in federally funded healthcare programs according to the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) and the System for Award Management (SAM) exclusion lists. Furthermore, a search of the OIG Exclusion database, SAM Exclusion database, Medicare Sanction/Reinstatement report and CMS Preclusion List is performed on all potential, existing and reappointed practitioners, PA-Cs, APRNs, psychiatrists, non-physician behavioral health practitioners/providers and ancillary practitioners/organizational providers to ensure all providers are in good standing with Medicare, Medicaid and

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		other state and federal regulations. This screening of healthcare providers is performed at the time of initial application to the plan, at the time of re-credentialing and ongoing each month. Additionally, state licensing board actions and other regulatory agency postings are reviewed monthly to assure continued credentialing of network providers. Enrollment & participation status reports issued by WV Medicaid (PROV12, PROV98, etc.) are also referenced at the time of initial application to participate with the MCO in the WV Medicaid program, at the time of re-credentialing and ongoing each month to assure program participation eligibility.
MR020	The Vendor must establish and maintain a records retention process in accordance with applicable federal and State requirements, as defined by the Department.	THP has an existing record retention policy that is in accordance with state and federal requirements.
MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.	The Health Plan maintains a comprehensive quality assessment and performance improvement program that complies with all regulatory and accreditation standards. All initiatives for performance improvement are data driven and address barriers and opportunities for improvement. Measurable goals, timeframes and measurable outcomes are incorporated in all activities pertaining to the quality assessment and performance improvement program implemented by The Health Plan. The objectives of our performance improvement programs are developed from identified key drivers that assist to create solutions that improve outcomes, keep costs affordable and improve health and wellness overall using the Triple Aim approach. Aspects of the quality assessment contain quality dimensions in healthcare incorporating quality of clinical care, safety of

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		clinical care, quality of service and members' experience.
MR022	The Vendor must participate in public meetings and other events at the request of the Department.	THP will participate in all meetings that are requested by 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.	As with all previous Medicaid membership or benefit implementation to manage care, THP will meet with various provider councils/associations on a monthly basis or more frequently if needed during the first year of implementation. After the first year, THP will move those meetings to quarterly with the provider community.
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.	After the first year of implementation, THP will meet with the Department and various provider councils/association on a quarterly basis or more frequently if needed.
MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as defined by the Department.	THP will participate in the EQRO reviews 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.	THP will participate in the oral presentations along with the proposed key staff in lieu of corporate or sales personnel.
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.	The Health Plan will provide all requested documentation and participate in the readiness review prior to implementation of this project.

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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.DHHR.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx	We have reviewed the policies and procedures currently on the websites of the West Virginia Office of Technology (WVOT) at https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx and the Office of Management Information Services of DHHR at www.DHHR.org/mis/policies.asp and agree to comply. As an organization guided by the principals of HIPAA, we have already been in compliance with all those policies and standards – with one exception. The Health Plan of West Virginia does not store or process any payment card information, so we do not follow any of the policies for the PCI-DSS standards. Policies in this area will not apply. Regarding compliance with future security policies and procedures...we will work with either WVOT or the Office of Management Information Services at DHHR to meet future compliance efforts. Part of our own compliance process ensures we regularly evaluate our existing policies and procedures to ensure we meet current industry best practices.
MR029	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.	The Health Plan of West Virginia agrees to ensure compatibility with the most current 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.	The Health Plan's (THP's) Compliance Department and Information Systems work closely together to promote compliance with HIPAA. THP's HIPAA privacy and security compliance plan consists of the following elements: 1. Policies and Procedures THP maintains detailed HIPAA compliance policies and

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		procedures to protect the integrity, security and confidentiality of protected health information (PHI). In addition, the policies implement HIPAA's administrative, physical and technical safeguards for the protection of PHI. THP's policies comply with HIPAA's privacy, security, and administrative regulations. The policies and procedures are reviewed on an annual basis, more often if needed. THP has access to outside legal counsel to assist in HIPAA policy development on an as needed basis. Policies and procedures are maintained in an electronic policy management system called PolicyStat which provides reminders when policies are due for review and automatically archives prior policy versions. All employees of THP have access to all HIPAA and Information System policies and procedures through PolicyStat. See Exhibit A for a list of related policies. 2. Privacy and Security Training and Education HIPAA privacy and security training is conducted at the time of hire and on an annual basis thereafter. Annual training is conducted by PowerPoint presentation with the completion of a post-test quiz. Employees must score at least 80% on the post-test quiz to successfully complete the training. Training completion is documented in THP's electronic information system called HEART. In addition to the annual training, the compliance department conducts specialized training on an ad hoc basis. Topics covered in recent specialized training sessions include HIPAA for customer service representatives, business associate agreements, and two-factor member identification.

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		Information Systems security training is also conducted annually. Like HIPAA privacy training, employees must pass a post-test to successfully complete training. HIPAA security reminders are distributed via email (generally twice a month) to all employees. Employees are tested through periodic phishing campaigns distributed by information systems; these campaigns are conducted at least monthly. Employees who fail a phishing campaign must complete additional security training. Through these initiatives, THP has been able to significantly reduce its risk of falling prey to malicious phishing. 3. Acceptable Use and Employee Security and Confidentiality Agreement All employees are required to review THP's Acceptable Use Policy and Employee Security and Confidentiality Agreement at hire and on an annual basis thereafter. All employees attest to each document's content as described below. From the Acceptable Use Policy all employees acknowledge and sign annually: • Effective security is a team effort involving the participation and support of every THP employee and affiliate who deals with information and/or information systems. It is the responsibility of every computer system user to know these guidelines, and to conduct his/her activities accordingly. • All THP computer system users are expected to maintain the confidentiality of any and all sensitive or proprietary information, including PHI and ePHI, and should take care not to intentionally or unintentionally disclose this information

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		by improper use of the Internet or email system. All employees acknowledge and sign an "Employee Security and Confidentiality Agreement" which communicates THP's security and confidentiality expectations to its employees. The following statements are included in the agreement: • I understand that I am responsible for complying with the Privacy and Security Policies, which were provided to me. • I will treat all information received in the course of my employment with The Health Plan, which relates to members as confidential and privileged information. • I will not access patient information unless I have a need to know this information in order to perform my job. • I will not disclose information regarding members to any person or entity, other than as necessary to perform my job, and as permitted under The Health Plan's policies. • I will not log on to any of the computer systems that currently exist or may exist in the future using a password other than my own. • I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my name tag. • I will not allow anyone, including other employees, to use my password to log on to the computer. • I will log off of the computer as soon as I have finished using it. • I will not use e-mail to transmit member information unless the information is appropriately encrypted and password

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		protected as instructed by IS. - Any member information taken from the premises in paper or electronic form shall be maintained in a secure manner and returned to the premises as soon as possible. Employees should have approval from their immediate supervisor prior to taking information from the premises. - I understand that The Health Plan has and will have products, prices, discounts, costs, business affairs, future plans, process information, customer lists, member records, software products, and other information (collectively, "information") which are confidential and/or proprietary. I agree that I will not at any time or in any manner, either directly or indirectly, use any information for my benefit, or divulge, disclose or communicate in any manner any information to any third party without the prior written consent of The Health Plan. I will protect the information and treat it as strictly confidential. - Upon cessation of my employment with The Health Plan, I agree to continue to maintain the confidentiality of information I learned while an employee and agree to turn over keys, access cards, or other device that would provide access to The Health Plan or its information. - I understand that during the course of my employment at The Health Plan I may be developing, creating or accessing intellectual property related to the business of the Company. Such property developed by employees will be deemed owned fully and completely by the Company. The

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		term "Intellectual Property" includes all information and records pertaining to any process, trademark, service mark, invention, technology, computer hardware or software, documentation software, trade secrets, financial and accounting data, personnel information, data processing and communications information, technical data regarding the business of The Health Plan, its services, and the method and manner of delivering those services, inventions, technological innovations, discoveries, designs, formula processes, patents, trademarks, service marks, copyrights, ideas, creations, improvements to all such property, whether written or not, and whether stored in plain or in code form that relate to, or compromise Health Plan knowledge or trade secrets. 4. Risk Assessment The Health Plan conducts annual security risk assessments through a software product called HIPAAOne. This risk assessment tests THP's compliance with HIPAA's security rule requirements related to administrative, physical and technical safeguards. The privacy team and security team work together to complete the annual assessment including any needed remediation. Penetration tests are performed on an annual basis by industry-leading network security research organizations. The scope of the test is any external device with an IP address. All devices are tested for all known vulnerabilities including web application penetration testing. The penetration test results are used by both the IT and Compliance

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		departments to help gauge enterprise vulnerability risk. If results are applicable to the software development area, they are shared with the software development manager. Discovered vulnerabilities are remediated in order of criticality, with high or medium risk vulnerabilities fixed first. 5. Business Continuity Plans THP uses a tool called Kings Bridge Shield Support. The software tool allows THP to identify and document its disaster/contingency teams, identify and grade its risks and develop plans in the event of a disaster. The purpose of the Emergency Response Plan is to establish a streamlined and clearly defined emergency response procedure to assist the company's normal operating forces responding to a severe emergency for an extended period of time. This plan maximizes the capacity to prepare for, respond to, and recover from all types of power system emergencies and disruptions. The IT department maintains a Data and Program Back-Up policy. The mainframe system is tested on a bi-annual basis. Data is restored at a contracted cold site located 3 hours away which is also THP's mainframe hardware and software support vendor. A claims processing job is executed to test integrity. Network servers are regularly restored by network operations staff to THP's Charleston, WV datacenter for regular change control and testing purposes. In addition, a security incident response plan is used to safeguard the confidentiality, integrity, and availability of

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		operational and member PHI through an established information security incident response process. THP's incident plan covers the standard 5 step plan: identification, containment, eradication, recovery, and follow-up/lessons learned. THP also has a security incident report template document to track events during an incident. 6. Monitoring Activities THP incorporates a number of monitoring activities into its HIPAA privacy and security plan. These activities include the following: Security metrics are reported monthly to the Senior VP of Information Systems who then presents a report to executive management. The security metrics cover the following areas: • Phishing test results including the company-wide click failure rate • Malware stats including the total number of emails blocked, the total number of websites blocked, and the total number of viruses detected • Network security vulnerabilities including the total number of external security vulnerabilities by risk (high, medium, low) • Security incidents including malware which evaded email filters and persistent external network attacks • Timelines of keycard and network access removal for terminated employees

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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.	THP will comply with all applicable State and Federal law regarding confidentiality/privacy. THP has a privacy and security program in place to promote compliance with the HIPAA privacy and security rules as well as other privacy-related regulatory requirements. The compliance team and Information Systems work together to regularly review, access, and improve its system for protecting the confidentiality of member data. The organization has administrative, physical and technical safeguard in place to protect the confidentiality and integrity of electronic protected health information. The organization has policies and procedures in place that prohibit the release of information other than as permitted by law.
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.	THP will incorporate all requirements that are mandated through federal, state and legislations into our processes including any new 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.	The THP Compliance Program covers all lines of business including Medicaid. The Compliance Plan includes a Medicaid addendum which addresses Medicaid-specific compliance requirements. The Compliance Program includes Medicaid related auditing and monitoring activities in its compliance and audit work plan. THP has a dedicated SIU department to address potential issues of fraud, waste and abuse (FWA) related to the Medicaid line of business including responding to requests for documentation from various regulatory authorities including the Medicaid Fraud Control Unit. The Compliance Department assists the Medicaid Department in tracking completion of various routine and ad hoc reporting obligations.

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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.	The Health Plan ensures our websites are Section 508 and West Virginia Medicaid compliant. We also earned a Security SSL grade of "A" in an annual external penetration test of all THP websites. This designation shows our commitment to the safety and security of each member's benefits and protected health information.
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.	The Health Plan of West Virginia, Inc. maintains a records retention policy compliant with State and federal requirements as well as those of our partners and will include the requirements of this Foster Care program. Our record retention period is at least ten (10) years for data related to our Medicaid contract(s). Data entered in The Health Plan's information system, including its network files, are archived and maintained for at least ten (10) years. The system is backed up in accordance with an established back-up schedule. Data is archived and accessible on the organization's network servers. Exact back-ups are maintained off site ensuring that in the unlikely event of data loss the data can be restored
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.	THP will obtain approval from the department for all key staff that are hired for this project. If necessary, THP will replace with staff of equal or greater experience and qualifications. All key staff will be assigned to the Medicaid block of business on a full-time basis. All of the key staff identified with this proposal are existing THP staff and will be officially moved to the project within 30 calendar days of the contract award. We will provide the department a 10-day notice of any key staff changes and will replace key staff within 30 business days. If needed, THP will request an extension from the department if we are not able to find a qualified replacement within the 30 days. THP will remove

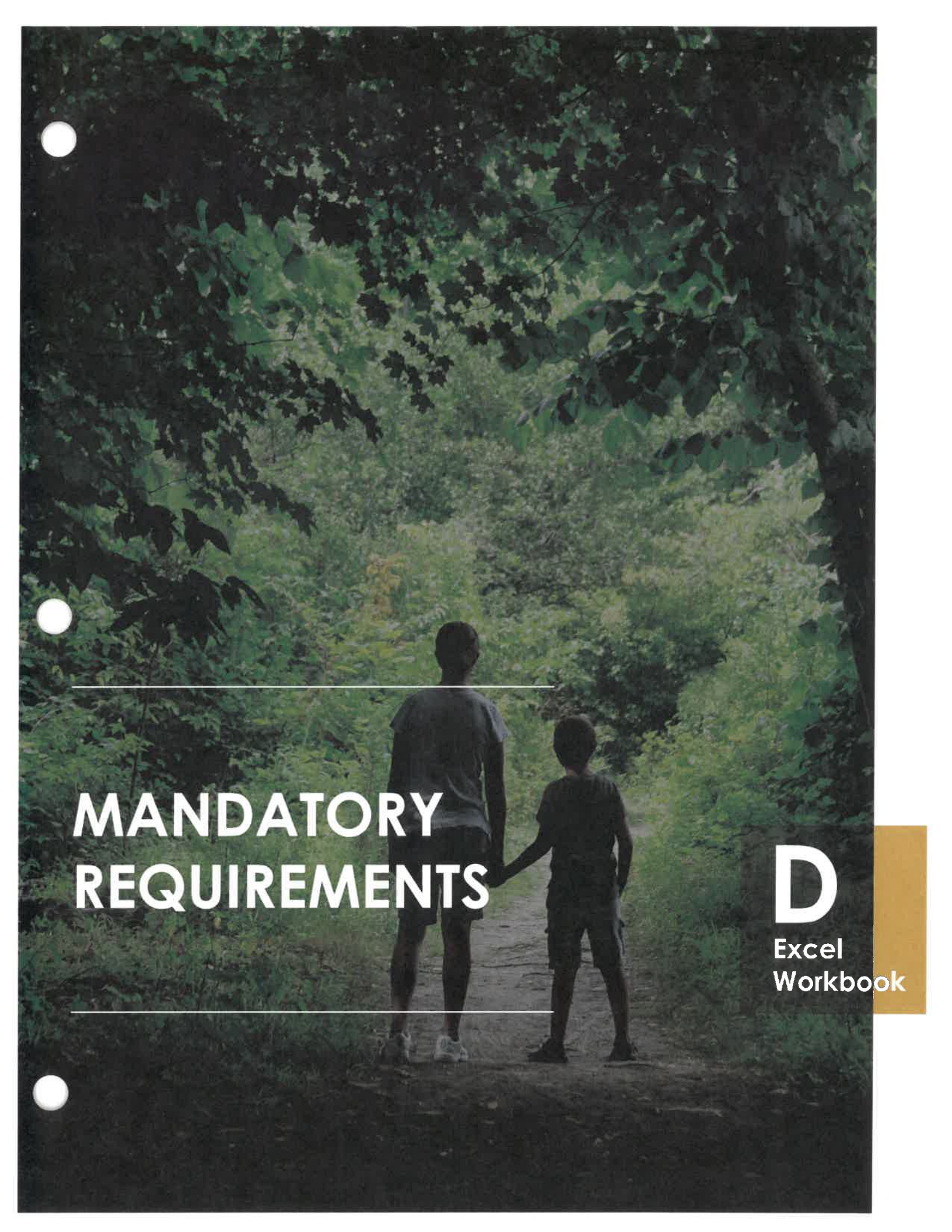
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		any staff that are involved in this project if the department determines that staff has interfered in the best interest of the project.
MR037	The Vendor must employ Key Staff assigned to the project on a full-time basis. Each Key Staff role must 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.	Refer to MR036.
MR038	The Vendor must provide the Department a minimum of ten (10) business days' notice for staffing changes.	Refer to MR036.
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.	Refer to MR036.
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.	Refer to MR036.
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.	THP accepts financial, legal, ethical and all other forms of responsibility for the conduct of our business partners, independent contractors, subcontractors, employees and other entities supporting this project.

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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 have multiple policies and controls in place to ensure protection of information from unauthorized staff and other users. See below for highlights: <u>Data Encryption Policy:</u> • "It is the policy of The Health Plan (THP) to implement technical security measures to guard against unauthorized access to, or modification of, electronic protected health information (ePHI) during transmission over an electronic communications network or removable media." <u>Integrity of Electronic Protected Health Information Policy:</u> • "It is the policy of The Health Plan (THP) to protect the integrity of the electronic protected health information (ePHI) it maintains in a manner which complies with the Health Insurance Portability and Accountability Act (HIPAA)." <u>Log In Monitoring Policy</u> • "It is the policy of The Health Plan (THP) to implement log-in monitoring within the capabilities of its information system applications in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule." <u>Acceptable Use Policy:</u> • "Computer system users must not automatically forward email to a third-party email system." <u>System Privileges Policy:</u> • "It is the policy of The Health Plan (THP) to restrict information system privileges based on the need-to-know."

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		<i>"All users must sign a compliance statement prior to being issued a user ID. A signature on this compliance statement indicates the involved user understands and agrees to abide by THP policies and procedures related to computers and networks"</i>
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.	Upon award of the contract, THP will ensure that all applicable staff have completed the Department Office of Management System Vendor Employee Confidentiality Statement 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.	THP complies with EEO, Clean Air Act and Clean Water Act. The Health Plan is an EO employer. The EEO statement is posted on our THP website and on our application. A statement is also located in our employee handbook. The Health Plan provides equal employment and advancement opportunities to all people. The Health Plan makes employment decisions based on each person's performance, qualifications, and abilities. The Health Plan does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual identity or orientation, transgendered status, homelessness, ancestry, national origin, age disability, military status, recipient of public assistance or any other characteristic protected by law.
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.	The Health Plan provides a drug-free, healthful, and safe workplace. Employees are required to report to work in appropriate mental and physical condition to perform their jobs in a satisfactory manner. While on company premises, no employee may use, possess, distribute, sell or be under influence of alcohol or illegal drugs. Each applicant for employment will be required as a condition of employment to undergo a pre-

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		employment drug screening. If an applicant tests positive and is determined to be in violation of this policy, the applicant will be ineligible for employment. THP has policies and procedures for a drug free workplace and this is also states in our employee handbook.
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.	THP has designated Jill Medley as our 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.	The Health Plan will no publish or copyright any data using the Department's name without prior written approval by the Department for every instance, 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 form 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 Health plan or its agents, subcontractors, or representatives pursuant to the contract other than The Health Plan's internal administrative procedure records."

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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.	THP accepts responsibility for all expenses required to obtain and maintain access to the Departments systems for this procurement.
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.	THP will make available to the department the results of all third party audits conducted when requested.
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.	THP agrees and will provide authorization for the State to have access to our records if our performance impacts the contract.



MANDATORY REQUIREMENTS

D
Excel
Workbook

Excel Workbook

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	Tab D	D-1
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	Tab D	D-1
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	Tab D	D-1
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	Tab D	D-1
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	Tab D	D-2
MR006	The Vendor must comply with requirements for qualified residential treatment program (Q RTP) placements as described in the Service Provider Agreement (SPA).	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Tab D	D-2
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	Tab D	D-3

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR008	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA).	Accreditation	Will Meet	Attachment D - Mandatory Requirements	Tab D	D-3
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	Tab D	D-3
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	Tab D	D-3
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	Tab D	D-4
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	Tab D	D-5
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	Tab D	D-5
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	Tab D	D-9
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	Tab D	D-11
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	Tab D	D-16

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
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	Tab D	D-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	Tab D	D-18
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	Tab D	D-18
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	Tab D	D-19
MR021	The Vendor must implement and maintain a quality assessment and performance improvement program, as defined by the Department.	Quality	Will Meet	Attachment D - Mandatory Requirements	Tab D	D-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	Tab D	D-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	Tab D	D-20
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	Tab D	D-20
MR025	The Vendor must participate in external quality reviews in alignment with federal and State requirements, as	External Quality Reviews	Will Meet	Attachment D - Mandatory	Tab D	D-20

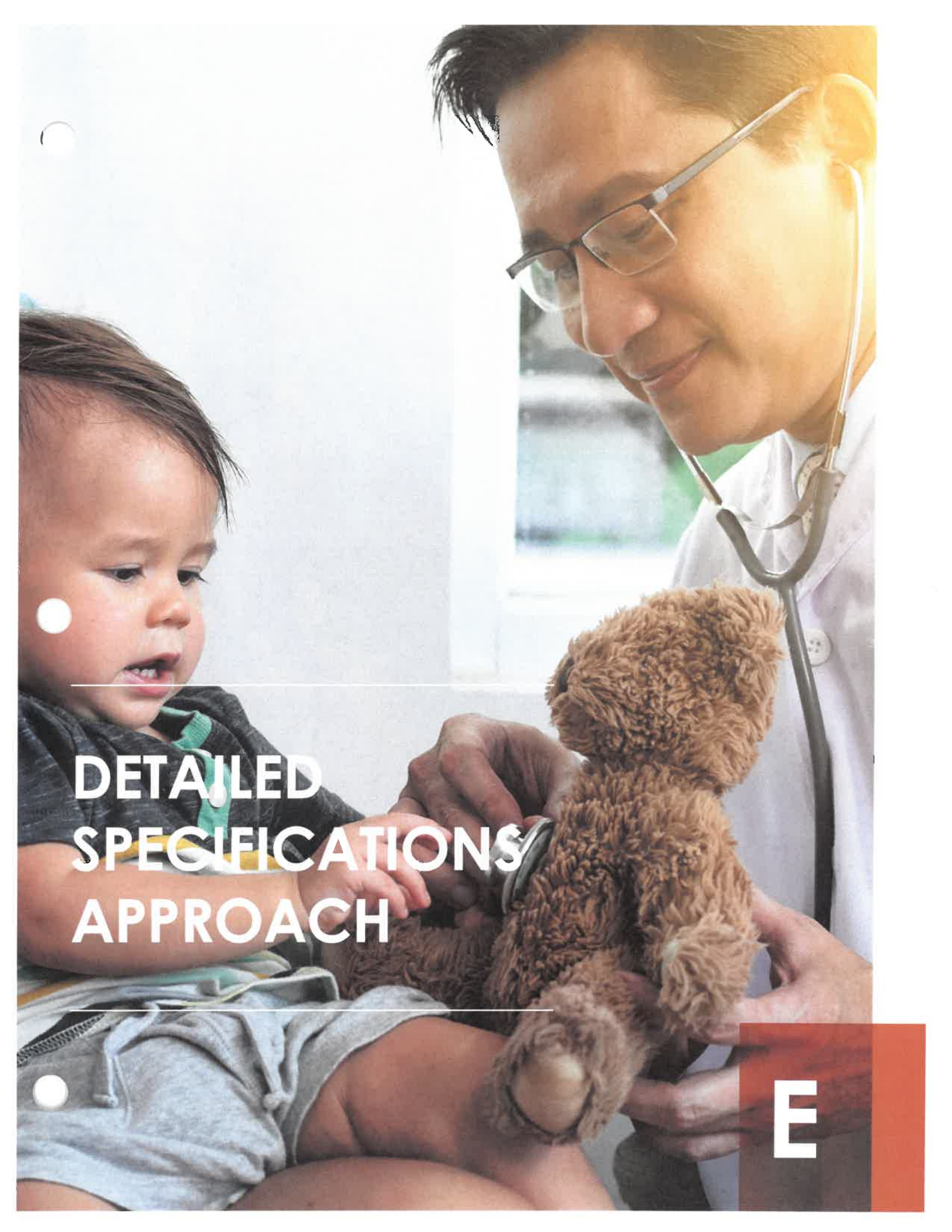
Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
	defined by the Department.			Requirements		
MR026	The Vendor must participate in the oral presentations to be scheduled during the proposal scoring period. Proposed key staff must be present for orals, in lieu of corporate or sales personnel being the primary participants.	Orals	Will Meet	Attachment D - Mandatory Requirements	Tab D	D-20
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	Tab D	D-20
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	Tab D	D-21
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	Tab D	D-21
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	Tab D	D-21
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	Security	Will Meet	Attachment D - Mandatory Requirements	Tab D	D-29

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
	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 reporting requirements.	Federal and State Requirements	Will Meet	Attachment D - Mandatory Requirements	Tab D	D-29
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	Tab D	D-29
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	Tab D	D-30
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	Tab D	D-30
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	Tab D	D-30
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 D - Mandatory Requirements	Tab D	D-31

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
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	Tab D	D-31
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 D - Mandatory Requirements	Tab D	D-31
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	Tab D	D-31
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	Tab D	D-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	Tab D	D-32
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	Tab D	D-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	Tab D	D-33

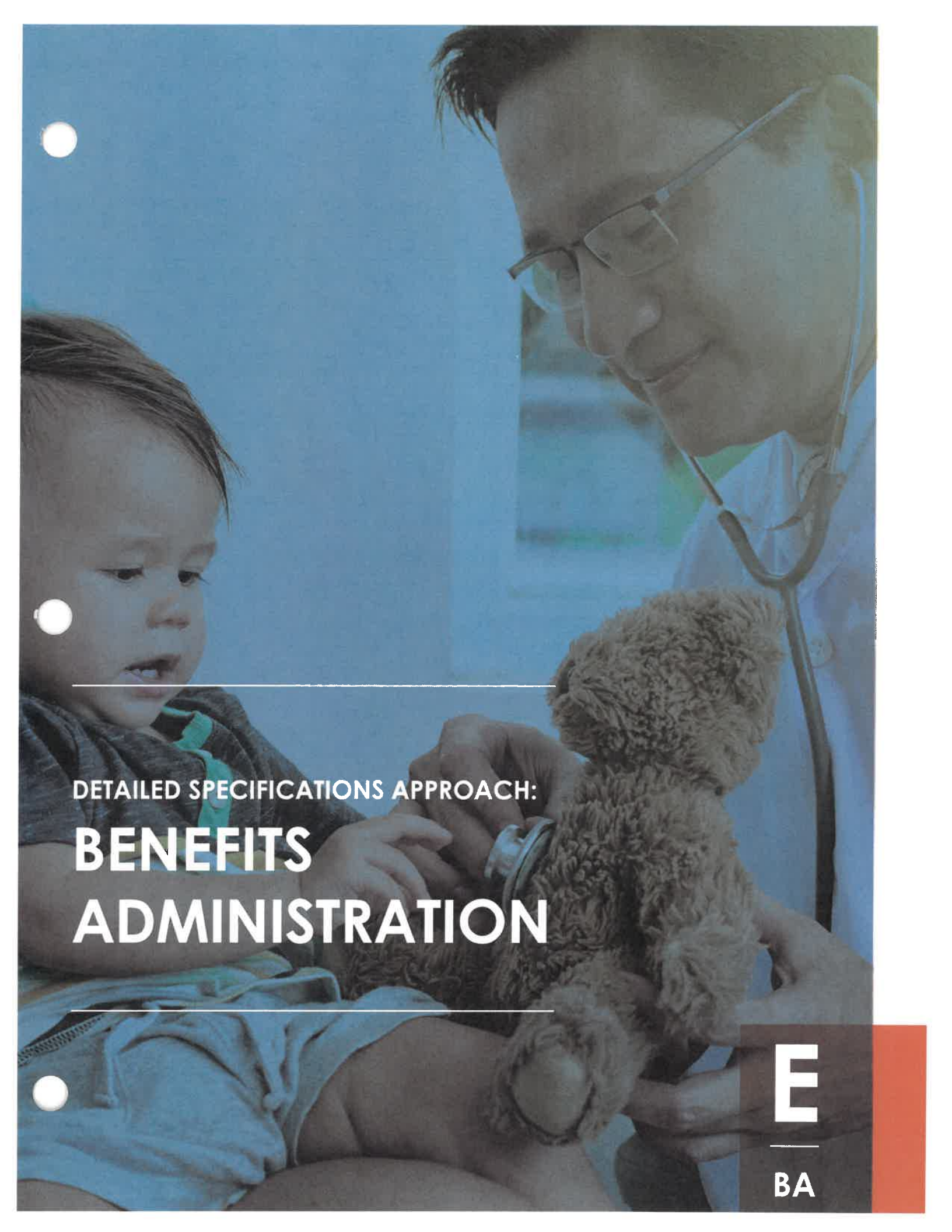
Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
MR045	The Vendor must provide a drug free workplace for employees and all applicable agents, including, but not limited to, subcontractors. All agents of the Vendor must not engage 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	Tab D	D-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	Tab D	D-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	Tab D	D-34
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	Tab D	D-35

Mandatory Requirements			Vendor Response			
Req ID #	Requirement Text	Type	Vendor's Disposition	Attachment	Section	Page #
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	Tab D	D-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	Tab D	D-35

A photograph of a male doctor with glasses and a stethoscope, smiling as he examines a brown teddy bear. The bear is being held by a young child with dark hair, who is looking at the bear. The scene is set in a bright, clinical environment with a window in the background. The text 'DETAILED SPECIFICATIONS APPROACH' is overlaid in white, bold, sans-serif font on the left side of the image.

DETAILED SPECIFICATIONS APPROACH

E

A photograph of a male doctor with glasses and a stethoscope, smiling as he examines a child's brown teddy bear. The child is sitting and looking towards the bear. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

BENEFITS ADMINISTRATION

E

BA

E. Detailed Specifications Approach

Benefit Administration

The foci of this section are the business processes and management system associated with: intake; utilization authorization; referral processes; provider identification and engagement; compliance monitoring; fraud and abuse monitoring and tracking; access to family and individual data; referral guidelines associated with provider network and non-network authorizations, as well as authorizations to specialty and sub-specialty providers, access to family and individuals' non-network providers' information, acute, in-patient care admissions, appointment scheduling and follow-up. It further outlines the manner in which family and individual general utilization of all services—primary, acute care, and behavioral health services are tracked and monitored; and, the manner in which individuals and families with special healthcare needs are managed.

Where appropriate, sections will be blended, but identified in the labeling process to ensure that the reader understands that THP understands that its primary goal in this section is to outline a comprehensive design of business processes that will support a more comprehensive approach to a fully integrated system to support total family and individuals' care, and access to services in a seamless manner. This submission reflects THP's experience in implementing a successful managed care organization that fully addresses patient intake and outcomes of its members and providers. THP will use the same logic that has made it a successful managed care organization to implement a fully integrated system that blends socially necessary services with medically necessary services for its members.

THP recognizes that often when individuals (and families) with co-occurring medical (physical and/or behavioral) health issues are not systematically addressed their socially necessary or medically necessary services will likely go lacking. The system proposed herein is one that blends all systems that individuals and families rely upon, and it brings to bear the skills and support of case managers who now will work with healthcare professionals to ensure that family and individual needs are appropriately addressed, that costs are managed, and that providers are teaming with care professionals for the successful outcomes of members.

Finally, this section presents a comprehensive outline of THP's approach to blending several systems of technology and tested business practices for an efficient approach to service acquisition, utilization, monitoring and compliance for children and families in the child welfare system. THP understands West Virginia's desire to draw upon the well-developed expertise of a managed care organization's approach to managing the healthcare and socially necessary needs of network foster care members. THP commits to deploying its experience in meeting federal and local utilization standards of members to this enterprise in a cost-efficient manner. This solicitation and THP's response to it, represents a tremendous opportunity for THP and the state of West Virginia to align two desperate systems serving the same population for improved outcomes of that population in a cost-efficient manner.

BA001	The Vendor should establish and implement authorization criteria for socially necessary services (SNS).
BA002	The Vendor should establish and implement a process for providers to request authorization for socially necessary services (SNS).

THP has reviewed and evaluated the current criteria for Socially Necessary Services (SNS). The criteria provided offers a framework for the initial evaluation of services. THP anticipates that we would work collaboratively with agencies, providers and DHHR to evaluate the criteria and update as appropriate.

- THP and KVC will jointly develop a team comprised of agencies and providers who will work in a collaborative effort with input from DHHR to:
 - Develop documentation and standards for review and approval of all socially necessary services (SNS) based on current criteria
 - Evaluate evidence-based criteria and utilize evidence informed tools to establish guidelines for SNS services.
 - Establish criteria consistent with requirements of the Family First Prevention Services Act
- Incorporate data from DHHR into this process, if available, and in future data collected by THP such as:
 - Historic utilization data by provider/member/region, such as over/under utilization concerns including spending by family and outcomes.
 - Review impact of SNS services on preventing removal of a child from the home and/or future CPS intervention in both a cost efficient and outcomes-driven manner
 - Analyzed data on service audits (i.e., did service meet criteria, did documentation support service delivery, etc.)
 - Develop tools and processes to ensure consistent documentation reflective of care standards
- THP's education component will be part of a process to ensure clear and consistent understanding of how services should be utilized, delivered, and reported:
 - Conduct DHHR case worker education to ensure correct services are requested at correct levels and frequency and educate agencies and providers with the expectations and processes.

THP handles medical and behavioral health service authorizations through existing processes that could easily be duplicated for SNS. THP provides multiple options for providers to submit authorization requests.

There are five options for submissions of authorization request:

1. Electronic submissions (provider secure portal, care connection file, and HIPAA compliant transaction)
2. Telephonic preauthorization submissions
3. Fax capability for submission of clinical information and written requests

4. 24 Hour Emergency Access line and physician access line for urgent/emergent requests

5. Secure email

All SNS service requests will be handled consistently with THP existing prior authorization processes and will meet the required specified timeframes. THP will provide necessary forms and information on the preauthorization process on the website and in the provider manual. Education will be provided to SNS providers prior to implementation.

The negotiated agreement with DOJ requires the development of Mobile Crisis Teams for children and families across the state, accessible to any child in crisis within one hour. These teams will be developed in compliance with the implementation plan developed by DHHR and approved by DOJ and will be utilized by the wraparound facilitators and navigators as an emergency intervention to support families and children.

BA003	The Vendor should establish and implement a process to review authorization requests for socially necessary services (SNS).
BA004	The Vendor should apply utilization management guidelines to retroactively review socially necessary services (SNS).
BA005	The Vendor should coordinate socially necessary services (SNS) 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.

THP intends to incorporate available historic data from DHHR's existing database to serve the foster care population and their caregivers and families. THP will evaluate from available data bases; historic utilization; providers; members' profiles; regions and localities; over/under utilization; family, children and youth outcomes; and costs of services.

THP commits to developing a methodology to evaluate socially necessary services (SNS) and their effectiveness, especially where children and youth have been removed from the home. Such an evaluation will assist THP in concluding what services are appropriate, effective, and have a decisive impact on whether children are or are not removed from the home. Our partnership with KVC Health Systems, along with THP's experience in managing costs, will allow us to collaborate as we determine necessary versus unnecessary services to ensure children, youth, and families are safely supported in the home. These strategies will ultimately reduce the number of children requiring out-of-home placement and out-of-state placements.

THP will transition this work to its system by auditing services and their appropriateness through sampling a limited number of cases during the past five (5) years. This sampling will retrospectively review the appropriateness of such services through the lenses of costs and outcomes and gauge the viability of the current approach. Moreover, the sampling will support the development of documentation tools reflective of care standards that support best practices in the delivery of SNS.

The education of all partners, social workers, case managers, THP Navigator(s), providers including foster care providers, is an essential component of THP's model of care. Caseworkers will be educated on the correct levels and frequency of services that children, youth, and families should receive. Learning modules for providers will be developed to ensure that providers are continuously kept up to date. Improving the knowledge base of all partners requesting services and using the system of services, over time, will determine how the services are accessed and utilized.

THP's service delivery model and tracking of member outcomes rely significantly on technology. Upon submission THP will facilitate handling of service authorizations and reviews and retroactive authorization requests. Information for all requests will be submitted electronically or one of the submissions indicated previously for authorization requests and will incorporate information from Individualized Service Plan (ISP) and the Multidisciplinary Treatment Team (MDT) documentation. THP shall review each authorization request in accordance with established guidelines through systematic means with additional review by THP SNS Referral Coordinators as needed. If it is determined that services requested do not meet established guidelines, the SNS Referral Coordinator shall forward the request to the THP Navigator who will review the information with the DHHR Caseworker and other members of the MDT if necessary. The authorization review shall follow the same required timeframes as Medical and Behavioral health authorization request. Upon completion, the authorization determination shall be provided to the SNS provider, the member and the MDT using THP's web portal or by mail when necessary.

THP's web-based technology allows member's records to be electronically filed for timely and consistent access to their information and tracking of their outcomes and costs. Maximizing the use of technology also ensures timely and consistent handling of requests, approvals, and denials, which are available for real-time viewing and decision-making. The model allows all parties—DHHR caseworkers, care managers, agencies, providers, and THP navigators, — immediate access to information necessary to make decisions and track members outcomes and costs through a "drop box" type technology that THP will facilitate THP will collaborate with the MDT in the development of the ISP and the Family Service plan (FSP) to guarantee care and services are coordinated across all systems. THP is cognizant of the DOJ negotiated agreement and understands the requirements regarding Child

Multidisciplinary Treatment Teams (MDTs)

- A team designed to assess, plan, and implement a comprehensive, individualized service plan for a child who is involved in court proceedings either because of child abuse and neglect, status offense, or delinquency proceedings. This team includes the child's custodial parent(s) or guardian(s), other immediate family members, the attorney(s) representing the parent(s) of the child, the child if over the age of twelve (12) or the child's participation is deemed appropriate, the Guardian Ad Litem, the prosecuting attorney, and any other person who may contribute to the team's efforts to assist the child and the family.

and Family Service Planning, coordinated by the Wraparound Facilitators. Part of the focus of this team will be to assist in identifying socially necessary services that will assist the family to successful reunification. THP will comply with all DHHR policies and procedures identified in the implementation plan to be approved by DOJ. Also please change any language about "community based case managers" to Wraparound Facilitators (WF).

THP shall employ a SNS liaison who will work with the MDT as needed to locate appropriate SNS providers and to assist in the coordination of services with the SNS provider. When necessary, the SNS liaison will assist in scheduling of services with the SNS provider.

THP will develop protocols for families designated as at-risk of losing their children to the foster care system. Through evidence-based approaches, THP will evaluate the families' risk factors that make them susceptible to losing their children and introduce timely interventions that reduce the likelihood of children going into the system. Areas to be reviewed for efficiencies are home visitation programs, strengthening family programs, West Virginia systems of care, the Child Help Line, Crisis tip line, and educational processes, among others.

The entire process will be data driven and impact focused. Leveraging data to develop best practices and evidence-based criteria will lead to system change.

THP recognizes the need to engage the foster child's biological and placement family in the MDT, and it will make every effort to do so. Additionally, THP will invite other parties that have insights potentially valuable to the MDT: child welfare providers, behavioral health providers, medical providers, community-based care managers ("Wraparound Facilitator"), youth service workers, educators, court representatives, and family representatives, as appropriate. If needed, other community-based providers, social workers, and relevant stakeholders will be included in the process. The MDT shall meet and evaluate the child in a timely and regular basis, but no less than every 90 days and within seven days of the initial preliminary assessment, and assure appropriate entities are included in the communication process.

THP will work with members of the MDT to promote a collaborative process and development of a cohesive plan adapted to the member's individual preferences and needs. Team coordination is an ongoing task facilitated by the THP Navigator (s). As changes to the treatment plan are identified, it is updated and shared with MDT members and others who need to be informed of necessary changes. Progress toward goals is documented in the plan. During MDT meetings or during transitions in care or care events, the team collaborates to evaluate progress and implement necessary changes to the plan of care. As appropriate, the THP Navigator(s) may recommend the addition of other members to the team for improved care planning such as:

- Pharmacists for medication reconciliation, medication review, medication discrepancies, drug interactions, etc.
- Behavioral health and/or SUD specialists when members are diagnosed with or have a behavioral health diagnosis, substance use disorder or severe and persistent mental health issue
- Disease Management THP Navigator(s) when complex disease or other specific needs are

identified in members with diabetes, respiratory conditions, cardiac conditions,

- Nurse Navigator management of perinatal process and high-risk pregnancy including neonatal abstinence syndrome (NAS)
- Clinical specialists when expert medical treatment and opinions are needed
- Primary caregiver for coordination, direction, and integration of services
- Social worker or community case worker when additional support is needed to access outside resources for improved outcomes related to social determinants of health
- Physical, occupational, and/or speech therapist when therapy is required to regain or maintain functionality in a particular domain
- Dietician or nutritionist when a need is identified for diet specific education
- Pastoral care to help support religious and cultural needs
- Socially necessary services providers
- Foster Care service providers

BA007 The Vendor should support the Department caseworker in the development of the member individualized service plan (ISP).

THP will work with the DHHR caseworker at every stage of the child(ren) and family's transition through the foster care system. This system consists of multiple stakeholders, all of whom will create a plan of care for either the child, the family or both. THP's navigators will be responsible for collating all of these plans into a unified whole in collaboration with the MDT. When a child and family are brought to the attention of a DHHR case worker, the case worker creates a Family Case Plan which, particularly if unsuccessful, can become a child's Case Plan.

When the child's case worker notifies THP that a child has been removed from parental care, the THP Navigator will immediately open a navigation case and begin addressing the child's immediate needs. An initial contact will be with the DHHR case worker to identify and assist with all information that the case worker was unable to address and to create a "drop box" to begin to make that information available, as it is collected, to the identified appropriate stakeholders. The THP Navigator will assist the DHHR case worker to develop the child's case plan which will be taken to the initial MDT meeting for discussion and amendment as necessary.

In the meantime, the THP Navigator has developed an internal case plan which begins to address immediate care needs such as medical evaluation, ensuring the medications and DME are available and that the child's initial appointments for EPSDT screening are made. When appropriate the THP Navigator will identify a Wraparound Facilitator to assist with activities that need to be addressed on site. THP is cognizant of the DOJ negotiated agreement and understands the requirements regarding Child and Family Service Planning, coordinated by the Wraparound Facilitators. Part of the focus of this team will be to assist in identifying any necessary services and supports that will assist the family to successful reunification. THP will comply with all DHHR policies and procedures identified in the

implementation plan to be approved by DOJ. The navigator will work closely with the WF to develop and implement a person and family centered plan that will be coordinated with the plan developed by the MDT, and reviewed, monitored and adapted as necessary.

All three care managers (DHHR case worker, THP Navigator and "Wraparound Facilitator") will attend the initial and ensuing MDTs in order to assist development of the MDT master service plan and to report on progress and make recommendations for amendment as appropriate.

BA008 The vendor should use family service plans (FSP) and individualized service plan (ISP) information, as applicable from the Department caseworker, to authorize socially necessary services.

The DHHR case worker will work with the THP Navigator to collect information that will facilitate development of the FSP and the ISP. These plans are an integral aspect of the materials available to the Navigator as part of the case management process. When SNS are identified as being necessary and appropriate in order to implement the Plan(s), the THP Navigator will assist the DHHR case worker to file the request for services and to process the authorization as needed. Because the THP Navigator is in frequent contact with the DHHR case worker and with the "Wraparound Facilitator", as well as the family and when appropriate, the child, the Navigator is always aware of the course of events with the child and family and remains on top of support services that may be needed by the family or the child, including any foster or kinship "parents" that are involved in the case. THP is cognizant of the DOJ negotiated agreement and understands the requirements regarding Child and Family Service Planning, coordinated by the Wraparound Facilitators. Part of the focus of this team will be to assist in identifying socially necessary services that will assist the family to successful reunification. THP will comply with all DHHR policies and procedures identified in the implementation plan to be approved by DOJ.

DHHR's caseworkers are critical to the overall functionality of this model. THP recognizes them as individuals with important relationships with children/youth and families. THP also knows that they have access to the most current and functional information about family and individual functionality and needs. THP will use information generated and provided by caseworkers to authorize both socially necessary and medically necessary services. THP intends to work closely with caseworkers to ensure that they have important and needed information to support their oversight and that legally mandated responsibilities are appropriately executed. This will mean that THP's deliberative teaming with DHHR's caseworkers will become a natural way of working. Over time, this collaboration will guarantee that families and individuals' service plans covering healthcare and socially necessary services meaningfully reflect needs that can be tracked, monitored, and measured.

As has been noted by the report done by DHHR entitled "West Virginia Child and Family Services Plan", there is a need for evaluation and quality management of SNS across the board, and this evaluation can be readily identified as a THP Quality Initiative.

BA009	The Vendor should establish medical necessity guidelines specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for applicable populations.
BA010	The Vendor should establish processes specific to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in all geographic areas, for applicable populations.
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.
BA012	The Vendor should use reports to monitor Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

As an established MCO, THP has demonstrated experience base in meeting the required EPSDT standards outlined in the SPA and intends to deploy its established experience to address these requirements in the population that THP will serve upon contract award. THP's experience in serving medically fragile populations, who are challenged because of inadequate access to information or because of cultural and socio-economic barriers, will serve as a guide for ensuring that all of the applicable populations served in the model will have access to readily available information about the necessity and importance of EPSDT. THP's past strategies in developing visual, audio, and paper-training materials that informs and guide populations served through THP's in a respectful manner will be tools modified specifically to inform the population being served under this solicitation.

Materials used will be culturally sensitive and developed at learning levels that teach and inspire the affected populations to access this service. As THP has done in its current service model, its EPSDT guidelines are based on federally mandated requirements, which will be transported into the service model that will be implemented under this solicitation. THP recognizes that its services are intended to be system-wide across the state of WV and must be population specific as they are aimed at the diverse populations across the state. THP will ensure that its literature and informational materials as well as its approach to guiding and monitoring individuals who will access these services are sensitive to the diverse needs of the populations served.

THP's medically necessary guidelines for the EPSDT services will be aligned with federal requirements and will be designed to ensure that the state consistently meets its federally mandated requirements. The medically necessary guidelines for this service will, where necessary be included in the individual service plan and/or the family service plan. Maintaining this information in this document will make tracking and monitoring possible as THP is putting in place a service delivery model that is fully integrated. The processes use to implement this program will be specific to the communities in which these services are being implemented.

THP has reports in place to monitor for EPSDT services. These reports are used to identify outreach needs with members and their providers and to ensure services are provided in a timely manner.

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.

THP has very sophisticated computer systems and the ability to interface electronically with various entities. This enables THP to incorporate a complete case record for the child and or family where caseworkers can track appointments, care needs and other key elements. This information can be used for reminders and outreach in a variety of ways:

- THP member advocates make targeted calls to members with appointment reminders, gaps in care or service and general follow-up on identified issues
- Electronic reminders through phone, texting and email can be generated through THP COMET systems as a means of reminders and engagement
- THP can collaborate with providers and other stakeholders to assist in reminder and engagement in other care needs.
- Through sharing of centralized information, the various stakeholders involved in the child's and/or family's care will all have access regarding scheduled appointments and needed reminders. THP will educate all of those entities to review those items every time they are involved with the child and/or family and/or caregiver.

BA014 The Vendor should assist in rescheduling appointments and removing potential obstacles to care, including, but not limited to, transportation.

Continuity of care is critical to the success of families and individuals' well-being regardless of their point of entry in the system. Developing a schedule for all appointments (annual physicals, behavioral health counseling, case management encounters, dental, etc.), and ensuring that those appointments are consistently kept through reminders, will be key to the well-being of families and individuals.

During intake, assessment of needs by the navigator will occur. Information will be gathered from the member to ensure that authorizations to resources and follow-up for visits are identified and completed. If barriers are identified, the navigator assists the member in making arrangements so that appointments are kept. Advocates will assist members in setting up all subsequent appointments as needed. THP realizes that there are a number of barriers that members encounter and, as a member of the members care team, will engage in problem solving with other team members to address the barriers. Care managers will identify the barriers to care during the initial assessment and through ongoing reassessment as needed.

THP will maintain an electronic tickler alert system that tracks members appointments, kept and missed. The navigator or advocate will contact the member or caregiver when an appointment has been missed and will attempt to reschedule missed appointments.

Where transportation is the issue, THP believes that coordination of non-emergent transportation for members promotes compliance and favorable outcomes with regard to continuity of medical care for its members. THP will coordinate non-emergent transportation through the NEMT broker contracted with West Virginia Medicaid.

Regular communication with providers will ensure that members are keeping appointments. Review of monthly claims will allow the navigator to determine if the member is following up with the provider. During outreach to the member, the navigator, social worker, and member advocates will work with the member to remove obstacles to care and to determine if social determinants of health need to be addressed. Identified barriers identified at intake will be monitored on an ongoing basis by the caseworker to ensure that obstacles will continue to be removed. All data will be maintained in the electronic database in the members' records for future reference by THP Navigator(s).

Case example: Ben, a 6-year-old child, has experienced a severe displaced fracture of the tibia and his PCP wishes him to see an orthopedic surgeon as the tibia does not seem to be healing well. The THP Navigator assists Ben's foster parents to locate and make an appointment with an orthopedic surgeon and registers them for transportation to the provider, which is quite distant. The THP Navigator calls the day before the appointment to remind the family of the appointment and to confirm their attendance. Unfortunately, Ben's Foster Father is ill and the family cannot make the appointment, which has to be rescheduled. The THP Navigator cancels tomorrow's transportation and with the Foster Mother on the phone, calls the Orthopedic Surgeon's office and reschedules the appointment. The Navigator then reschedules the transportation and again calls the family to remind them of the appointment the day prior to the rescheduled appointment.

BA015	The Vendor should develop and review utilization management guidelines for physical health and behavioral health services.
BA016	The Vendor should apply utilization management guidelines to authorize payments or services for physical and behavioral health.
BA017	The Vendor should apply utilization management guidelines to retroactively review payments or services for physical and behavioral health

THP develops and reviews utilization management guidelines for physical and behavioral health services minimally on an annual basis. Clinical Analytics, Population Health, the Physician Advisory Committee (PAC), Network Services and The Medical Director's Oversight Committee (MDOC) work cooperatively at THP to provide statistical analysis of utilization management activities. UM reports provide information on CPT codes, place of service, providers referring, providers receiving, length of stay, readmissions, services requested, services approved, services denied, services redirected or services coordinated through an out-of-network provider to ensure THP's UM requirements and preauthorization list are clinically appropriate and relevant to the populations served to effectively manage care.

The above data is reviewed for patterns and trends. Patterns and trends are analyzed and discussed at the MDOC committee level for inclusion or removal from THP's preauthorization list and UM Program. Annual and ad hoc analysis of data supports the addition of clinically relevant care and service triggers like new technologies and treatments that often require strict review and adherence to national guidelines to ensure the best outcome for members in need of care. The same analysis additionally allows for removal from the preauthorization list or UM program of care that providers are accessing and utilizing appropriately, defined as care that can safely and cost effectively be delivered without additional THP review as evidenced by past practice patterns and experiences with historic UM review demonstrating achievement of positive member outcomes.

To achieve the best outcomes and manage care The Health Plan utilizes only recognized evidenced based clinical criteria for the review of all services. Evidenced based criteria and resources for Utilization Management may include:

- Interqual,
- Center for Medicare and Bureau of Medical Service published criteria (including BMS Manual, National Coverage Determination and Local Coverage Determinations),
- Department of Health and Human Resources (DHHR) published guidelines as administered by KePro,
- Hayes Technology Review (for determination of experimental and investigational),
- Professional publications such as The ASAM (The American Society of Addiction Medicine) Criteria or up-to-date, as well as
- Policies developed internally at THP under Pharmacy and Therapeutics or Transplant and Technology with clinical references supporting basis upon evidenced based standards of care.

Criteria sets are sent out annually to the PAC for review and comment.

The Health Plan applies the UM guidelines described above to authorize payments and services for physical and behavioral health. Guidelines utilized for individual services are attached internally to documented requests and referenced clearly and specifically in denial language provided to both members and providers. Copies of full criteria are made available to members and providers upon request and forms are available on THP's website outlining required information necessary for submission to achieve an approval of medically necessary services. The THP information system allows viewing of all clinical guidelines utilized and authorization or denial status across clinical services, customer service and operations for clear communication to all parties as well as for clean execution of payment decision. THP allows for retro review of medically necessary services utilizing the same criteria sets described above for consistency of care across all settings and situations.

BA018	The Vendor should help expedite the submission and return of service authorization data from providers.
BA019	The Vendor should leverage a utilization management system with the ability to include text fields, including, but not limited to, the following:
BA020	Clinical notes
BA021	Inpatient Requests
BA022	Review Criteria
BA023	Case History

THP is prepared to expedite the submission and return of service authorization data from each member of its provider network because of its well-established system that is currently used in the management of healthcare for its current membership. THP will employ the same logic in achieving the goals associated with capturing data of clinical case notes, inpatient requests, review criteria and case histories that it uses with its members. THP's current system relies on a system that permits telephonic, electronic and web-based authorizations. Authorizations are then housed in portals that permit for expedited authorizations that are assigned pending codes. Authorizations are then listed in order of importance depending on the pending codes assigned by the system. Expedited authorizations are always placed at the top of the list to be addressed immediately. Routine reporting and tracking of all pre-authorizations occurs and ensures timeliness processing. This process also allows for the plan to be called in directly to an RN reviewer or Medical Director who are accessible 24 hours per day, seven (7) days per week. THP's current system, which will be maintained as this project is implemented will allow for urgent and emergent needs to be addressed immediately.

Inpatient requests are entered into the HEART system in the census screen. On the census screen, all demographic information is entered. This includes the HID number, the date of birth, and the effective date of coverage with THP. Additional information on the main screen includes the admitting doctor, the facility, the diagnosis, admit status, and contact person. The hospital review nurse enters a narrative note in the admit review to indicate the member's reason for admission. This also includes a review of pertinent history, current symptoms, medications, and discharge plans. The concurrent review tab houses the clinical information received to determine continued stay criteria. The diary is a note box that allows the navigator to add additional information related to timeliness of the review, notes to the medical director, and contact information. The medical director enters his/her review in the diary for the navigator to review as well. From this screen, the "add doc" and "heart doc" tabs allow the faxed clinicals to be attached directly to the census for review. When claims are received, the claims staff is able to reference the census screen as well as the clinical information attached to determine appropriate payment of services. If there are quality issues that need to be reviewed, the QI referral can be made from this screen to communicate to the QI department

of any safety issues related to the admission or other issues that affect the quality of care the member is receiving.

When the member is discharged, the navigator will update the discharge status to indicate the disposition. This includes the date of discharge. Additionally, the number of days authorized is auto generated with the length of stay clearly indicated for claims purposes.

The name of the navigator is listed on the front of the census, the change log indicates the navigator who entered any type of information in the system for this particular admit, and each change is time stamped. The last covered day and next review date are also listed on the front of the census screen.

When the member is discharged, the census is released and will be available in the member's claim history tab. The census can be filtered to pull a list of admits which list the facility, the length of stay, the type of admission, and the claim status.

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:
BA025	Medicaid Management Information System (MMIS)
BA026	Call Center

THPs utilization management systems integrates with all of our internal claims applications and is able to support claims adjudication and payment. Utilization data information regarding authorization approvals or denials, limitation on services, benefit limitation and other utilization driven data is all integrated into one central system called HEART. External data can be incorporated into HEART from third parties through data exchange processes. We accept electronic information in all HIPAA formats including the 837 (HealthCare Claim Record), 834 (Enrollment), 270/271 (Eligibility Checks) and 276/277 (Claim status). We also have the ability to interface with non-HIPAA compliant file formats when the workflow requires these exceptions.

Members who are approved for services, both physical and behavioral are entered into THP HEART system authorization records with a specific start and end date. Entry of authorization records can be manual or electronic depending upon the receipt format of the information. Once the information is loaded into the HEART system and evaluated by appropriate clinical staff for medical appropriateness, it accessible throughout the enterprise system including by claims staff.

- The inpatient navigator gathers information from medical records, hospital staff members, involved practitioners, and other providers to determine medical appropriateness.
- Information in HEART is adjudicated systematically and reviewed by the claims staff when processing claims. Authorizations, admission reviews, and claims information are all cross-integrated into COMET from the claims system known as HEART. This information system is

afforded all the required security measures to ensure privacy and the system back up ensures that data is maintained and preserved.

THP does not subcontract for behavioral health services so both physical health and behavioral health claims are processed through the same integrated system.

We currently exchange a number of files with the Medicaid Management Information Systems in West Virginia including providing 837 claims files to the state for our Medicaid population in WV and receiving 834 enrollment files. In addition to claims information, we have the ability to exchange Electronic authorization requests through both HIPAA supported file and in other reporting requests from the state. We have worked with the Medicaid systems in the past on exchange of authorization information. We have also adapted our system to be able to accept CareConnection files layouts that are used by the states vendor for behavioral health authorizations eliminating the need for the Behavioral Health providers to develop separate file layouts. These are all loaded into our systems and integrated into our claims payment processes. Our in-house staff of developers allows THP the flexibility to address file compatibility issues in a timely and efficient manner and integrate data into our HEART system.

THP is able to respond to inquiries from providers and members in a variety of fashions. As previously stated, we are able to accept and respond to HIPAA transaction-based files from trading partners. This includes elements such as claims submission and payment information, benefit validation, referral and authorization request and reply files and enrollment and eligibility verification. Our website hosts a web portal available to members and to providers.

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HEART Overview

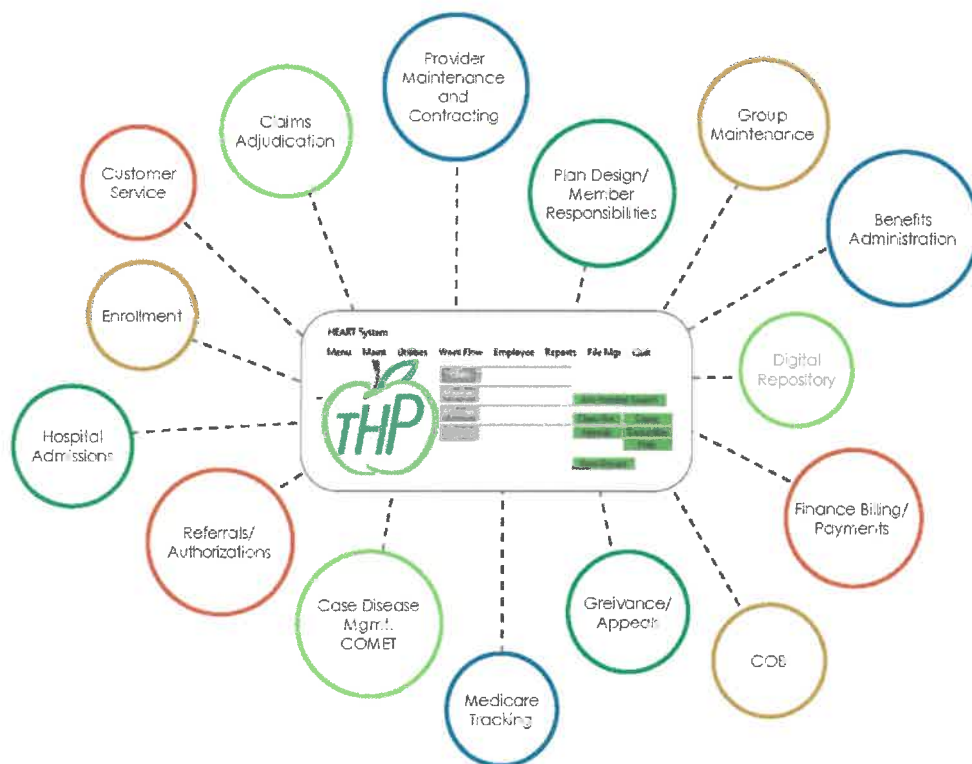
Brief System Overview:

The Health Plan originally purchased the COMPRE CARE software system in February 1985, which was a turnkey software system specifically designed for HMO processing utilizing Hewlett Packard hardware.

This system is sometimes referred to as MiniSoft by some of the employees because that is the name of the terminal emulation software, they used to access the HP3000.

The Health Plan started retooling the front-end software that would access the HP3000 data to be a more user-friendly interface about 18 years ago, and this has evolved into what is now known as the HEART system.

HEART System Capabilities:



The following is an overview of several of our key system modules:

- Claims Adjudication
 - Physician, Hospital, Dental, Pharmacy and Member Reimbursements.
 - Ability to view original claim and/or paper documents sent along with claim.
 - View all information sent on an electronic claim.
 - Real-time pricing when modifying.
 - Integrated with WorkFlow that allows us to assign and create work queues based on various claim criteria and allows monitoring of claim flow to ensure time

requirements are met.

- Managers have the capability to design queues so that they can focus review on new groups, lines of business or specific providers as just a few examples.
- On-line edit review system that records all areas claim was flagged and released.
- System is integrated with the member's claim history to make claim review more efficient.
- Track and log all claim activity.
- Provider vouchers are viewable on-line.
- Integrated with ClaimsXten for coding information and review.
- Integrated to use third-party pricers.
- Provider Maintenance and Contracting
 - Capture all basic demographics.
 - Ability to exclude/include from various Lines of Business.
 - Maintain separate payment arrangements based on Lines of Business or Group Numbers.
 - Tie together unlimited number of addresses associated with: Locations, Billing and Tax Information.
 - Apply numerous restrictions.
 - Customize which directories provider will be listed and how.
 - In-Office/LAB Procedures approved for.
 - Track all licensing, education and credentialing information.
 - Provider Sanctions history.
 - Ability to add detailed remarks that are public or private.
 - Complete maintenance history.
 - Imaging system that can be tied to Tax ID, NPI, Provider ID, Contract Type or Delegation Code for online information.
- Plan Design/Member Responsibilities
 - Plans can be designed to apply Copay, Coinsurance, Deductibles, Member Responsibilities and Pre-Cert Penalties.
 - All amounts can be set to track In-network, Out-of-network and Special Network.
 - Ability to have the same amount applied to numerous networks if required.
 - Ability to require at least 1 or more family members to reach the individual limit before the family limit can be satisfied.
 - Plan can be designed to accumulate based on calendar year, group contract year or specific date range.
 - Attachment and Maximum levels can be set differently for each area.
 - Plan Managers have the ability to design benefits based on various criteria, such as age, sex, place of service and provider specialty for just a few.
 - Copays and Coinsurance can be applied at various levels, all the way to specific procedures.
 - Flexibility to set design new plans without any recoding.
 - Deductible Carryover.

- Ability to carry amounts applied across different group numbers.
- On-line SBC design and archival.
- Customer Service
 - Member Summary screen that ties information from various modules in order to give a quick snapshot of current information.
 - All information is displayed based on cross reference logic. This allows members under more than one policy to have all their information pulled together when warranted regardless of the ID they give.
 - One Click design to get to detail information from various modules such as Enrollment, Group and Provider information.
 - On-line access to member documents: Explanation of Coverage, Schedule of Benefits, Pharmacy Benefits, Chiropractic Benefits, Vision Benefits, Dental Benefits, Privacy Information and Group Card Specifications.
 - Access to all Copay and Deductible information, including current amounts applied.
 - Any special programs or management member is flagged for.
 - Order new ID cards or generate a temporary card that can be immediately emailed or faxed to the member.
 - Unlimited number of Alternate Address's for each member.
 - Select various letters to be sent.
 - Advance Directive information.
 - View all digital folder information.
 - Sign member up for MyPlan secure portal.
 - Ability to view information from Member portal as if logged in as the member.
- Enrollment
 - Accept unlimited Alternate Address's for members.
 - Flag members for special programs or management that follows them to other modules.
 - Work with several HR Services to receive electronic enrollment information in various formats.
 - Employer Module that allows group administrators to submit their own enrollment changes and view their census information in real- time.
 - Detailed audit logs of all changes.
 - Select various letters to be sent.
- Group Maintenance
 - Ability to rate groups using Community or Age/Band rating.
 - Ability to administer cafeteria plan design.
 - All benefits can be set at group level or a consolidated group.
 - Track and price unlimited number of rented networks per group.
 - Plan documents are set at group level and viewable on-line.
 - Premium Estimator for Small Groups and Individuals.
- Hospital Admissions

- Integrated with a DRG grouper.
- Integrated with Hospital Contracting module to generate an estimate for the stay.
- Perform detailed admission reviews and document all changes.
- Integrated with Interqual Criteria for reviews.
- Attach supporting documentation directly to the census.
- Ability to view all active admissions and filter based on numerous criteria, such as: Line of Business, Facility, Facility Type, Days Admitted, Admission Type, etc.
- Capture detailed newborn information that is integrated into HEDIS reports.
- Authorizations
 - Ability to Gold Card certain providers so they don't need authorizations.
 - Integrated with our claims editing process.
 - Multiple review levels can be performed at Nurse and Medical Director level, with reviewer and date information logged.
 - Integrated with Interqual.
 - Pending screen for Nurse's and Medical Director's to perform reviews.
 - Authorizations that are sent out are also in the member's digital folder for online access.
 - Ability to submit certain specialty authorizations through a secure Provider portal.
 - Attach supporting documentation directly to the referral.
- Case/Disease Management
 - Health Assessments.
 - Set Goals and track progress.
 - Capture meeting/progress notes.
 - Create correspondence.
 - Interfaces with all other modules of HEART, such as Enrollment, Claims, Authorizations and Admissions.
 - Trigger system generated alerts when specific actions occur, such as admissions and authorizations.
 - Attach supporting documentation directly to the case.
- Benefits Administration
 - Coordinates enrollment and benefit packages for several clients.
 - Customized benefits and reporting for each client's requirements.
 - Web interface for members to verify/select their coverage levels during open enrollment periods.
 - Inbound/Outbound automated file transfers with several third-party vendors.
- HR System
 - Capture all the basic employee demographics.
 - Track job history within company.
 - Custom built Time Off module tracks:
 - All scheduled and unscheduled leave time.

- Employees can view their own status and submit time off for review.
- Apply carry over hours from the previous year.
- Generates reports for quarterly review and approval.
- View department coverage for specific time spans.
- Integrated with our system security capabilities.
- Fax/PDF Management
 - All of our incoming faxes are saved as PDF'
 - Capability to file PDF's as:
 - Document Repository folders.
 - Attachment in HEART.
 - Re-route to various work queues.
 - Email as attachments.
 - Other functions specific to the fax line being worked.
 - Users can file any PDF straight into Document Repository folders as if it was WinScanned.
- Finance
 - Generate all group/individual billings and payments.
 - Group bills are available for online viewing.
 - Ability to prorate members and groups.
 - Claim lag reports for calculating IBNR and other financial reports.
 - Provider credit balance history.
 - Module for tracking WV Medicaid billing Reconciliation.
 - ACH Workflow module
- COB
 - COB demographic information.
 - Insurance Carrier information
 - Employer Information
 - Medical and RX Information for complete family
 - COB Confirmation Letters
 - Part D information
- Medicaid
 - Accept the WV Medicaid's 834, and the complete record of information is viewable.
 - Quarterly report package required by the state.
 - Prenatal Outreach tracking.
 - EPSDT Outreach tracking.
 - Generate monthly Maternity Billing.
- Medicare Tracking
 - Submit directly to CMS's MARX any of our enrollments we receive by paper, electronic files from HR Services or from our on-line WEB form.
 - Accept the Medicare on-line enrollment file from CMS.

- Process all inbound files from the MARX and distribute to the various departments.
- Ability to track and follow-up on paper applications.
- Module to track compliance to ensure enrollment is sent within contracted timeframes.
- Create HCC and RAP files.
- Integrated with a third-party vendor to perform chart review for missing claim information.
- Part C Quarterly Summary.
- Grievance/Appeals
 - Detailed tracking for Appeals, Complaints, Grievances, IRO Information, DOI Information, Administrative Review, Maximus Information and ALJ information.
 - All levels are date stamped.
 - Ability to tie to claims.
 - Automated reports are sent based on system triggers and timeframes.
 - Customized user generated reports.
 - System generated letters.
- Marketing
 - User requested Profit/Loss reports based on group numbers and emailed in an electronic format.
 - Custom report packages for ASO clients
 - SBC System
 - Generated from existing plan structure or from scratch.
 - Dollar amounts are totally customizable by the user.
 - Stored on-line as a PDF.
 - Capability to place a final product in the group's digital folder.

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:
BA028	Medicaid Management Information System (MMIS)
BA029	Call Center

THPs utilization management systems integrates both with all of our internal claims and customer service applications and is also able to support inbound member and provider and member inquiries by interfacing with vendor systems as needed. We accept electronic information in **all** HIPAA formats including the 834 (Enrollment), 270/271 (Eligibility Checks) and 276/277 (Claim status). We also have the ability to interface with non-HIPAA compliant file formats when the workflow requires these exceptions.

We currently receive monthly 834 enrollment files from the state for our Medicaid population in WV. In addition to enrollment information, we have the ability to exchange Electronic authorization requests through both HIPAA supported file submission as well as through a web-based portal. We have worked with the Medicaid systems in the past on exchange of authorization information. We have also adapted our system to be able to accept CareConnection files layouts that are used by the state vendor for behavioral health authorizations eliminating the need for the Behavioral Health providers to develop separate file layouts. Our in-house staff of developers allows THP the flexibility to address file compatibility issues in a timely and efficient manner and integrate data into our HEART system.

THP is able to respond to inquiries from providers and members in a variety of fashions. As previously stated, we are able to accept and respond to HIPAA transaction-based files from trading partners. This includes elements such as claims submission and payment information, benefit validation, referral and authorization request and reply files and enrollment and eligibility verification. Our website hosts a web portal available to members and to providers.

The Provider Web Portal provides the following:

- Ability to search patients and verify enrollment
- Deductibles
- Copays
- Benefits
- Group and network information
- View patient ID card
- Submit and view claim status and pre-authorizations, including behavior health
- Administration capabilities
- Manage new users/administrators
- Grant permissions
- View and download member rosters, remittances, policies
- View and download forms
- Access to a subset of clinical data including clinical guidelines and criteria

The Member Web Portal provides the following:

- Easy to understand benefits summary
- Basic enrollment information
- Deductibles
- Copays
- View and change Primacy Care Provider and/or Secondary Care Provider
- Download and view EOBs and claims status
- Access integrated tools utilizing single sign on
- Wellness Health Risk Assessment and Wellness tools
- Prior authorization Requirements
- Member Rights and Responsibilities including Appeal Rights

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BA030	The Vendor should establish interface(s) and conduct testing that meets all Department-specific interface requirements, including but not limited to, the following:
BA031	Medicaid Management Information System (MMIS)
BA032	Families and Children Tracking System (FACTS)
BA033	Integrated Eligibility Solution (IFS) when applicable

The Health Plan of West Virginia, Inc. (THP) commonly establishes interfaces with its network providers, clients, clearing houses, government entities and other third-party vendors. THP uses Electronic Data Interchange (EDI) management software from Edifecs to support all HIPAA formats, ensuring only HIPAA-compliant transactions are accepted for processing. THP's EDI management software ensures transaction are CAQH CORE compliant. This includes the 837I, P, and D medical claims submissions as well as 834 eligibility submissions. THP is also capable of working with the client's and their vendor's proprietary data formats. THP uses test scenarios which exercise different data situations and data size. For example, eligibility interfaces are tested using new member adds, member data changes, and member terminations as well as good and bad data scenarios. THP will work with the foster care children and family's vendor's test processes.

THP currently shares a number of data items, both receiving and transmitting, through the Medicaid Management Information Systems utilizing protocols that the state has provided and based on federal specifications. As a current Medicaid contractor in West Virginia, THP is familiar with the data layouts and how to efficiently exchange data with the state and is prepared to establish an interface with other state and federal sanctioned systems and assures the contract administrator that all newly established electronic interfaces will be HIPAA compliant.

As the state transitions to the new Integrated Eligibility Solution (IES) THP will be able to integrate with that platform. We currently support all HIPAA transaction sets and will be able to accommodate any state specific requirements with development through our in-house development team.

THP is familiar with FACTS+ and the data that is housed in the environment. Our electronic care navigation system COMET (The Health Plan **C**are **O**rganization **M**anagement **E**valuation **T**ool) has the ability to house varied components of health records and clinical information allowing easy access to the information by THP stakeholders. For the Foster Population, we will work with DHHR to determine an appropriate process to integrate information available on the FACTS system within our clinical record. From this centralized clinical record, we will be able to incorporate data and information from various stakeholders into our care plan development. Additionally, with appropriate security measures in place, we will also be able to ensure access to needed information in a secured manner by DHHR Caseworkers, providers of care and other appropriate stakeholders.

BA034	The Vendor should leverage a system with the ability to maintain case history.
BA035	The Vendor should establish utilization management processes for members, including, but not limited to, the following:
BA036	Medical necessity review
BA037	Socially necessity review
BA038	Approvals
BA039	Denials

THP will leverage its COMET (The Health Plan's **C**are **O**rganization **M**anagement **E**valuation Tool) platform as a venue for maintaining the complete case history. This provides great flexibility and is versatile enough to allow for growth and adaptation as the needs of the program grow and change. THP will work with various stakeholders throughout the implementation period and post implementation to provide opportunities for collaboration on alternatives to efficiently transfer information back and forth from various stakeholder systems into COMET and vice versa using avenues such as the West Virginia Health Information Network.

COMET is the electronic care navigation system which allows for tracking of all patient management considerations in one integrated tool. This system, previously known as COMET, is available to all members of the interdisciplinary team who are employed by The Health Plan. The tool eliminates silos of information and allows for integration of clinical information from the patient medical record, communications, claims and other assorted resources. COMET supports health risk assessments, clinical documentation, interdisciplinary treatment team meetings, clinical variables, care planning, short- and long-term goals, member authorizations, and reminders. Data can be captured as frequently as necessary to monitor outcomes measures and incorporate interventions.

COMET has several capabilities to allow for the navigation of our members in a collaborative manner in an interdisciplinary fashion. The screen below provides an overview of the various components of the tool. Within each tab/folder the user has the ability to carry out various care management activities.

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BA040	The Vendor should operate utilization management monitoring activities in conjunction with fraud and abuse detection activities.
BA041	The Vendor should prevent and detect fraud and abuse related to pharmacy services.

The Health Plan (THP) maintains a fraud, waste, and abuse plan that demonstrates a commitment to the prevention, detection, and correction of potential fraud, abuse, or erroneous billings. Policies and procedures are in place to ensure compliance with laws and regulations, and employees regularly participate in related training to ensure they understand how to recognize and report suspicious activity. THP also creates and distributes member education related to recognizing and reporting fraud, waste, and abuse.

The Health Plan uses a number of system edits and programmatic reviews of data designed to detect suspicious activity. Claims processing software allows for retrospective review of claims, trending, and outlier identification. Through claims analysis, THP identifies suspicious activity. The Health Plan also utilizes STARSSentinel, a data analytics software program which offers provider alerts, identifying top scoring providers across numerous schemes, as well as pharmacy and member alerts, identifying outliers related to prescription utilization. STARSSentinel is a powerful tool for identifying potential fraud, waste, and abuse, identifying claims containing potentially falsified procedure codes, services not rendered, upcoding, over-utilization and other common fraud tactics. Using STARSSentinel, over 100 data mining reports are created each month. Additionally, the Special Investigations Unit (**SIU**) runs multiple reports monthly to identify outliers in specific high-risk areas. Notable prescription monitoring reports include, but are not necessarily limited to:

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

The SIU examines reported incidents of suspicious activity from all sources and provides both a telephone tip line and a website portal to facilitate receipt of referrals. A comprehensive and analytical review of reported issues is conducted to identify misuse, inconsistencies, misrepresentations and/or intentional deception and to determine the appropriate course of action. Routine monitoring for services not rendered also includes calls to a sample of members each month to verify receipt of services.

Those identified as having suspicious billing patterns or other areas of concern are subject to investigative action. THP may utilize any combination of extended monitoring, provider education, pre-payment review, medical records review, interviews, payment suspension, or termination of coverage or contracts. In cases of suspected fraud or abuse, referrals are made by the SIU to the appropriate regulatory and/or government agencies. The SIU works with designated state and federal agencies, including the National Benefit Integrity Medicare

Drug Integrity Contractor (NBI MEDIC), the West Virginia Offices of the Insurance Commissioner, the West Virginia Medicaid Fraud Control Unit, and other law enforcement entities to pursue individuals or organizations who may be involved in activities related to healthcare fraud and abuse.

THP also employs in-house pharmacy personnel to monitor pharmacies submitting suspicious claims. Upon review and investigation and when warranted, pharmacies may be barred from billing THP, members may be locked in to only one pharmacy for their controlled substance prescriptions, and/or a referral may be made to the appropriate law enforcement entities.

The Health Plan's PBM is Express Scripts Inc. (ESI). ESI's Special Investigations Unit investigates fraud related to network pharmacies. ESI proactively identifies suspicious activity, monitors CMS alerts, Medic Risk Assessments, media tips, and fraud tips. In addition to data mining activities, which include use of a proprietary predictive modeling tool, ESI also conducts member verifications to confirm the member received the medication, prescriber verifications to confirm the prescriber ordered the medication, and purchase verifications to confirm the pharmacy had sufficient inventory to justify the claim volume. ESI's SIU also conducts both desk and on-site investigations that include reviews of prescriptions, delivery records, quality assurance and other relevant documentation, and employee interviews. ESI maintains an exclusive contractual relationship with a pharmacy under investigation, and utilizes its many investigative tools allowed via the contract in tandem with all applicable federal or state laws, rules and regulations. Substantiated improper conduct is referred to the appropriate authorities and to the Pharmacy Disciplinary Action Committee for potential discipline up to and including termination.

ESI also conducts a number of audit programs to help ensure accurate submission and payment by utilizing a collaborative approach that emphasizes the education of network pharmacies in proper claims submission procedures. The predictive model review process aids in the detection of high-risk claims, followed by additional review by auditors. ESI's desk audit program completes an automated review, using a large number of outlier indicators, of all claims submitted by network pharmacies the previous day. The historical audit program is an ongoing retrospective review of claims, in addition to the daily claims selected during the desk audit. Lastly, on-site audits include in-person reviews of prescription claims and operating practices to evaluate a pharmacy's compliance with federal regulations, pharmacy practice, and ESI's provider manual. Pharmacies are selected for an on-site audit based on various criteria which may include findings from desk or historical audits, reliable tips, and/or selection via ESI's proprietary audit selection tool.

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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:
BA043	Standing referrals
BA044	Expedited utilization review processes

The Health Plan is sensitive to the special healthcare needs of various populations and makes accommodations to typical utilization management protocols to optimize service delivery, support ease of access to service and ensure desired outcomes. Members with complex cancer diagnosis are a prime example of members who require special attention. Cancer care planning is coordinated through the use of standing referrals. Cancer care is accomplished through a service plan called a road map. It generally specifies not only chemotherapy at set intervals, but also the plan for specialist visits, labs draws and PET scans. Standing referrals are built in cooperation with oncologists, tertiary facilities and PCPs to ensure that care is easily accessed and smoothly delivered so that members and families who are stressed do not have any additional worries about the authorizations allowing them to focus strictly on care and recovery. By authorizing a road map or service plan all at once care can be arranged for a specified period of time minimizing provider focus on authorization, reinforcing shared care planning and reinforcing member centered care.

Standard utilization management protocols may also be modified for CSHCN or when EPSDT requests are identified. Services that are supported by a PCP order, coordinated by a PCP through a specialist and are specifically requested to correct or ameliorate a condition or disability that may allow, or support age appropriate or developmental capabilities may be allowable over and above specified benefit limits. An example of this situation is a power wheel chair that lowers to the floor to allow for independent transferring as well as raising to standing level to allow for eye to eye contact for peer interaction, with special traction wheels that allow for playground transition. THP was able to approve such a chair for a pediatric Medicaid member under EPSDT due to supportive information that demonstrated the functional independence said chair would provide despite not meeting standard THP CMS DME criteria.

THP additionally expedites services not only as requested by providers and members but when UM staff identifies that services requested require an expeditious decision to prevent loss of life or limb, permanent disability or are necessary to treat or resolve pain. Members and providers are notified telephonically of all service decisions scheduled or requiring service within 48 hours.

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BA045 The Vendor should establish condition-specific protocols or standards that will be used to manage members with special healthcare needs.

The Health Plan develops condition specific protocols, standards or Clinical Practice Guidelines to help practitioners make decisions about appropriate healthcare for specific clinical circumstances including members with special healthcare needs. Practice guidelines are based on nationally recognized clinical literature, expert consensus, and reflect industry best practices and are chosen based on THP specific population assessment to impact outcomes.

The Quality Improvement Department in conjunction with Clinical Analytics, Population Health, PAC and MDOC reviews and establishes new practice guidelines as opportunities for improvement in care delivery are identified in our member population. Existing active guidelines are reviewed and updated at a minimum of two years and more frequently if changes to professional standards of care occur. New target areas for care improvement opportunities may be added or standards removed based upon review of the UM Program and analysis of clinical analytic data confirming needs or resolution of clinical population health issues.

The Health Plan currently posts and educates providers on the follow Clinical Practice Guidelines:

- ADHD
- Substance Use Disorder
- Depression
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Diabetes Mellitus
- Coronary Artery Disease
- Perinatal Care
- Access to Care and Services
- Management of Asthma
- Patient Records
- Preventive Health Services

These guidelines serve as a reference for any professional to standards of care to which providers can be directed to support optimizing outcomes for conditions or issues for which THP has targeted interventions and specific goals for improvement based on our identified population's needs.

An example of a condition specific protocol developed to meet the needs of a special population is Perinatal Care. The Perinatal Care guideline is specifically chosen, based on a need's analysis of our Medicaid population, to impact Children with Special Healthcare Needs. Perinatal guidelines published by The American College of Gynecology (ACOG) are used to support not only the importance of prenatal care and testing at routine intervals but also to reinforce the importance of no early inductions, no elective C-sections without medical

necessity and early referral to treatment and support for substance use disorder during pregnancy, all with a goal to improve neonatal outcomes and prevent or reduce the likelihood of disability.

To support this clinical practice guideline and ensure provider compliance, The Health Plan follows all high-risk pregnancies via navigation. The navigator supports engagement of obstetric providers, ensures adherence to standards of care/or directs provider via peer to peer back to published guideline for direction, supports maternal referral to parenting resources, promotes March of Dimes preterm delivery prevention information, facilitates smoking cessation and supports post-delivery referral to CSHCN when physical needs, functional limitations, multiple service needs or medical nutrition needs are identified in infants following birth. All THP Medicaid staff are educated on CSHCN eligibility criteria and given the information to ensure warm handoffs to CSHCN Program occur when needed. Admission to CSHCN program is facilitated by assistance with parent consents and Screener completion in the hospital when needs are identified early and through emails and phone calls post discharge from the hospital newborn nursery or NAS facility when engagement is achieved in the home setting post discharge. Children identified as CHSCN are flagged in the THP system and remain in navigation for coordinated care needs until they disenroll or age out following a completed transitional care plan into adulthood.

BA046 The Vendor should update and share condition-specific protocols or standards with primary and specialty care providers.

in-network Clinical practice guidelines are derived from valid and recognized clinical evidence-based sources. Guidelines are implemented to target areas for preventive health, chronic conditions and behavioral healthcare. At least two non-preventive acute or chronic condition guidelines and two behavioral healthcare guidelines are in place at all times.

Current Guidelines in place include:

Behavioral Health

- Guideline for ADHD
- Guideline for the Treatment of Substance Abuse
- Management of Depression
- Additional behavioral health guidelines can also be accessed via The Health Plan's web site.

Quality Improvement

- Standards for Access to Care and Services
- Guideline for the Management of Asthma
- Guideline for Patient Records
- Guideline for Preventive Health Services

Disease Management

- Guideline for the Management of Congestive Heart Failure
- Guideline for the Management of Chronic Obstructive Pulmonary Disease (COPD)
- Guideline for the Management of Diabetes Mellitus
- Guideline for Perinatal Care
- Guidelines for the Management of Coronary Artery Disease

As prevalent conditions change and as practice standards are updated, guidelines are revised, added and retired based on clinical review of THPs Quality Improvement Committee.

The Quality Improvement Management Program includes activities around the development and review of clinical practice guidelines. Practitioner oversight is required for this development and review. Practice guidelines are selected to improve overall member experiences and member health outcomes. To ensure Practitioner oversight in the development and review of practice guidelines, all guidelines and supporting literature research are disseminated to practitioners prior to adoption for review and recommendations. Once the recommendations are reviewed and incorporated, the clinical practice guidelines follow designated workflows and advisory committee structures at The Health Plan for final approval. Practitioners are notified once guidelines are finalized and implemented. Practice guidelines are reviewed at a minimum of every two years for any necessary changes to reflect the most up to date standards. Guidelines are available on The Health Plan website and on the provider portal and provider manual for access.

The development of clinical practice guidelines is based on published guidelines, relevant medical literature, and McKesson Interqual criteria. THP monitors adherence to guidelines based on objective clinical criteria from HEDIS measures, and other relevant data sources. A quantitative and qualitative analysis is done annually for each guideline in place.

Practice guidelines are developed through the following objectives:

Objectives:

1. Ensure the involvement of the Medical Directors, the Quality Improvement Committee, and The Health Plan practitioners in guideline development.
2. Ensure the distribution of the guidelines to all applicable practitioners. Guidelines are placed on The Health Plan website for access. Practitioners are notified of existing and new and encouraged to review and comply with the guidelines.
3. Ensure the development of methods for the regular evaluation of the delivery of clinical care consistent with guidelines. Clinical practice guidelines will be researched, adopted, and distributed to appropriate participating practitioners to ensure the most current clinical practices are in place for the treatment of The Health Plan members. All practice guidelines adopted by The Health Plan will be coordinated through the Physician Advisory Committee(s).

Process:

- Topics selected for guideline development will be related to areas determined to be high risk, high volume, and/or problem prone areas. This will ensure that the topics selected are worthwhile, population based, and deserving of resource commitment. At least two non-preventive acute or chronic condition guidelines and two behavioral health guidelines will be maintained at all times.
- Research of medical literature will be conducted to identify the most current national recommendations. The pertinent medical literature will be reviewed by all those individuals responsible for guideline development. The literature review will assist in collecting information from existing guidelines and in the establishment of thresholds and acceptable standards of care.
- The draft form of practice guidelines will be forwarded to practitioners, based on specialty, for review and input. After receipt of specialist input and review of nationally recognized resources, the draft guidelines are reviewed by the Physician Advisory Committee. The Quality Improvement Department will be responsible to maintain the schedule for guideline review/revision.
- The Health Plan benefit coverage materials and member educational materials will be reviewed to ensure that guidelines are consistent with those materials.
- The final practice guideline will be approved by the Medical Directors Oversight Committee.
- Clinical practice guidelines will be made available to the appropriate practitioners after final approval. This will be accomplished by placing the guidelines on The Health Plan's website and notifying the practitioners of the availability via practitioners' newsletters. As new practitioners become participants with The Health Plan, they are educated on the availability of the guidelines on the website.
- Compliance with the guidelines will be monitored to meet all NCQA accreditation standards.
- Each guideline will be reviewed no less often than biennially by the Physician Advisory Committee to ensure that the information contained within the guideline remains consistent with medical advancements in technology and standards of care.

Guidelines may be retired when any of the following occur:

- They are no longer relevant to the Plan's population; or
- Practitioner compliance with the guidelines remains consistently high; or
- Recommendation by the Quality Improvement Committee

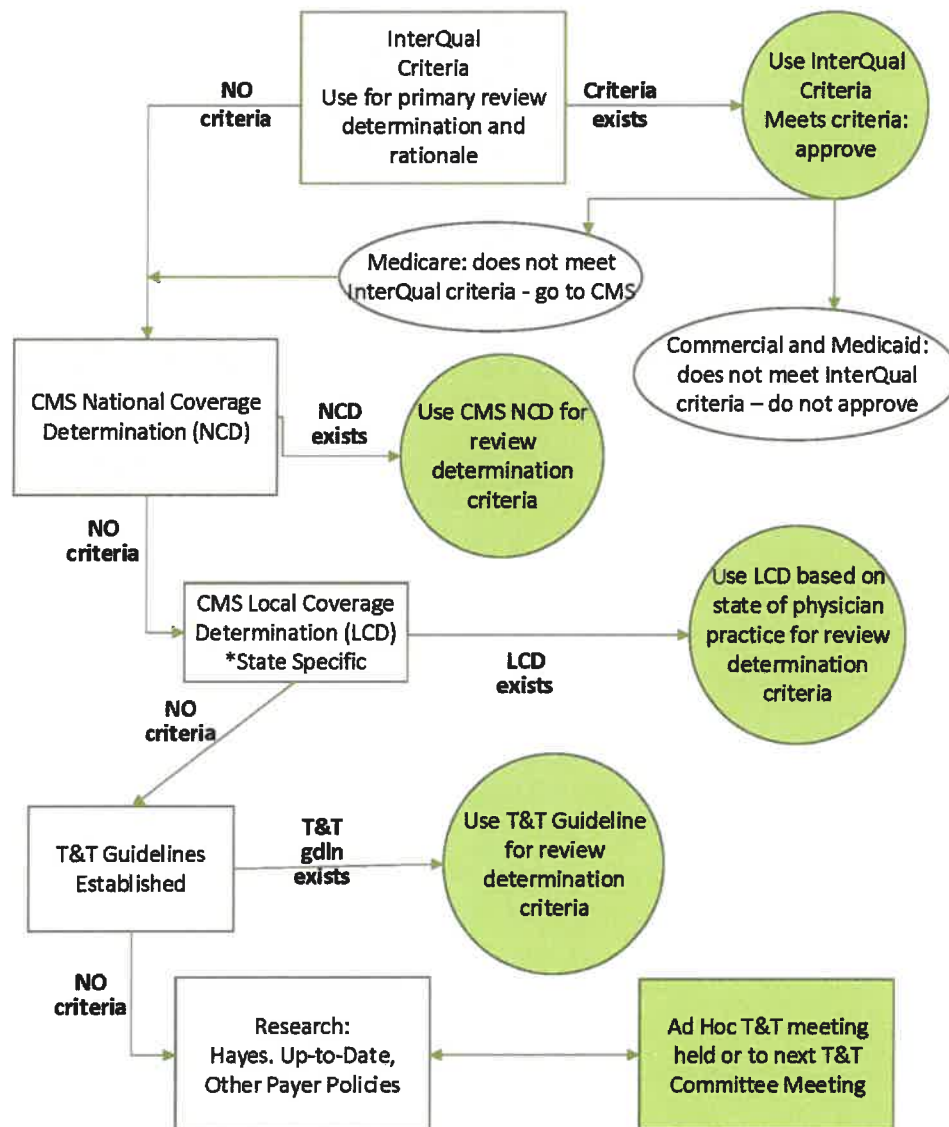
The Health Plan utilizes McKesson Interqual criteria as a screening guideline to assist with medical appropriateness of healthcare services. Any participating provider may, upon request, review the specific criteria used in an active clinical review process of a service.

Examples of condition specific protocols that are shared on the web for providers include the clinical guidelines for ADHD, Perinatal Care and Diabetes. During clinical analysis of authorization information and utilization review, THP may refer providers to the guidelines for

standards of care for denials of things like early induction, primary C-section for patient preference or timelines for diabetes management. THP targets specific clinical guidelines based on clinical analytics and updates every 2 years or more frequently as changes are warranted.

An example of our clinical coverage criteria algorithm can be found below.

Clinical Coverage Criteria Algorithm 2019



January 2019

BA047 The Vendor should establish, implement, and update guidelines for the services or types of services that require prior authorization (PA) by the Vendor.

Requests for prior authorization of treatment and reporting of crisis encounters can be submitted telephonically, electronically, or through the secure provider portal on THP's website. They may also be faxed. Each of these methods is HIPAA compliant. While these are strategies that THP uses with its members for medically necessary services, THP intends to use these same methods of communicating with its members for socially necessary services. The MDT will be involved in the notification and approval process as this new work is integrated into the organization's business model.

Prior authorization requirements and forms will continue to be available on THP's website under the provider tab and will now include providers who provide socially necessary services. Protocols associated with changes in care and changes in prior authorization currently is, and will continue to be, communicated to the provider via email blast, and provider relations education, and through updates on the provider portal on THP's website.

Utilization criteria for medical appropriateness and guidelines for coverage provide the objective data necessary for utilization management decisions that are fair, impartial, and consistent in order to service the best interest of THP's members and maximize the effectiveness of their care.

All reviews are determined by written criteria that are based on medical and/or socially necessary evidence. Consideration is, and will continue to be, given to the members particular individual needs. THP's protocols require that review criteria be updated annually.

Since a number of the children and families with foster care involvement that will now make up THP's member network may require expensive services, indications for prior authorization will include those high cost services e.g., PET scans, etc. Consequently, the decision to use criteria based on best practices to determine the need for the service is part of THP's standard practices and will be used when making the determinations for the foster care population both for medically necessary and socially necessary services. Psycho and neuro-psychotherapy are other areas where THP applies practice standards that have evolved out of best practices. Authorizations for these services are used to keep track of treatment and to ensure that the provider is using the criteria set forth by the American Psychological Association for the testing that is being done. Data analysis consistently occurs, and if the reviews indicate that over and/or underutilization is occurring this information is flagged, and an examination occurs to determine factors that may lead to fraud or abuse. If the review suggests fraud and/or abuse, a thorough examination occurs that will begin at the point of admission and move through the entire service identification and determination processes. This process of systems examination allows THP to determine specifically where, when and if fraud and abuse has occurred. If the process determines that fraud and abuse exist or if there are system errors that may have to be addressed, THP will take the necessary steps to address the issues.

THP's experience reveals that its system of prior authorizations to ensure that the services being requested are appropriate is a successful approach, and reduces abuse, misuse, and fraud.

Data analysis of the use of services for various populations is used to determine the need for prior authorization. THP's practice patterns requires that all new techniques or new technologies and treatments are prior authorized to ensure that the members are not receiving treatment that is not necessary or in the member's best interest.

THP's Physician's Advisory Committee is responsible for the development and approval of practice guidelines. The medical director's function as a guide and resource to the committee. Information is gathered from nationally recognized resources and presented for review. Medical directors are directly involved in the implementation of the standards and guidelines as well as the re-evaluation process. THP realizes that medical directors will not necessarily give input through the prior approval process for socially necessary services; however, appropriate social workers will be involved with THP to help determine what socially necessary services are intended.

In summary, THP has implemented prior authorization lists for medical, behavioral health and pharmacy services. Copies of THP's current pre-authorization list are available through our website. High cost procedures and new technologies that have specific coverage guidelines should always be pre-authorized. THP's Clinical Analytics Department participates in an annual review of preauthorized services to identify over- and under-utilization patterns for any necessary changes to the preauthorization list. Individual provider performance patterns are analyzed, benchmarked and shared with the provider. Updates to these lists are also necessitated when changes in medical technology and updated methods or approaches to performing procedures and services are introduced. Preauthorization lists and notice of preauthorization changes are displayed on THP's provider website. Changes to preauthorization lists are also communicated in the quarterly provider newsletter.

Below is a list of services that require notification, pre-authorization and/or medical appropriateness review. Please check plan benefits for network limitations.

Out-of-Network Care

- All out-of-network care per plan design

Tertiary Care

- All services require pre-authorization per plan design

Inpatient Care

- All elective inpatient care. Notification of urgent and emergent admission is expected within 48 hours or as reasonably possible hours or as soon as reasonably possible
- Skilled nursing and rehabilitation inpatient care
- Out-of-network / out-of-area care
- Long-term acute care (LTAC)
- All elective C-sections and all elective inductions

Diagnostic Testing and Studies

- MRI of the shoulder, knee, hip, extremity, elbow, ankle, foot, wrist, and the spine (cervical, thoracic, lumbar)
- Low-dose CT for lung cancer screening
- CT / MRI / MRA – Pre-authorization is required by all non-physician practitioners only

- CT angiography for CAD
- SPECT MPI (myocardial perfusion imaging) – Pre-authorization is required by all non-cardiologists only
- PET scan / PET/CT fusion scan
- Virtual colonoscopy – CT colonography
- Urine Drug Testing:
- Medicaid member - definitive urine drug testing (G0483, G0659) for all services.
- Medicaid member - all other urine definitive and presumptive codes have service limits. Preauthorization for medical necessity is required beyond established limits.

Procedures

- Automatic implantable cardiac defibrillator / wearable cardioverter defibrillator /CRT-D
- Bariatric and weight loss surgery
- Bone anchored hearing aid (BAHA)/ cochlear implants
- Cosmetic procedures (reduction mammoplasty, rhinoplasty, blepharoplasty, sclerotherapy, otoplasty, scar revision, abdominoplasty, panniculectomy, etc.)
- Hysterectomy
- Kyphoplasty / vertebroplasty
- Continuous intraoperative neurophysiological monitoring
- Prophylactic mastectomy All sleep apnea surgeries
- Podiatry – surgical procedures other than in-office
- Photographic surveillance of malignant melanoma
- Transplant and all related services
- Balloon sinuplasty

Ambulatory Services

- Ambulatory blood pressure monitoring
- Cardiac outpatient monitoring / mobile real-time
- Capsule endoscopy – esophageal pH monitoring (Bravo)
- Continuous glucose monitoring
- All genetic, genomic, pharmacogenetic, pharmacogenomics, and pharmacodynamic testing
- Cologuard Infertility treatment
- Oncotype DX assay / MammaPrint gene expression assay
- Skin substitutes (e.g., Dermagraft, Apligraf)
- Surgical / invasive varicose vein treatment
- TMJ – diagnostics and treatment
- Urinary / fecal incontinence clinic and therapies, including percutaneous tibial nerve stimulation
- Hyperbaric oxygen

Ancillary Providers and Services

- Ambulance/ambulette – non-emergent
- Audiologists (independent practices) all evals and testing
- Chiropractic care – all ages requires pre-authorization
- Home health services will no longer require pre-authorization during the first certification period. If services are to extend past the first certification period (60 days), pre-authorization is required to the start of the second certification period
- Hospice/private duty nursing
- Infusion therapy
- Insulin pumps and Initial order for insulin pump supplies
- Speech therapy- all visits

- PT/OT – outpatient - all services after initial evaluation
- Orthotics or prosthetics ≥ \$500 as required by The Health Plan fee schedule
- All molded-to-patient model and custom fabricated prosthetics/orthotics
- Wheelchairs and accessories
- Durable medical equipment ≥ \$500 (rental or purchase) and as required per The Health Plan fee schedule; go to healthplan.org for complete information

Unlisted/Miscellaneous Codes

- Will be reviewed to assess if it is non-covered or an up-coded procedure, service or equipment.

New Technology

It is imperative that providers contact The Health Plan to verify coverage of all new technology. Investigational services are not covered. Pre-authorization is required for these services:

- Artificial urinary sphincter
- Autologous chondrocyte implantation
- Bioimpedance / biventricular pacemaker / CRT-D
- Bone morphogenetic protein (BMP)
- Botulinum toxin injections
- Carotid artery stenting
- Chemo-embolization
- Cryosurgery for renal masses
- DSEK and DSAEK for corneal endothelial degeneration
- Enhanced external counterpulsation (EECP)
- HALO 360 coagulation system
- Intensity modulated radiation therapy (IMRT)
- Intrastromal corneal ring inserts (Intacs)
- Implantable / insertable loop recorder
- Gamma knife / stereotactic radiosurgery
- Gastric electrical stimulation
- Ventricular assist devices (LVAD, RVAD, Pediatric VAD, (percutaneous) pVAD)
- ProstaScint
- Provenge immunotherapy for prostate cancer
- Radiofrequency ablation for chronic back pain
- Selective internal radiation therapy
- Sacral nerve stimulation / spinal cord stimulator
- X STOP interspinous process decompression system
- Xiaflex injections

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.

THP has guidelines for the types of services that may be approved by the member's PCP for both physical and behavioral health services. Members may select a secondary care provider (SCP), as well as, a PCP. An Ob/GYN may be selected as a SCP. The following specialties may be selected as a SCP for members with a chronic disease: endocrinology, oncology and nephrology. In most cases if a member selected a SCP, they pay the PCP copay and a referral

is not required from the PCP. Section 2 of the Provider Manual discusses *Secondary Care Physician Guidelines*.

The PCP, upon identification of the need for specialty care over an extended period of time for a chronic condition that is life-threatening, degenerative, or disabling may initiate a standing authorization. Short term care (6 months or less) can be requested for ongoing care over an extended period of time. This is requested as a standing referral type and the number of visits are based upon the treatment plan. The approval is limited to one year at which time a concurrent review can be requested for subsequent visits as required for the member's care. The specialist will communicate with the PCP with regular reports on the care provided to the member.

A list of services that require medical prior authorization is included in the Provider Manual in Section 7 *Medical Management*. The preauthorization list for behavioral health services is included in Section 9 *Behavioral Health* in the Provider Manual. The preauthorization lists for medical and behavioral health services are also located on THP's website.

Direct access to behavioral health providers is supported under mental health parity and preauthorization is not required for outpatient evaluation and counseling related to mental health or substance use disorders. Primary care physicians (PCP) may provide medical management for a limited amount of behavioral health diagnoses to THP members (i.e. seasonal depression and anxiety). THP's credentialing guidelines state that providers must provide services within the scope of their practice. Page 5 of the THP's *Credentialing Policy* addresses this topic. THP does encourage PCPs to screen members for behavioral health needs and the PCP may assist in coordinating with THP to ensure the member receives the appropriate behavioral health services. In Section 2 of THP's Provider Manual under *Physician Availability* the PCP's role in screening for behavioral health needs and how PCPs can initiate dialog on alcohol and other drug dependence treatment are addressed. The PCP is at the center of the services for the member. Specialists are engaged as appropriate.

Services that are needed for the member are determined based on the PCPs assessment of the member and the history of services received by the member. If the member needs additional services from a specialist or ancillary service, the PCP will refer the member to those services. The Health Plan then authorizes those services based on the assessment and recommendation of the PCP who is in charge of the member's care. If members are in need of specialty care, the primary care physician can refer directly to the in-network specialist.

BA049 The Vendor should establish, implement, and update guidelines or types of services to which the member can self-refer.

When members become eligible with THP, they receive a Member Handbook. Within the Member Handbook it describes how members can access in and out-of-network services, family planning services and services they can self-refer. THP members can self-refer to any in-network specialty care provider for disease specific needs, most outpatient behavioral health

services and 24 hour on call nurse for support and direction to appropriate services. In addition to the Member Handbook, THP's Member Outreach Advocates discuss family planning services and self-referral services with new members when conducting the new member orientation calls. Members can self-refer for case management services by calling The Health Plan's utilization management department.

BA050 The Vendor should establish and implement a required length of time for providers to request prior authorizations (PAs) for services.

The Health Plan renders determinations and notifications as expeditiously as the member's health condition requires to minimize any disruption in the provision of care and services to our members. This applies to all decisions whether they are made on the basis of benefit coverage or medical appropriateness. Written notifications ensure that the practitioner/provider and member are provided a clear explanation of the reason and reference for the non-authorization of requested services and allows for an informed decision to pursue an appeal.

All providers are required to request prior authorization before a service is rendered unless deemed urgent/emergent. This requirement includes both outpatient and inpatient services. The provider must indicate if a request is emergent so the review may be expedited. Scheduling a test/procedure does not warrant an expedited review. Unless an emergency, scheduling should be done after THP approval. The guideline regarding prior authorization is located in the *Medicaid* section (Section 5) in THP's Provider Manual.

After normal business hours, on weekends and holidays for urgent/expedited requests, including behavioral health and pharmacy, The Health Plan operates a medical emergency nurse line, pharmacy emergency line and a behavioral health line that are available 24/7. If a physician determines that care is indicated urgently before authorization can be obtained, then The Health Plan will retrospectively review the authorization request on the next business day.

The Health Plan accepts service requests telephonically, by fax, mail, secure email and by secure electronic transmission through THP's provider portal using standards established by the Council for Affordable Quality Health on Operating Rules. Preauthorization request forms are available on the website at <https://myplan.healthplan.org/Provider/Authorizations>. Decision timeframes are followed as mandated by legislation per state and various regulatory agencies for services deemed non-urgent and urgent or expedited for concurrent, pre and post-service requests as defined per our Timeliness of UM and Behavioral Health Decisions and Notifications.

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BA051	The Vendor should establish and implement 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.

THP has a well-established authorization process for its current members. As foster care children and families are introduced into THP's system, and authorization is sought for socially necessary services, THP will use many of the same algorithm used for authorization of medically necessary services that members receive with this population when request for services are authorized and made available.

THP will honor any prior authorization request for behavioral health assessment that is the result of DHHR established protocols for this population (for example, foster care required assessments, assessments required as an aspect of the settlement with the DOJ, MDT) and will liberally review any assessment that is requested by the Child and Family Service Planning Team. THP does not require prior authorization for any outpatient behavioral health service other than admission to a CSU, and the first three days of that service are considered to be emergent and are therefore not subject to authorization.

THP process requires that when a request for services is received for members, the utilization management staff enters the information related to the request and sends a referral to the inpatient navigator or the referral navigator for review. The request is reviewed for appropriateness and medical or social necessity. If the request meets criteria, the authorization is approved. If further information is needed or if services need revision to meet the member needs, the navigator reaches out to the provider making the request for clarification. In all cases of a possible adverse determination, the medical director is consulted, or the lead social worker will be consulted. The medical director may, as appropriate, discuss services through peer-to-peer consultation. Only a medical director is permitted to deny services to members. Appeals are sent to same or similar type specialist for a secondary review.

THP has established a network for primary, secondary and tertiary providers to ensure the appropriate delivery of care to members. Each level is related to the complexity of a member's individual needs as well as the skills and specialties of the provider. When THP is managing socially necessary services, navigators and/or social workers will coordinate with the DHHR Caseworker regarding any concerns around the requested services.

Services that are not available through the in-plan network for both medical/behavioral health and socially necessity may be approved to provide the best care and treatment for members. These services require a prior authorization. The PCP, specialist or social service provider may request an authorization by contacting THP telephonically, via fax, or by electronic submission. THP's system also has the ability to support self-referral of members. This process is discussed later in this response.

General practitioners, internal medicine practitioners, family PCP, nurse practitioners and physician assistants, and other medical and behavioral health practitioners are included in the

in-network contract with THP to provide services and to act as the coordinator of care for members. When treatment for any of members is needed from a specialist, THP works in collaboration with the PCP and social worker to arrange for appointments to ensure the member is receiving quality services. The THP Navigator(s) and/or THP Navigator(s) discusses the needs of the network member with the PCP and arranges for services. This is all done in collaboration with the member, taking into consideration related to care and support.

Secondary care specialists who focus on a specific system or specific disease/condition, may treat the member in collaboration with the PCP for specialty services. Examples of such specialty services include but are not limited to, endocrinology, oncology and nephrology, and certain behavioral health services.

Members who require highly technical and specialized services for severe or complex health or psychosocial issues may be treated in a tertiary facility. This type of care is provided in a medical center that is usually affiliated with a university. The PCP or specialty provider may request prior authorization for these services following a medical or psychosocial evaluation to determine the needs of the member.

Consideration for the appropriateness of all services is given to members' individual needs when determinations are being made. These services are approved when medically or socially necessary. In the event a service does not meet medical appropriateness guidelines, a physician review is required prior to denial of services. The physician review is typically handled by a THP Medical Director; however, an outside specialist may be used if specialty expertise is required.

All services for the member are coordinated by THP staff to ensure quality services are provided.

All prior authorization requests are handled within the required timeframes. Authorization notifications are provided either electronically or by mail to both the referring provider and the provider being referred to. Members also receive copies of the referral notification. In the case of a denied service, the letter includes information on the rationale for the denial and the appeal rights which in West Virginia includes the Fair Hearing process.

Sample copies of Authorization Request approval and denials letter are included below.

SAMPLE APPROVAL REQUEST



1110 Main Street
Wheeling, WV 26003-2704
P: 1.800.624.6961
healthplan.org

JASON
Street Address
city name, WV 99999

IMPORTANT: This notice explains your rights to appeal our decision. Read this notice carefully. If you need help you can contact us by using the information provided in this notice.

Notice of Approval of Medical Coverage

Date : 07/12/2019
Name : member name

Effective Date : 11/01/2018
Member ID : H1700999999

Ref Number : 201919160031

Your request was approved:

We have approved the medical services/items listed below requested by you or your doctor:
Portable oxygen from Lincare.

Why did we approve your request?

We approved the medical services/items listed above because:

It is medically necessary.

36 month capped rental thru 6/2022, M&S thru 6/2024

Notice of Action Statement

If you do not like a decision made by The Health Plan or are not happy with any services received, or are unhappy about any other part of The Health Plan or your provider (without getting in trouble), you can get in touch with The Health Plan by calling at 1.888.613.8385 (TTY: 711) or write it down and send it to 1110 Main Street, Wheeling, WV 26003-2704.

The Health Plan can help you with completing any forms, translation (reading) services, and auxiliary aids and services at no cost to you.

Informal Grievances

Informal grievances are when you call The Health Plan to tell us you are not happy with any matter related to The Health Plan such as our decision to not pay a bill or okay it for you, or you are unhappy with any part of your benefits, services, The Health Plan or its list of providers. If you call the Member Service Department at 1.888.613.8385 (TTY: 711) they will take all of the information you give them and look into the problem. They will try to get you an answer in 30 calendar days. This timeframe may be extended up to 14 days if you ask for it or if The Health Plan shows that more information is needed, and the delay could help you in the grievance. If they are not able to answer your question in 30 calendar days they will call you or write you back and let you know. You can file a grievance at anytime.

Formal Grievances

If you are not happy with our answer to your informal grievance, you or someone with your okay (including a provider) can file a formal grievance. You may also skip the informal grievance process and file a formal grievance right away. To file, or to ask for help with filing a grievance or appeal, contact us at The Health Plan.

Appeals

If your formal grievance is because we told you no to any part of your request for a service, it is called an "Appeal." You or your representative or someone acting on behalf of a deceased member can file an appeal. To file an appeal, you will need to send us a letter that has:

- Your name
- Your provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think helps your appeal, such as written comments, additional paperwork or information related to your appeal

You must file a grievance or appeal in sixty (60) calendar days from the date on the notice of action from The Health Plan.

You should send your written grievance or appeal to:

The Health Plan
1110 Main Street
Wheeling, WV 26003-2704
Fax: 1.888.450.6025

A committee will look at your appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not approve or pay for the health services you are appealing. If your appeal involves a medical problem, the committee will also talk to a medical person who has the right training and experience in the field of medicine necessary for making the decision on the medical problem. If your appeal is an administrative appeal (one not based on a medical problem), the Appeal Committee will consist of The Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to have someone speak for you during the appeal process. You may also request a copy of the benefit provision, guidelines, protocol, or criteria on which the appeal decision was based. You are entitled to receive, upon request, reasonable access to or a copy of all the relevant documents ruled upon to make the appeal decision free of charge.

If your appeal is for a service that you have not received yet, you will get the decision in 30 days after we get your appeal.

If The Health Plan needs more information for the appeal, or if you want to give us more information, you or The Health Plan can ask for 14 more calendar days to finish the appeal. If The Health Plan tells you they will extend the review time to finish the appeal, you will be told in writing in (2) two calendar days that you have the right to file a grievance if you do not like the longer time.

For your information, we have provided the titles and qualification of individuals participating in your appeal decision review:

- Medical Director - Board-certified practitioners (Radiology, Behavioral Health, Obstetrics/Gynecology, General Surgeon) with current state licensures
- Nurse Navigators - Registered nurses with current state licensures

Fast Appeals

If your appeal is about our decision to not approve or pay for some or all of your services and you need an appeal decision fast because you have not gotten the services and you might be badly hurt if you had to wait for a normal appeal decision like the one described above, you can ask for a fast appeal. If we allow a fast appeal, we will schedule a meeting with the committee no later than 48 hours after we get your appeal. We will call you 24 hours after we get your appeal to let you know the date, time and place of the meeting. We will make a decision on your appeal no later than 72 hours after we get your appeal. You will get a letter explaining the next steps. The Health Plan will report your request for a fast appeal to the State so they can determine a time line for a decision.

If we tell you your appeal is not a fast appeal, we will handle your appeal like the normal appeals described in the section above.

State Fair Hearing Process

If you are not happy with The Health Plan's appeal decision and your appeal is about our decision to not accept, lower, change or stop payment of your bill, you can ask a State Fair Hearing if it is in 120 days of the notice of The Health Plan's appeal decision. You can only ask for a State Fair Hearing if it relates to a denial of a service, a lowering of service, stopping of a previously approved service, or not to give you service timely. You will get a notice mailed to you in ten (10) days before any action is taken.

If you ask for a State Fair Hearing, the State will hear your case and give you a decision in writing in 90 days of the date you asked for a State Fair Hearing. If are still not happy with the decision, you can take your case to Circuit Court. If you want to take your case to Circuit Court, you must file in 30 days after your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).

Send your letter asking for a State Fair Hearing to:

Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708

The BMS decision will be sent to you in writing.

The Health Plan will continue your benefits during the time of an appeal process or State Fair Hearing when:

- You or your provider file an appeal on a timely basis;
- The appeal involves stopping, holding, or lowering of a previously approved course of treatment;
- The services were ordered by an approved provider;
- The first period covered by the first approved has not expired; and
- You ask for a longer time to keep their benefits.

To ask for longer time to keep your benefits, call Customer Service at 1.888.613.8385 (TTY: 711).

The Health Plan will pay for the services in question when the final result of the appeal to change the first decision. The Health Plan will pay for some or all of the services as they were given to you by the final appeal decision. If the final result of your appeal is to keep the first decision to not accept, lower, change or end payment of your bill, The Health Plan may take back the money that was paid for the services while the appeal was getting talked about, and you will have to pay for the services.

Appeals after 120 Days

If you did not ask for a State Fair Hearing in the 120 days, you may still be able to appeal The Health Plan's appeal decision that you are unhappy with. You can also use these steps if the decision is related to a complaint rather than an appeal. You must have gone through The Health Plan's grievance process and it must be in one year of the date of the first decision or issue that you did not like with or were not happy with.

Keeping Your Grievance and Appeals

The Health Plan will keep copies of your grievance and appeals paperwork and information about the grievance and appeal for your review for ten (10) years.

Member Information

Member ID: H17007086 01
Member Name: name xxxxx
Birthdate: 08/xx/xxxx
Group No.: 01423001 (MHS)
Effective: 11/01/2018
Contract: 07/01/2019
PCP Name: JASON
PCP Phone: 304xxxxxxx

Referred By:

JASON Provider ID: Hxxxxxx
Phone Number: 3044xxxxxx

Referred To:

LINCARE - WV Provider ID: DMExxxxx
215 WARWOOD AVE
WHEELING WV 26003-6835

Referral Information

Date: 07/12/2019
Ref Number: 201919160031
Start Date: 07/10/2019
Expiration Date: 12/31/9997
Visits Approved: 0036
Appeal Language Code: MHT

You may request to look at, or be sent a copy of the rules, procedure, benefit or standards on which this decision was based. If you request the documents used to make this decision, it will be at no cost to you.

If you would like to discuss this referral decision or utilization management concern with a medical director, behavioral healthcare reviewer, pharmacist reviewer or an other appropriate reviewer, they may be reached by phoning Clinical Services during normal business hours (Monday - Friday 8 a.m. to 5 p.m.) 1.800.624.6961 Ext 7643. After 5 p.m. you may speak directly to a staff member, by calling 1-866.NURSEHP

**PLEASE CONSULT YOUR HANDBOOK FOR COMPLETE
COPAY INFORMATION AND LIMITATIONS**

SAMPLE DENIAL



1110 Main Street
Wheeling, WV 26003-2704
P: 1.800.624.6961
healthplan.org

IMPORTANT: This notice explains your rights to appeal our decision. Read this notice carefully. If you need help you can contact us by using the information provided in this notice.

Notice of Denial of Medical Coverage

Date : 07/18/2019	Effective Date : 07/01/2019
Name : name	Member ID : 99999999
Ref Number : 201919160028	

Your request was denied:

We have denied the medical services/items listed below requested by you or your doctor:

MRI (detailed images) of the left knee.

Why did we deny your request?:

We have denied the medical services/items listed above because:

The MRI (detailed images) of the left knee does not meet The Health Plan rules (Interqual - Imaging, Knee). The rules say before an MRI is done you need to try 6 weeks of physical therapy or home exercises. The office notes sent to The Health Plan do not say you have tried therapy or exercises for your left knee pain. We suggest you follow up with your doctor to discuss further care.

You should share a copy of the decision with your doctor so you and your doctor can discuss the next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

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- Your provider's name
- The date of service
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A committee will look at your appeal. None of the people on the Appeal Committee will have been involved in our initial decision to not approve or pay for the health services you are appealing. If your appeal involves a medical problem, the committee will also talk to a medical person who has the right training and experience in the field of medicine necessary for making the decision on the medical problem. If your appeal is an administrative appeal (one not based on a medical problem), the Appeal Committee will consist of The Health Plan senior management. You can come to the Appeal Committee meeting and talk to the Appeal Committee. You have the right to have someone speak for you during the appeal process. You may also request a copy of the benefit provision, guidelines, protocol, or criteria on which the appeal decision was based. You are entitled to receive, upon request, reasonable access to or a copy of all the relevant documents ruled upon to make the appeal decision free of charge.

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If you ask for a State Fair Hearing, the State will hear your case and give you a decision in writing in 90 days of the date you asked for a State Fair Hearing. If are still not happy with the decision, you can take your case to Circuit Court. If you want to take your case to Circuit Court, you must file in 30 days after your notice of the State Fair Hearing decision. You can file an appeal to the Bureau for Medical Services (BMS).

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Charleston, WV 25301-3708

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Member Information

Member ID: 9999999999
Member Name: name
Birthdate: 02/xx/xx
Group No.: 01413001 (MHB)
Effective: 07/01/2019
Contract: 07/01/2019
PCP Name: WAXXXXXXXXXX
PCP Phone: 30443299999

Referral Information Date:

07/18/2019
Ref Number: 2019191600
Start Date: 07/10/2019
Expiration Date: 07/10/2019
Visits Approved: 0000
Appeal Language Code: MHT

Referred By:

DAVID Provider ID: WV145
Phone Number: 6813499999

Referred To:

UNITED HOSPITAL CENTER Provider ID: WV
327 MEDICAL PARK DRIVE
BRIDGEPORT WV 26330

You may request to look at, or be sent a copy of the rules, procedure, benefit or standards on which this decision was based. If you request the documents used to make this decision, it will be at no cost to you.

**PLEASE CONSULT YOUR HANDBOOK FOR COMPLETE
COPAY INFORMATION AND LIMITATIONS**



Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- ∞ Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- ∞ Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1.877.847.7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7907 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7907 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-847-7907 (TTY: 711)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ملحوظة: إذا كنت تبحث عن اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 1-877-847-7907 (رقم هاتف الصم والبكم: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-847-7907 (TTY: 711) पर कॉल करें।

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-847-7907 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-847-7907 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

Wann du Deitsch (Pennsylvania German / Dutch) schwetzschts, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

AANDACHT: Als u nederlands spreek, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajilla gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

BA053 The Vendor should develop and use clinical guidelines for prior authorizations (PAs) for physical and behavioral health services.

THP's Guidelines for clinical services are currently available on the provider portal on the THP website. The services for foster care children will also be on THP's website so that providers and members will have ease of access. THP's guidelines are based on nationally recognized clinical literature, expert consensus, and reflect industry best practices. In crafting guidelines for THP's new members, THP will draw upon evidence-based materials developed specifically for social services for children, youth and families involved in the foster care system.

THP's clinical and socially necessary guidelines are used to make determinations for a request for prior authorization using InterQual criteria, BMS guidelines, and current DHHR Social Necessary Service guidelines. Guideline information currently includes the service code, the description of the service, a covered service and the criteria used for the specific service provided. THP intends to use many of the same algorithms found in its clinical model for THP's new members. Information related to preauthorization requirements for all services is and will continue to be listed with the guidelines.

Determinations for services are reviewed according to necessity by the THP Navigator(s). When a request for services is received for members, staff enters the information related to the request and forwards the request to the navigator for review. The request is reviewed for appropriateness and medical necessity based on the established criteria. If the request meets established criteria, the authorization is approved. If further information is needed or if services need revision to meet member needs, the navigators reach out to the provider making the request for clarification. In all cases of a possible adverse determination, the medical director, clinical psychologist and/or social worker is consulted based on the referral type. The medical director may, as appropriate, discuss services through peer-to-peer consultation.

Sample of referral process – next three pages

Below is a sample of a referral process documenting the various steps in the clinical review process.

Initially the authorization request as shown below is received by THP and information is gathered and tracked electronically—in this case the request was submitted through the WEB.

Referral - Display (Live System)

READ ONLY MODE

Control Number: 2019
Member Number: H190

DOB: 02/27/1966 Age: 53
Dates: 07/01/2019 12/31/9999

Caller: HEATHER
Phone Number: 681-342-3543 Ext: 3543
Referral Set: MR/CAT Scan
HIPAA Sub Set: MR - MRI
Referral Type: MR - MRI
Referral Sub Type: - Empty
Specialty: - Empty

Start Date: 07/10/2019 LOS: 0
End Date: 07/10/2019 Units:
System: WEB
Taken By: WEB REFERRALS
Taken Date: 07/10/2019 01:35 PM
Proc Date: 07/10/2019 01:35 PM

Leakage: -
Pay Level: -
Level Of Care: -
Status: -
Timeliness: NUPRS-Non-Urgent_Pre Service
Pay Line: DENY Visits Allowed/Taken: 0

Initial Referral? YES
Clinical Trial? NO
Expedited? NO

Oral Notifications
Member: Click To Set
Provider: Click To Set
Mailed: 7/16/2019 10:30:00 AM

Referring Provider: HP ID: WV14570 NPI: 1225366933 Tax ID: 550525724 Name: DAVID C WEBSTER PA-C
Refer To Provider: WV02 1184606600 550525724 UNITED HOSPITAL CENTER
Hospital/Pharmacy: WV02 1184606600 550525724 UNITED HOSPITAL CENTER

Diagnosis: Low back pain
CPT: MRI LOWER EXT ANY JOINT, TWO CON.
Reconsideration: D - Denied
Reconsideration Date: 7/18/2019 10:28 AM
Reconsideration By: Robert Cross

Diagnoses | CPT | Review | Remarks | Delay | Service Extensions | Expedited | Utility | EPSDT | Letters

ICD Type: 10
Diagnosis Type: Secondary
Diagnosis Code: M25.62
Description: Pain in left knee
M54.5 Primary: Low back pain
S83.209 Primary: Unsup tear of unsp meniscus, current injury, unsp

Notes (Click here to clear)
OFFICE NOTES FAXED

482 characters remaining

As the review is takes place the THP navigator documents the information provided by the provider to support the authorization request.

Referral - Display (Live System)

READ ONLY MODE

Control Number: 2019
Member Number: H190

DOB: 02/27/1966 Age: 53
Dates: 07/01/2019 12/31/9999

Caller: HEATHER
Phone Number: 681-342-3543 Ext: 3543
Referral Set: MR/CAT Scan
HIPAA Sub Set: MR - MRI
Referral Type: MR - MRI
Referral Sub Type: - Empty
Specialty: - Empty

Start Date: 07/10/2019 LOS: 0
End Date: 07/10/2019 Units:
System: WEB
Taken By: WEB REFERRALS
Taken Date: 07/10/2019 01:35 PM
Proc Date: 07/10/2019 01:35 PM

Leakage: -
Pay Level: -
Level Of Care: -
Status: -
Timeliness: NUPRS-Non-Urgent_Pre Service
Pay Line: DENY Visits Allowed/Taken: 0

Initial Referral? YES
Clinical Trial? NO
Expedited? NO

Oral Notifications
Member: Click To Set
Provider: Click To Set
Mailed: 7/16/2019 10:30:00 AM

Referring Provider: HP ID: WV14570 NPI: 1225366933 Tax ID: 550525724 Name: DAVID C WEBSTER PA-C
Refer To Provider: WV02 1184606600 550525724 UNITED HOSPITAL CENTER
Hospital/Pharmacy: WV02 1184606600 550525724 UNITED HOSPITAL CENTER

Diagnosis: Low back pain
CPT: MRI LOWER EXT ANY JOINT, TWO CON.
Reconsideration: D - Denied
Reconsideration Date: 7/18/2019 10:28 AM
Reconsideration By: Robert Cross

Diagnoses | CPT | Review | Remarks | Delay | Service Extensions | Expedited | Utility | EPSDT | Letters

Diary Remarks Entry | List View | Day

Entry Date: 7/11/2019 2:45:00 Entered By: Amanda Bigler Entry: NUPRS, Web request / clinicals attached - MRI left knee, C/O pain / swelling. No recent injury, injury Sept 2017. Pain 8/10. Worse with walking, bending, knee negative. Taking tramadol. Treatment next - 4AC/Amny. Requesting MRI left knee. IO not met. To Med Dir for review.

Entry Date: 7/11/2019 2:50:00 Entered By: Robert Cross Entry: iq not met no pt no hep

Entry Date: 7/11/2019 3:39:00 Entered By: Amanda Bigler Entry: Denied on medical review. Denial with rationale called to

Entry Date: 7/18/2019 9:12:00 Entered By: Amanda Bigler Entry: Received in xrayogram from Michael M. - clinicals attache

Entry Date: 7/18/2019 10:19:00 Entered By: Robert Cross Entry: iq not met no pt no hep

Notes (Click here to clear)
OFFICE NOTES FAXED

482 characters remaining

The navigator completes the review and has documented that the request does not meet interqual criteria. Accordingly, the request is forwarded for Medical Director review.

Referral - Display (Live System)

READ ONLY MODE

Control Number: 201918150
Member Number: H19021996

DOB: 02/27/1966 Age: 53
Sex: M 07/01/2019 12:31:9999

Caller: HEATHER
Phone Number: 581-342-3543 Ext: 3543
Referral Set: MRI/CAT Scan
HIPAA Sub Set:
Referral Type: MR - MRI
Referral Sub Type:
Specialty: - Empty

Start Date: 07/10/2019 End Date: 07/10/2019 LOS: 0
System: WEB
Taken By: WEB REFERRALS
Taken Date: 07/10/2019 01:35 PM
Proc Date: 07/10/2019 01:35 PM

Leakage:
Pay Level:
Level Of Care:
Status:
Timeliness: NUPS-Non-Urgent_Pro Service
Pay Line: DENY Visits Allowed/Taken: 0

Initial Referral?: YES
Clinical Trial?: NO
Expedited?: NO

Cost Notifications
Member: Click To Set
Provider: Click To Set
Mailed: 7/16/2019 10:30:00 AM

Referring Provider	Referral Provider	Hospital/Pharmacy	HP ID	NPI	Text ID	Name
DAVID C WEBSTER PA-C	DAVID C WEBSTER PA-C	UNITED HOSPITAL CENTER	WV14570	1225366933	550525724	DAVID C WEBSTER PA-C
UNITED HOSPITAL CENTER	UNITED HOSPITAL CENTER	UNITED HOSPITAL CENTER	WV02	1184606600	550525724	UNITED HOSPITAL CENTER

Diagnoses: CPT [Review] Remarks [Diary] Service Extensions [Expedited] Utility [EPSDT] Letters []

Diary Remarks Entry List View Diary View

Entry Date	Entered By	Entry
7/11/2019 2:45:00	Amanda Bigler	NUPS. Web request/ clinicals attached - MRI left knee. C
7/11/2019 2:50:00	Robert Cross	iq not met no pt no hep
7/11/2019 3:39:00	Amanda Bigler	Denied on medical review. Denial with rationale called to
7/18/2019 9:12:00	Amanda Bigler	Received in actiongram from Michael M. - clinicals attache
7/18/2019 10:19:00	Robert Cross	iq not met no pt no hep

Notes (Click here to clear): OFFICE NOTES FAXED

482 characters remaining

On 7/11 the Medical Director completes the review and documents that interqual criteria is not met and case should be denied. Further documentation on 7/11 shows the Navigator completes the denial and notifies the office of the denial and rationale for the denial.

ON 7/18 the Navigator receives a notification that additional clinical information has been received and therefore a reconsideration should be completed to review the new information.

Referral - Display (Live System)

READ ONLY MODE

Control Number: 201918150
Member Number: H19021996

DOB: 02/27/1966 Age: 53
Sex: M 07/01/2019 12:31:9999

Caller: HEATHER
Phone Number: 581-342-3543 Ext: 3543
Referral Set: MRI/CAT Scan
HIPAA Sub Set:
Referral Type: MR - MRI
Referral Sub Type:
Specialty: - Empty

Start Date: 07/10/2019 End Date: 07/10/2019 LOS: 0
System: WEB
Taken By: WEB REFERRALS
Taken Date: 07/10/2019 01:35 PM
Proc Date: 07/10/2019 01:35 PM

Leakage:
Pay Level:
Level Of Care:
Status:
Timeliness: NUPS-Non-Urgent_Pro Service
Pay Line: DENY Visits Allowed/Taken: 0

Initial Referral?: YES
Clinical Trial?: NO
Expedited?: NO

Cost Notifications
Member: Click To Set
Provider: Click To Set
Mailed: 7/16/2019 10:30:00 AM

Referring Provider	Referral Provider	Hospital/Pharmacy	HP ID	NPI	Text ID	Name
DAVID C WEBSTER PA-C	DAVID C WEBSTER PA-C	UNITED HOSPITAL CENTER	WV14570	1225366933	550525724	DAVID C WEBSTER PA-C
UNITED HOSPITAL CENTER	UNITED HOSPITAL CENTER	UNITED HOSPITAL CENTER	WV02	1184606600	550525724	UNITED HOSPITAL CENTER

Diagnoses: CPT [Review] Remarks [Diary] Service Extensions [Expedited] Utility [EPSDT] Letters []

Diary Remarks Entry List View Diary View

Entry Date	Entered By	Entry
7/11/2019 2:45:00	Amanda Bigler	NUPS. Web request/ clinicals attached - MRI left knee. C
7/11/2019 2:50:00	Robert Cross	iq not met no pt no hep
7/11/2019 3:39:00	Amanda Bigler	Denied on medical review. Denial with rationale called to
7/18/2019 9:12:00	Amanda Bigler	Received in actiongram from Michael M. - clinicals attache
7/18/2019 10:19:00	Robert Cross	iq not met no pt no hep

Notes (Click here to clear):

500 characters remaining

On 7/18 the Medical Director evaluates the new information and documents that interqual criteria is still not met.

Referral - Display (Live System)
READ ONLY MODE

Control Number: 20191916002
Member Number: H19021996

Caller: HEATHER
Phone Number: 681-342-3543 Ext. 3543
Referral Set: MR/CAT Scan
HIPAA Sub Set: MR - MRI
Referral Type: MR - MRI
Referral Sub Type: - Empty
Specialty: - Empty

Start Date: 07/10/2019
End Date: 07/10/2019
System: WEB
Taken By: WEB REFERRALS
Taken Date: 07/10/2019 01:35 PM
Proc Date: 07/10/2019 01:35 PM

Leakage: -
Pay Level: -
Level Of Care: -
Status: NUPS-Non-Urgent_Pre Service
Pay Line: DENY Visits Allowed/Taken: 0

Initial Referral? YES
Clinical Trial? NO
Expedited? NO

Oral Notifications
Member: Click To Set
Provider: Click To Set
Mailed: 7/16/2019 10:30:00 AM

Referring Provider: WV14570 1225366933 550525724 DAVID C WEBSTER PA-C
Refer To Provider: WV02 1184606600 550525724 UNITED HOSPITAL CENTER
Hospital/Pharmacy: WV02 1184606600 550525724 UNITED HOSPITAL CENTER

Diagnoses: CPT Review Remarks Diary Service Extensions Expedited Utility EPSDT Letters

Assignments

Initial	MD/Ph	Initial Final	Reconsideration	Second Appeal	Sec Appeal MD/Ph
Amanda Bigler	Robert Cross	Amanda Bigler	Robert Cross		
7/10/2019 2:01:00 PM	7/11/2019 2:46:00 PM	7/11/2019 3:35:00 PM	7/18/2019 10:19:00 AM		

Review Decisions

MD/Ph	Decision	Date
D - Denied		7/11/2019 2:46:00 PM
Initial Final	D - Denied	7/11/2019 3:35:00 PM
Reconsideration	D - Denied	7/18/2019 10:19:00 AM
Second Appeal		
Sec Appeal MD/Ph		

Diagnosis: Low back pain
OPT: MR LOWER EXT ANY JOINT, VNO CON.
Assignments: First Amanda Bigler
Reviewer: Reconsideration Robert Cross
Decision Date: 7/18/2019 10:19:28 AM
Decision By: Robert Cross

Notes (Click here to clear)
OFFICE NOTES FAXED

482 characters remaining

Systems are updated to show various review processes, dates and status.

Referral - Display (Live System)
READ ONLY MODE

Control Number: 20191916002
Member Number: H19021996

Caller: HEATHER
Phone Number: 681-342-3543 Ext. 3543
Referral Set: MR/CAT Scan
HIPAA Sub Set: MR - MRI
Referral Type: MR - MRI
Referral Sub Type: - Empty
Specialty: - Empty

Start Date: 07/10/2019
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System: WEB
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Taken Date: 07/10/2019 01:35 PM
Proc Date: 07/10/2019 01:35 PM

Leakage: -
Pay Level: -
Level Of Care: -
Status: NUPS-Non-Urgent_Pre Service
Pay Line: DENY Visits Allowed/Taken: 0

Initial Referral? YES
Clinical Trial? NO
Expedited? NO

Oral Notifications
Member: Click To Set
Provider: Click To Set
Mailed: 7/16/2019 10:30:00 AM

Referring Provider: WV14570 1225366933 550525724 DAVID C WEBSTER PA-C
Refer To Provider: WV02 1184606600 550525724 UNITED HOSPITAL CENTER
Hospital/Pharmacy: WV02 1184606600 550525724 UNITED HOSPITAL CENTER

Diagnoses: CPT Review Remarks Diary Service Extensions Expedited Utility EPSDT Letters

Requested Letters

Requested	Requested By	Processed	Acknowledged	Comments	Mailed	Date Mailed	Canceled	Canceled By
07/11/2019 05:30	Web Referrals	08/06/2019 11:46	08/06/2019 12:13	MEMBER COPY PRINTED	Yes	n/a	n/a	n/a
07/18/2019 05:30	Web Referrals	08/06/2019 11:47	08/06/2019 12:26	MEMBER COPY PRINTED	Yes	n/a	n/a	n/a

Notes (Click here to clear)
OFFICE NOTES FAXED

482 characters remaining

Letters are automatically generated corresponding with both review dates. Copies of the letters are automatically filed in the member folder.

BA054 The Vendor should honor medical, behavioral health, pharmacy, and socially necessary services (SNS) authorization approvals from previous coverage during the transition period.

THP will honor medical, behavioral health, pharmacy, and socially necessary services authorization approvals from previous coverage during the transition period. Assistance will be provided to members who are transitioning to THP from fee for service or another MCO to ensure continuity of care.

THP will review prior service authorizations upon receipt of the existence of a service authorization. THP will ensure that members receiving services through a service authorization from another MCO or FFS continue to receive these services for the same amount, duration, and scope for the shortest period of one of the following:

- Until the end of the current authorization period granted by either another MCO or FFS
- Until THP has evaluated and assessed the member and issued a denial or new service authorization.

THP assures DHHR that the member will have services that are consistent with previous treatment and may return to their provider for a period of 30 days to allow THP to develop a plan of care. Discharge planning will be coordinated with the previous provider to ensure the member continues to receive necessary services.

THP's process to ensure that all entities are aware of the services that are transitioning includes entry of an informational referral into the HEART system. All information necessary for claims payment, care navigation, and discharge planning is included in the informational referral. The start date of the informational referral is the date of transition to THP. The end date of the informational referral is the original end date or 30 days. If the end date of the transition referral is 30 days, THP navigators will review the need for continued services and proceed with the review of the referral. A decision on service continuation will be made prior to the end of the 30-day transition period.

BA055 The Vendor should notify providers and/or members regarding expiration of existing medical, pharmacy, and socially necessary services (SNS) authorizations.

As existing authorizations are provided to THP they will be loaded into THP systems with a reference number, a start, and a stop date. Referral notifications will be generated providing the information to the provider(s) and members including information on the expiration date of the referral. Additionally, during the new member outreach, staff will communicate with the member regarding any referral authorizations that are in place and anticipated expiration dates of those authorizations.

For new or updated referrals, the information is received and processed in THP's HEART system. The system generates the expiration date based on the number of units that are requested and the anticipated timeframe to receive the services. When the navigator authorizes

services, this information is communicated to the provider, the case worker, and the member. The expiration date is specifically indicated and is verbally communicated to the provider, the case worker, and the member. Additionally, the authorization is posted to the provider portal. If there are any questions related to the expiration of the authorization, the navigator communicates the information telephonically to the provider so there is ample time to request a re-authorization of services as necessary for the member. THP's success with this process is reflected in the organization's and network members' outcomes and costs management. THP intends to use this process with its new network members.

THP provides assurances with this submission that staff will be available to answer questions about the utilization management process and authorizations for care and services. Current protocols require staff availability Monday through Friday from 8AM to 5PM in the office. An after-hours nurse is and will continue to be available to receive calls by telephone, email, fax, or via the web if there are questions related to treatment.

BA056	The Vendor should authorize out-of-network services, including, but not limited to, the following:
BA057	Emergency situations
BA058	Non-emergency situations, including, but not limited to, both medically necessary and non-medically necessary services

THP will approve out-of-network services, including, but not limited to, emergency situations, and non-emergency situations, including but not limited to, both medically necessary and non-medically necessary services. THP's process allows the MCO to approve emergency services, urgently needed services, post stabilization care as well as temporarily out of area services without prior authorization. Urgently needed services are those provided for an unforeseen medical or behavioral health condition that requires attention without delay. Urgent services that cannot be addressed by the PCP or social worker promptly, and urgently needed services that are incurred by the member who is temporarily out of THP network, requiring prompt treatment by a physician's office or urgent care center are covered. THP's 24-hour access process provides assistance to members who are in need of urgent treatment when necessary to locate a provider to perform such services and information regarding how members can access emergency services as needed.

Provider information for approving such services is outlined in the provider manual, provider contract, and reinforced in provider's ongoing trainings. THP requires that all providers have an answering service and/or an answering machine to let the members know how to access care after hours. THP's standards require that providers respond within one hour of answering service/answering machine message.

As providers are added to the delivery system, THP will survey all providers, new and existing to determine how many can and will meet the standard for 24-hour access. Where gaps exist, THP will work with its provider network to build their 24-hour support infrastructures. And where

necessary, will provide incentive payments for after hour services, work with our provider partners to identify and train relevant providers throughout the state, and ensure that case workers have access to those providers who can provide urgent and emergent services on a continuous basis.

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.

THP facilitates ongoing specialist care and coordination for members. This applies when the PCP, in consultation with the specialist, identifies the need for specialty care over an extended period of time for a chronic condition that is life-threatening, degenerative, or disabling.

Specialist and standing authorizations are subject to timeliness review. The PCP or treating practitioner is responsible for initiating authorizations and supplying appropriate medical history. The referral request is reviewed by the clinical department. Short term care (6 months or less) can be requested for ongoing care over an extended period of time. This is requested as a standing referral type and the number of visits are based upon the treatment plan. The approval is limited to one year at which time a concurrent review can be requested for subsequent visits as required for the member's care.

Upon approval, the specialist or practitioner will provide the care as relevant to the member needs and the provider's expertise. The specialist will communicate with the PCP with regular reports on the care provided to the member.

All members with special healthcare needs are identified upon enrollment and during case management. They are automatically placed into a referral to case management. This referral is generated automatically based on the questions in the health risk assessment completed by the member advocate or the THP Navigator(s).

Members are afforded direct access to Behavioral Health providers and practitioners without the need for a referral.

Services that require an authorization from a PCP or specialist are listed in the member handbook. If the service is not listed, it does not require a prior authorization and the member can self-refer.

Standing authorizations are subject to timeliness reviews. Authorizations are granted based on medical and social necessity with the number of visits determined according to individual member need. Authorizations may be granted for up to 12 months.

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BA060	The Vendor should develop and implement physical health and behavioral health guidelines for the extent to which a specialist provider may:
BA061	Admit patient for inpatient care
BA062	Choose the hospital of admission
BA063	Determine that the patient must remain hospitalized
BA064	Schedule or provide ancillary services, such as laboratory testing
BA065	Refer patients to sub-specialists or other providers

THP will develop and implement physical health and behavioral health guidelines for the extent to which a specialist provider may admit patients for inpatient care, choose the hospital of admission, determine whether the patient must remain hospitalized, schedule or provide ancillary services, such as laboratory testing and, refer patients to sub-specialists or other providers. THP has a well-evolved utilization system and has discussed it in detail in other areas of this section. THP's utilization criteria for medical appropriateness and guidelines for coverage provide objective data necessary for the consistent care that is in the best interest of our members.

THP uses a process that allows for clinical information to be used to make critical decisions. Consequently, when clinical information is received from the specialist for inpatient admission, the records are reviewed by the Inpatient Navigator. The criteria for admission is based on the guidelines specified in InterQual related to the type of admission, the hospital that is chosen for care, the length of stay as well as any ancillary services that are requested.

Ancillary services are covered during the hospital stay for diagnostic purposes. If specialty care is not available in-network a referral may be made to a specialist who is out-of-network. THP facilitates ongoing specialist care and coordination for the benefit of the members. The primary care practitioner consults with specialist practitioners to identify the need for specialty care.

Appropriate member history is submitted by the PCP and a treatment plan is formulated by the practitioner and includes input from the member. A coordination of care form is used to communicate the network member needs and treatment progress between providers.

The process of utilization review is used to determine the appropriate determination of medical necessity of services and to determine ancillary services.

(BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK)

BA066 The Vendor should refer members to out-of-network providers using guidelines that the Vendor develops, and the Department approves.

Out-of-network care is defined as care outside of The Health plan's contracted network of in plan (primary, secondary or tertiary) providers and facilities. Out-of-network care requires preauthorization. Preauthorization requests for out-of-network care should be submitted from a participating in-network primary, secondary or tertiary care provider following medical evaluation. Consideration of the member's medical needs and determination if their needs can be met with an in-network provider or facility is reviewed by a medical director. Out-of-network care is approved only when services or providers required to meet a member's medical needs are not available within The Health Plan's network or cannot be safely provided in-network due to complexity of care.

Examples include tertiary care. Complexity of care or procedures that are not available within the local service area. A child with a rare cardiac procedure would be set up for treatment in an out-of-network facility if those services were not available by any surgeons in plan. Additionally, for children or youth who may be placed in a facility outside of THP's service area, THP will work to identify providers to meet care needs regionally. If THP is not able to contract with providers where the child is located, out-of-network services will be authorized to ensure the child/youth has access to needed services.

The THP Navigator(s) collaborates with the PCP and the specialist to arrange services and transportation to and from the facility for the child and family as needed.

BA067 The Vendor should establish and implement a process through which members and/or providers can request out-of-network authorizations.

THP currently has an established process that is followed for out-of-network services. Members and Providers can request out-of-network services through the Medical Management Department when the services are not available within THP's provider network. Members are educated regarding the out-of-network process through the member handbook, newsletters, and member outreach advocate phone calls.

BA068 The Vendor should ensure that the information from non-network providers is shared with the member's primary care provider (PCP).

THP is a team-centered organization. This approach to managing and supporting the work associated with the health and well-being of our members allows the organization to place emphasis where they should be on working together in creating a treatment plan, strengthens the lines of communications between primary care practitioner, specialty care practitioner and other practitioners/providers of healthcare and socially necessary services. Key to our

process are our navigation programs, which serve as the communications links for effective and consistent member care and support.

During the review of a requested service, the THP Navigator(s) gathers all available information from any number of sources including primary care practitioner, specialty care practitioner and other practitioners/providers. The THP Navigator(s) facilitates the sharing of information regarding the member's care between all providers involved in the care of the member including the PCP.

The THP Navigator(s) maintains regular communication with the member and family to gather information on the current status of the member and determine impact, if any, to the care plan. The THP Navigator(s) maintains current communication with the practitioners and healthcare providers to discuss issues and make adjustments to the care plan as appropriate.

The THP Navigator(s) communicates with practitioners and providers in the transition of care needs. The THP Navigator(s) researches appropriate practitioners/providers for services when those services are not available from network practitioners/providers.

BA069	The Vendor should review and process medical referrals according to the guidelines that the Vendor develops, and the Department approves.
-------	---

THP will enter into a partnership with DHHR that ensures that the department's input and approval processes are honored and meets compliance criteria established in the beginning of THP's engagement. Currently, in THP's system, referrals are received in multiple ways including fax, telephonic, and electronically by way of the web and are tracked throughout the process to ensure timely and proper completion of the authorization request in the required timeframes.

Upon receipt of a referral, the information is entered into the HEART system in the referral portal and assigned to the appropriate navigator for review. The request is reviewed to ensure that the services are appropriate. If further information is needed, the navigator contacts the provider to request any needed clinical information. When the referral is completed in the HEART system, a letter of determination is automatically generated to the member, the case worker, and the provider(s). A copy of the letter is maintained electronically in THPs system files.

If the clinical information received does not meet the guideline for the procedure requested, the navigator and/or coordinator may contact the requester for clarification. This can include further clinical history if needed, the procedure that is being requested, the number of units or time needed, etc. If clarification is successful, the navigator will proceed with the authorization. If the furnished information provided does not meet the guideline, the referral is designated for the medical director or specialist for review and final determination. After the determination, the medical director communicates back to the navigator who then notifies the network member, the case worker, and provider telephonically and in writing.

THP has written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. Within those policies we provide for:

- Consultation with the requesting provider by a THP Medical Director or specialist reviewer when appropriate
- Evaluation to ensure consistent application of review determinations and notifications
- Ability to specify information sources and the process used to review and approve the provision of medical services including clear documentation of criteria for decisions on coverage and medical necessity
- Assurance that decisions to deny service authorization or to authorize a service in amount, duration or scope that is less than requested must be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease and who has knowledge of local patterns of care
- Notification of any changes to authorization requirements at least 30 days prior to implementation

Admission, continued stay, and discharge criteria used by the THP is communicated to all providers through our provider manual, website and newsletter and is made available to members when requested.

THP makes authorization decisions and provides written notice to the requesting provider, PCP and member as expeditiously as required by the member's health condition, and no later than seven (7) calendar days of receiving the request for service. This seven (7) calendar day period may be extended up to fourteen (14) additional calendar days upon request of the enrollee or provider, or if the THP justifies to DHHR in advance and in writing a need for additional information and that the member will benefit from such extension. THP provides an expedited authorization for services when the provider indicates that the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. THP will make the expedited authorization decision and provide notice to the member and provider(s) as expeditiously as the enrollee's health condition requires, but no later than two (2) business days after receipt of the request for service authorization. This two (2) day business period may be extended up to forty-eight (48) hours for expedited pre-service authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if THP justifies to DHHR in advance and in writing a need for additional information and that the member will benefit from such extension.

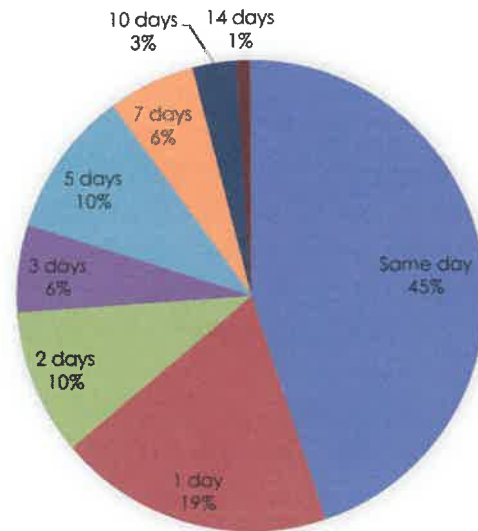
Authorizations on durable medical equipment or other services necessary for an enrollee to be discharged from an inpatient stay are reviewed within two (2) business days so as not to delay the enrollee's discharge. THP does not place prior authorization requirements on oxygen concentrators necessary for discharge.

THP does not structure compensation to persons or organizations conducting utilization management activities so as to provide inappropriate incentives for denial, limitation, or discontinuation of authorization of Medically Necessary covered services.

Every effort is made by THP to ensure that the care of enrolled enrollees is not disrupted or interrupted.

THP does not require service authorization as a condition for payment for emergency care or for family planning services whether rendered by a network or out-of-network provider.

2018 Medicaid Pre-Authorization Timeliness



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 Medical Director.

THP currently has guidelines that support network members' choices. The guidelines provide direction and assistance to members in obtaining medical and behavioral healthcare and services when benefits are exhausted, when a provider contract is discontinued, or during coverage changes. If the member is in agreement, the nurse navigator assists with the transition of care to another provider during an active course of treatment. (An active course of treatment is one in which discontinuing the services would cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.)

The guidelines cover steps that navigators take to obtain information necessary to determine health status, treatments plans, and medication management strategies,

For example, the guidelines will determine whether,

1. The member requires routine monitoring for a chronic condition only;
2. THP has discontinued the contract based on a professional review action as defined in the Healthcare Quality Improvement Act of 1986; or
3. The practitioner is unwilling to continue to treat the member or accept THP's payment or other terms as determined by provider relations.

THP guidelines also prescribe how members transition from one provider to another under the direction of the PCP with the assistance of a THP Navigator. Where possible, both the new and

existing provider(s) are engaged and are encouraged to share patient information to provide for smooth transition of care. THP has a process in place to ensure members receiving services through a service authorization from another MCO or FFS receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following:

1. Until the need of the current authorization period as granted by either another MCO or FFS;
2. Or for up to ninety (90) days or longer if THP is unable to transition the member to an in-network provider.

THP guidelines also provide for continued care and services from the out-of-network provider in the event THP does not contract with a sufficient number and mix of providers resulting in the member being unable to access the needed care and/or services within THPs network.

BA071 The Vendor should perform ongoing monitoring of emergency room (ER) usage.

THP is digitally integrated with West Virginia and bordering facilities by way of the PreManage and WVHIN systems, which are systems designed to allow sharing of electronic health record information in a real-time environment. Additionally, THP has full access to West Virginia University Hospital Facilities through their medical record system Epic. These connectivity solutions provide immediate clinical reporting of members' use of the Emergency Room allowing for real-time action and intervention with members including concurrent or post ER follow-up calls to coordinate required behavioral health and medical follow-up care to address alternatives to use of the emergency room.

Additionally, THP analyzes claims data to identify members with ER overutilization and condition-specific risks. Reports are pushed to care navigation staff and outreach staff for specific targeted intervention and redirection to primary or specialty care when appropriate.

THP also incorporates data on emergency room usage in value-based arrangements (VBA) with providers. The goal of the value-based arrangements related to emergency room use specifies interventions to increase primary care efficacy and further reduce emergency room utilization. Interventions with current VBA facilities include sharing of clinical analytic reports on individual members and monthly clinical huddle discussions with population health teams from both the provider and the health plan resulting in a collaborative approach to solutions for inappropriate emergency room utilization.

BA072 The Vendor should apply the "prudent layperson" standard for all emergency room (ER) visits.

Under THP's plan protocols, THP applies the "prudent layperson" standard for all emergency room visits. Under THP's protocols, emergency room services do not require prior authorization. THP is responsible for covering emergency services and urgently-needed services in the following instances:

- Regardless of whether services are obtained within or outside The Health Plan's service area;
- Regardless of whether there is pre-authorization for the services;
- If the emergency situation is in accordance with a prudent layperson's definition of "emergency medical condition," regardless of the final medical diagnosis; and

Whenever a Plan provider with whom The Health Plan has a written contract to furnish plan covered services to its members or other plan representative instructs a member to seek emergency services within or outside The Health Plan. Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

This standard is applied to the review of all emergency claims. In instances when the service does not meet the standard, a full clinical review is completed by a THP Medical Director who makes the final determination on any denial.

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.

THP has a well-evolved system for transitioning members from an out-of-network provider to in-network providers and provides assistance to Medicaid members to make the transition to THP from previous coverage when prior care and services have been authorized through the previous coverage to prevent interruptions in care. The following reflects THP's current process for transitioning non-members to its network:

Inquiries regarding care transition needs are forwarded to the Clinical Department and answered or reviewed by a THP Navigator. The THP navigator obtains clinical information from the provider and inquires if the services are ongoing and authorized under previous coverage or a new course of treatment after the member's effective date with The Health Plan. The provider is encouraged to consider participation as a network provider with THP; whereby, the provider would be able to continue to provide care and services to the member.

The THP navigator gathers the clinical information necessary to determine if the member is receiving an active course of treatment for an acute episode of a chronic condition, an acute condition, or is in the second or third trimester of pregnancy. An active course of treatment is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.

Care or services which were previously approved by another carrier or Medicaid FFS will continue to be authorized until the expiration of the existing referral or ninety (90) days whichever is sooner. In the meantime, the THP navigator will work with the member and his or her PCP to establish a plan to transition the care to an in-network provider.

The THP navigator works with the member and practitioner(s) to assure a smooth transition of care.

There is proactive collaboration between all areas of Clinical Services including Medical, Behavioral Health, Pharmacy and Social Services for member management, medication adherence, obtaining medical and behavioral healthcare, community resources and services are coordinated with various stakeholders throughout the process. Staff oversight of care transitions and member navigation is accomplished by management staff through COMET reporting of new cases, member logs, reminders, reviews and notes.

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.

Through its performance of the THP navigators' functions, The Health Plan's Medical Department staff strive to support and enhance the partnership of member and primary care practitioner, to ensure continuity and coordination of care along with member understanding of and participation in their care. All practitioners involved in a member's care must share clinical information with each other and the member in a timely fashion.

THP navigators will educate members regarding their rights and responsibility to provide input to practitioners as to their care preferences. The practitioner should document such education appropriately.

Navigation programs serve as the communication links ensuring effective and consistent member care. The THP navigator gathers all available information from any number of sources. Confidentiality is maintained as per federal mandate related to certain behavioral health and substance use disorder information. In such cases, the navigator works with the member to obtain a signed release of information from the member to share the requested information. The member is educated on the need for the sharing of vital clinical data to ensure continuity of care.

Information received from both the previous and current clinicians will be referenced in development of the plan of care for the member.

All information related to the care and treatment of the member will be stored in the HEART/COMET systems for future reference should the member transition to multiple providers throughout their membership with THP.

A document repository along with clinical attachments entered into the member's electronic medical record will serve as a centralized location to store all information relevant to the member's care.

THP navigators work in collaboration with providers and other stakeholders, to gather and provide pertinent information to those providing and arranging for the members care needs.

BA075	The Vendor should inform members of their choices in Family Planning services, for applicable populations.
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NOTE: Also see #49

When members become eligible with THP, they receive a member handbook. Within the member handbook it describes how members can access in and out-of-network family planning services. In addition to the member handbook, our Member Outreach Advocates discuss family planning services and self-referral services with new members when conducting the new member orientation calls. Members are made aware of their ability to access Family Planning services through both in-network and out-of-network providers and they are encouraged to obtain needed Family Planning services.

Members can self-refer for case management services by calling The Health Plan's utilization management department. A THP navigator will assist the member in understanding available services available.

BA076	The Vendor should facilitate timely payment for Family Planning services for in-network and out-of-network providers, for applicable populations.
BA077	The Vendor should identify pregnant women at enrollment and on an ongoing basis.
BA078	The Vendor should promote "early and often" prenatal care for women who are identified as being pregnant, for applicable populations.

THP's enrollment system provides for the identification of pregnant women of child bearing age upon enrollment using the Comment File it receives from the State. This is developed based on information from the members provided during enrollment through DHHR. In addition, THP completes monthly reports (MH520r1, MH520OB, QA394R1) which are claims driven using pregnancy diagnoses. Members may also be identified as pregnant while Advocates are completing the Health Risk Assessment during their Welcome Calls. Depending on their answers they may be referred to a High Risk Registered Nurse using THPs internal tracking system.

- As members are identified as being pregnant an Advocate attempts to contact them three times within the first month of enrollment. Upon contact the member is educated on keeping her appointments and evaluated for high risk pregnancy. If she is considered to be high risk (based on the prenatal assessment) she is flagged in the HEART system for a prenatal navigator to begin case management. Members are educated during Welcome calls and during prenatal\postpartum calls. These calls are conducted during each trimester and the member is encouraged to contact the Advocates at any time if they are

having any complications or questions. Members are reminded to keep all of their scheduled appointment and to follow-up with their practitioner with any issues. Additionally, the THP navigator is available to assist with any questions or concerns.

While Advocates talk with members during their third trimester and postpartum, Family Planning is discussed. Based on the answers given by the member, processes are explained on how to obtain particular Family planning options. In addition, the THP navigator identifies those infants with NAS to perform close follow-up upon discharge. The navigator will educate the members on their care plan.

THP provides education and to members through the member handbook, the newsletter and through outreach calls on Family Planning Services. Family planning services may be obtained by a Medicaid member without a referral or prior authorization through any Medicaid family planning provider, regardless if they are in The Health Plan network or not. Family planning services are defined as those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy.

These services include:

- Health education and counseling necessary to make informed choices and understand contraceptive methods
- History and physical exam
- Pap smear and lab tests if medically indicated as part of the decision-making process for
- Diagnosis and treatment of sexually transmitted diseases (STD) if medically indicated
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up and care for complications associated with contraceptive methods issued by the family planning provider
- Provisions for contraceptive pills, devices, and supplies (Depo-Provera injections are permissible, prescriptions are to be issued for contraceptive pills)
- Tubal ligation and vasectomies (consent forms required)
- Pregnancy testing and counseling
- Family planning provided at postpartum visits and/or discharge post-delivery (postpartum care should be provided within eight weeks of delivery)

For members with pharmacy needs, THP provides information on how to contact the Medicaid pharmacy provider via the WV Pharmacy helpdesk.

Consistent with the family planning providers, THP allows Family Planning providers (in and out-of-network) to bill THP and claims will be accepted and are reimbursed at the Medicaid rate. THP encourages member to permit out-of-network providers to share their family planning information with their in-network PCP.

BA079	The Vendor should identify individuals with complex or serious medical conditions on an ongoing basis, for applicable populations.
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THP uses analytic software that builds episodes of care from claims data, and refreshes the data on a monthly basis, to identify individuals with complex or serious medical conditions. THP's system targets medical conditions and risk scores are identified each month and sent to Medical Management for assessing and developing interventions. Examples of conditions that are identified by the software include, but are not limited to, autism spectrum disorder, cystic fibrosis, personality disorders, and congenital anomalies. Additionally, case navigation reports are reviewed to identify members in need of care management based on complexity of need. Reports can be generated to include engagement of member, intensity of engagement, case open date, case closed date, program type, and level of participation.

For instance, the list of members receiving services for children with special healthcare needs can be sorted to include the date the case was opened/closed, the type of programs that they are enrolled in, and the assigned navigator. In addition to sorting the members enrolled in the program, the list of members can be added to our CAVE analytics program to further identify the needs of the member based on the care need index and the predictive score.

Once identified, the member is assigned to a THP Navigator(s) to determine the intensity of services needed and to provide assistance in getting the treatment required to resolve any identified issues. Ongoing evaluations of member needs are done by utilization of information from past claim history, census information, service pre-authorizations, and any other related clinical information received from practitioners and facilities. If a member is found to need services, an active case is opened in COMET and the appropriate case navigator is assigned.

An evaluation is completed to determine any further needs the member may have. The assessment includes the overall status of the member's health, a clinical history, which includes current and previous medication, activities of daily living, social determinants of health, and the need for any socially necessary services. Our integrated data system allows the navigator to set automatic reminders for reassessment and ongoing evaluation of the member's needs, which will prompt a review and applicable revision of the plan of care.

BA080 The Vendor should use information systems to identify members with special needs.

THP will use an integrated management information system to identify members with special needs. The state's MMIS system provides a specific set of rate codes within the enrollment file that drives the member into different categories, one of which is "Children with Special Healthcare Needs". THP uses this category to identify members in the Special Needs category and coordinates care and services with the state programs for Children with Special Healthcare needs. Additional members not already enrolled in this Special Needs category are identified through the following mechanisms:

- THP analytical software is in place to develop risk scores based on special needs and utilization of services. These are updated monthly and reviewed by Medical Management to determine what support maybe needed and include identification of members with high-risk conditions and special needs.
- Through diagnostic reporting from THP claims system

- Through Health Risk Assessment Information
- Through disease and case management reporting

BA081 The Vendor should use Information systems to isolate data specific to eligibility category or diagnosis.

THP relies on analytical software to identify medical conditions, which are updated monthly, and reviewed by Medical Management for engagement with the member. Reports are available based on specific medical conditions known to be high risk for complications and requiring integration with community services, behavioral health support, and other services.

The state's MMIS system provides a specific set of rate codes within the enrollment file that drives the member into different categories, one of which is "Children with Special Healthcare Needs" and another is pregnancy. THP uses these categories to identify members needing care coordination. These members are referred to THP navigators for follow-up.

BA082 The Vendor should ensure timely access to crisis stabilization services.

In-network out-of-network Crisis stabilization for members does not require pre-authorization as this is considered an emergency service. Emergent services provided in-network or out-of-network do not require pre-authorization. THP requests admission review within the initial 72 hours of admission. When this clinical service is received, a review is completed, utilizing evidenced based nationally recognized criteria (InterQual). If the admission meets criteria, a concurrent review date is scheduled. This will continue through discharge. The initial 72 hours of service are always covered.

The initial 72 hours are covered, and concurrent review schedule established just as with an in-plan admission. For out-of-network cases, THP navigators will work with the facility to transfer the member to the appropriate in-plan facility or program when the member is stabilized. The navigator will contact network staff to determine if this out-of-plan facility should be approached for contracting or for a single case agreement for this stay. If a service, whether in-plan or out-of-plan, does not meet medical criteria, the THP navigator will contact the facility for additional clinical information which will be reviewed by a Medical Director prior to any denial of care.

As previously noted, THP members have direct access to behavioral health providers in a crisis situation. Emergent visits to the emergency department do not require prior authorization. Admissions into a crisis stabilization unit are approved for a 72-hour stabilization phase without clinical review.

THP will incorporate WVHIN and PreManage ALERTS (e.g., immediate notifications that THP receives through network provider Electronic Health record information regarding patient access to services such as emergency room, outpatient surgery, admissions, etc.) into the process to ensure appropriate THP navigators are aware of relevant encounters in order to

follow-up and make sure appropriate follow-up is provided. This information will be incorporated into treatments plans and shared through the MDT process.

BA083 The Vendor should manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.

THP operates pharmacy benefit services in its Wheeling, West Virginia headquarters. THP employs nationally certified pharmacy technicians to staff our call center which services our members and providers. In addition, THP has nine pharmacists on site to oversee our pharmacy operations. THP uses this staff to complete utilization management and pharmacy care programs for our membership. In addition to the pharmacy staff THP also has medical directors on site in our Wheeling headquarters allowing for additional integration and coordination of care for our membership. THP works to provide integrate care to drive member outcomes. With respect to the pharmacy benefit coordination of services is possible with an integrated pharmacy, medical, and behavior health benefit. Using pharmacy data to initiate member care programs helps THP achieve more timely identification and enrollment of members into care programs. Examples include THP's antidepressant and ADHD first fill initiatives.

Internal work groups have been established to ensure THP is managing benefits consistently with BMS contracts as well as any additional state/federal/licensing group mandates. THP adheres to the strict timeliness and quality measures set forth. The pharmacy department meets monthly to discuss any plan changes and review performance these meetings are integrated with our quality improvement team to help ensure THP Rx is operating as effectively as possible.

BA084 The Vendor should develop and implement prescription limits, including, but not limited to, limitations on brand name and generic prescriptions.

THP has a well-developed system that manages prescription limits for members when their medical and pharmacy plans are managed by THP.

THP is able to code the state's PDL and utilization management requirements into their PBM's claims processing platform. By coding the PDL into the claim's adjudication platform THP is able to ensure that members are utilizing the state's preferred drugs. By having an integrated medical, pharmacy and behavioral health program, THP is able to manage medical necessity situations. In these situations, THP is able to look holistically to determine the best way to achieve the best outcome of care. THP also has internal grand rounds where the entire coordinated care team can be called together to review the member's case to determine the best care for the member.

The claims processing platform also allows for the coding of quantity management and safety management. Quantity management is utilized to ensure the most efficient dosage is used to

fill a prescription. Concurrent DUR is utilized to provide a means for safety checks of both drug and disease interactions prior to a pharmacy filling a prescription.

A specific example of prescription limits is the approval of H.P. Acthar which cost the state over \$300,000 during 2017. The Health Plan has very strict authorization criteria for the use of H.P. Acthar due to the abundance of more affordable steroids available. The Health Plan works closely with their P&T committee to develop coverage criteria to augment the coverage rules the state outlines in their PDL.

The Health Plan convenes a quarterly pharmacy and therapeutics committee (P&T) whose role is to oversee policy and procedure development, formulary management and utilization management. The Health Plan's P&T committee will evaluate non-PDL drugs for addition to formulary and creation of utilization management criteria policies. The non-PDL formulary will be coded and electronically maintained for claims processing via The Health Plans contracted PBM. THP's contracted PBM also maintains an electronic portal allowing for customized non-PDL drugs to be coded for portal submission.

BA085 The Vendor should identify and manage polypharmacy utilization.

THP's integrated analytic system allows it to manage polypharmacy utilization of its members. Data from THP's experience indicates that when it manages both the medical and pharmacy benefits, it is able to employ several clinical solutions for combating polypharmacy and gaps in care. THP utilizes an integrated medical/pharmacy data analytic software that examines over 20 different evidence-based clinical parameters (including polypharmacy) to identify potential safety issues and gaps in care. These clinical alerts are then integrated into providers' workflows for fast resolution.

As previously noted, THP utilizes a multidimensional platform enabling access to and analysis of integrated medical and pharmacy data in near real-time. This platform enables the mining of actionable analytics including polypharmacy and an almost limitless number of customizable data analytics. Both of these programs have been validated using controlled long-term studies to validate their beneficial impact on clinical outcomes including closing gaps in care and reducing polypharmacy. Both however require the integration of all clinical and pharmacy data for the platforms to be effective.

THP is aware of the requirement contained within the negotiated agreement approved by the DOJ regarding required pharmacy review of any case in which a child is prescribed three or more psychotropic medications. THP has a large team of pharmacists and behavioral health professionals capable of performing this function in collaboration with RDT as necessary and appropriate.

BA086	The Vendor should monitor potential abuse or inappropriate utilization of controlled prescription medications.
BA087	The Vendor should manage members with a history of prescription drug abuse, including, but not limited to, lock-in.

THP has the ability to monitor potential abuse or inappropriate utilization of controlled prescription medications through its data mining activities. These activities are specific to potential abuse and/or inappropriate utilization of controlled substances and other high-risk drugs. THP uses a number of system edits and programmatic reviews of data designed to detect suspicious activity. Claims processing software allows for retrospective review of claims, trending, and outlier identification. Through claims analysis, THP is able to identify suspicious claim activity from providers and/or members. THP's Special Investigations Unit (SIU) runs multiple reports each month to identify controlled substance outliers. Similar reports can be extracted as they pertain to member overutilization.

THP also utilizes a "lock-in program", restricting members to one pharmacy for a period of one year, if they meet certain criteria including receiving multiple controlled substance prescriptions from multiple prescribers, filled at multiple pharmacies during a 60-day time period. Members with medical histories that support the prescription activity may be exempted from the "lock-in".

The Health Plan's PBM is Express Scripts Inc. (ESI). ESI's Special Investigations Unit team investigates fraud related to network pharmacies. ESI proactively identifies suspicious activity, monitors CMS alerts, Medic Risk Assessments, media tips, and fraud tips. In addition to data mining activities, which include use of a proprietary predictive modeling tool, ESI also conducts member verifications to confirm the member received the medication, prescriber verifications to confirm the prescriber ordered the medication, and purchase verifications to confirm the pharmacy had sufficient inventory to justify the claim volume. ESI's SIU also conducts both desk and on-site investigations that include reviews of prescriptions, delivery records, quality assurance and other relevant documentation, and employee interviews. ESI also maintains an exclusive contractual relationship with a pharmacy under investigation, and utilizes its many investigative tools allowed via the contract in tandem with all applicable federal or state laws, rules and regulations. Substantiated improper conduct is referred to the appropriate authorities and to the Pharmacy Disciplinary Action Committee for potential discipline up to and including termination.

ESI also conducts a number of audit programs to help ensure accurate submission and payment by utilizing a collaborative approach that emphasizes the education of network pharmacies in proper claims submission procedures. The automated predictive model review process aids in the detection of high-risk claims, followed by additional review by network auditors. ESI's desk audit program completes an automated review, using a large number of outlier indicators, of all claims submitted by network pharmacies the previous day. The historical audit program is an ongoing retrospective review of claims, in addition to the daily claims selected during the desk audit. Lastly, on-site audits include in-person reviews of prescription claims and operating practices to evaluate a pharmacy's compliance with

federal regulations, pharmacy practice, and ESI's provider manual. ESI selects pharmacies for on-site audits based on various criteria that may include findings from desk or historical audits, reliable tips, and/or selection via ESI's proprietary audit selection tool. Claim components verified include, but are not limited to:

- compliance with all applicable laws;
- the Express Scripts Pharmacy Provider Agreement, and the Pharmacy Provider Manual;
- compliance with specific benefit parameters;
- claims submissions in accordance with prescriber guidelines and documentation, dispensed as written code usage; and
- refill authorizations, proper quantities dispensed, and pricing used, compounds, and specialty claims.

Members that are identified through our monitoring programs are referred to THP's behavioral health department for outreach and case management. THP utilizes a lock-in program, restricting members to one pharmacy for a period of one year, if they meet certain criteria including receiving multiple controlled substance prescriptions from multiple prescribers, filled at multiple pharmacies during a 60-day time period. Members with medical histories that support the prescription activity may be exempted from the lock-in.

BA088 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.

THP's system allows primary care providers (PCPs) to maintain information shared by behavioral health providers as regarding the outcomes of behavioral health screenings and evaluations, including but not limited to a patient's medical record. THP uses THP Navigator(s) to contact discharge planners for all admissions of behavioral health patients. Prior to discharge, the THP Navigator(s) contacts the network member and discusses needs, aftercare appointments, and medication. The Navigator fully engages in the post-care protocols for all behavioral health members.

Upon discharge, the THP Navigator(s) send a review of the members needs to the THP Navigator(s) as necessary to ensure that needs will be met in the member's system of care. This process ensures that gaps in care are addressed on the front end and prior to discharge, including children on psychotropic medication, children with ADHD, and children on antidepressant medications. Mini rounds are conducted weekly with the staff to discuss any barriers to discharge, discharge needs, and supportive treatment needed.

THP's protocols require that all providers follow follow-up within seven days of discharge for medication reconciliation and ensure that prescriptions are filled.

THP encourages the sharing of information between PCPs and behavioral health providers. *"Any information that is shared between practitioners/providers should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to*

ensure care coordination, the Behavioral Health Services Department is available to provide this service. All federal and state confidentiality laws should be followed. The Health Plan expects that this information be shared accordingly and recognizes the right to keep progress notes private. The Health Plan also understands that there are special situations where information cannot be shared."

Consent forms and Continuity of Care forms are available on THP's provider website: myplan.healthplan.org. Articles encouraging continuity of care are placed periodically in the Provider Focus newsletter. Training and education of providers to discuss these protocols to ensure compliance and proper patient care and management of its members is conducted by THP's Behavioral Health Specialist, staff in the Behavioral Health Department and provider engagement representatives. The protocols are outlined in the educational materials and provider manuals issued to providers once they are accepted in THP's provider network.

Mini Rounds also provide an opportunity for teams to work on patient planning issues.

BA089	The Vendor should inform primary care providers (PCPs) about changes in a member's behavioral health, including, but not limited to:
BA090	Hospitalization
BA091	Emergency room (ER) usage
BA092	Change of medication

THP's system of care for its members regards the network member as the center of care. Each member of the care team is responsible for the care and maintenance of the network member. THP's care management process is designed to ensure that each member's primary care physician is informed about changes in a member's total health plan, including behavioral health. THP's experience in managing a member's behavioral health demonstrates that all facets of the member's health is adequately managed, the member's PCP is integral to the process and with the scaling of this body of work, THP assures the state that members in the foster care system healthcare will be closely monitored and integrated.

PCP are notified by The Health Plan of all admissions. Any issues with regard to Emergency Room usage are communicated to the PCP. PCPs are required to perform medication reconciliations upon discharge of the patient from a facility. THP staff works with patients with medication issues to ensure they communicate medication changes with their PCP.

Treatment plans that are developed include information on key indicators including hospitalizations, ER usage and medications. THP Navigators share this information with the PCP and other members of the MDT.

The PCP is also notified of any authorizations/pre-authorization for behavioral health services. A depression screening is included in the Medicaid HRA. When this is completed and the member scores positively for depression or indication of self-harm or harm to others, the PCP receives a letter and a copy of the screening to alert the provider of this score. (The member is contacted by THP.) Urgent and emergent situations may entail direct contact from THP to the

PCP, provider of care or appropriate medical services.

When the member is discharged from any facility, the PCP receives a letter from THP regarding follow-up care.

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.

THP will ensure that the member is assessed by a behavioral health professional within 7 to 10 days following identification as a member of the foster care population. In addition to that initial assessment, the member will receive much more comprehensive assessment within 30 days per DHHR policy. Depending on the results of those assessments, and in conjunction with the DHHR case worker and the MDT as appropriate, on-going behavioral health interventions will be scheduled by the THP navigator with consultation with the placement entities, be it emergency shelter, foster care placement, or kinship care. Preference will be given to any BH provider entity with whom the member is already engaged. Authorizations for treatment/assessment will be provided to any entity who is not in-network but otherwise the assessment is authorization-free save for psychological testing, which can be authorized in advance as necessary. The behavioral health professional will be provided with any background information available to the team at the time of the evaluation(s) so as to be sensitive to any issues of trauma, in particular.

The THP navigator will coordinate care in partnership with any identified ("Wraparound Facilitator") engaged in the case, relying on the "Wraparound Facilitator" for assistance with transportation and appointment reminders as appropriate. If there is no "Wraparound Facilitator" available, the THP navigator will utilize THP care management systems to create reminders to trigger calls to the member and placement entities with appointment reminders. Additionally, the navigator will set up transportation for the family/member if needed. Per DHHR policy, additional evaluations are a required aspect of the foster care placement agency and those will be facilitated by the "Wraparound Facilitator" and THP navigator.

The behavioral health provider is a vital part of the treatment team and is consulted at every treatment junction, included in team meetings if at all possible. The BH provider may suggest amendments in the treatment approaches or other goals/objectives of the MDT ISP.

During the team meetings, goals and interventions are reviewed and updated as appropriate. This process and the outcomes are documented. The navigator is responsible for making sure that THP care management plans are up to date and shared with the team. Additionally, the navigator will ensure that the other providers in the member's system, particularly the PCP, are aware of the existence of any BH providers and will assist in obtaining necessary releases to facilitate sharing of information between the PCP and the BH provider. THP will assist the Wraparound Facilitator to coordinate and implement the Child and Family Service Team which will assist in identifying any behavioral health service that may be helpful for the child. The WF and navigator will ensure that the services are obtained and monitored for efficacy,

and adapted as necessary. Emerging behavioral health needs will be immediately addressed by the WF and navigator, with assistance provided in making urgent appointments as necessary.

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.
BA095	The Vendor should remind members of upcoming initial and periodic dental screenings, for applicable populations.
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.
BA097	The Vendor should monitor dental screening utilization on an ongoing basis, for applicable populations.
BA098	The Vendor should intervene if a member has not had a dental screening in over one year, for applicable populations.

THP is contracted with Skygen USA as the administrator to provide dental services to our members. Dental services are provided to members under 21 years of age for services that are covered under the contract. Those services are managed to ensure that costs are contained, services are timely and do not exceed the contracted duration, and the health of the member is at the center of the decision made about their dental care.

Members under the age of 21 who require dental services in a hospital setting, THP's dental provider is required to obtain a prior authorization from Skygen USA for the procedure. Once the provider obtains the prior authorization from Skygen USA, the hospital services are required to be authorized through THP. The process requires providers to contact Customer Service to obtain the prior authorization before initiating services. Upon receipt of the authorization number, that information is provided Skygen USA who must relay that to THP for final authorization.

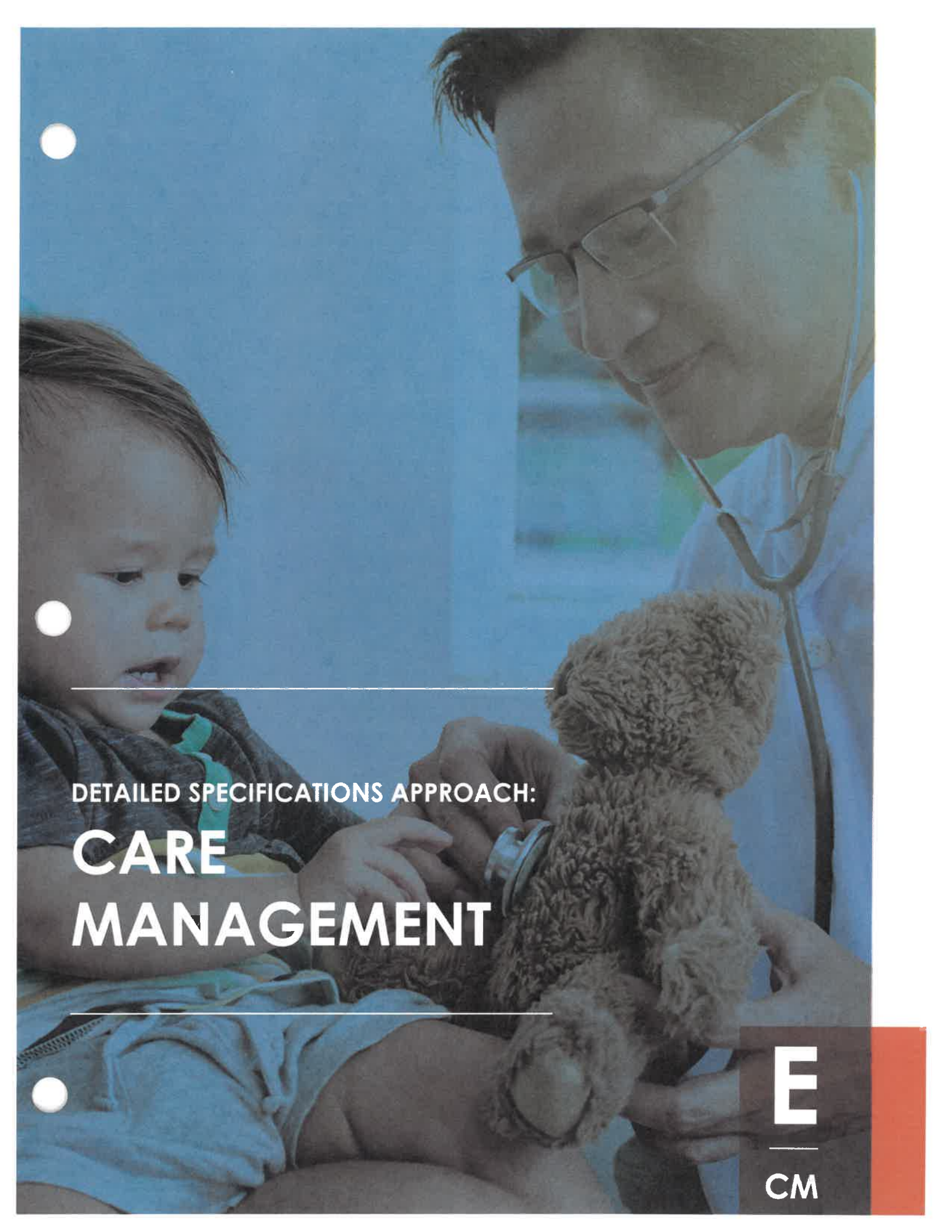
THP Navigator(s) play a significant role in ensuring that members receive timely care and maintain appointments for routine dental care. When a member identified as needing dental services or has missed an appointment the THP Navigator(s) will reach out and provide a tutorial to the member on the importance of dental care and how it affects the overall health of the member. The navigator then works with the member to schedule the requisite appointment and follows up to ensure that the member keeps the appointment, which may mean that transportation is provided to the network member for the scheduled appointment. THP pays particular attention to appointment schedules. In the event a member is approaching a year's anniversary since his/her last dental visit, the THP Navigator(s) reaches out to the member and begins the process designed to ensure that the member is scheduled for the appointment, and arrangements have been made to ensure that the appointment is kept.

A link to Skygen USA dental is on the THP website. THP staff assist members in finding providers and with registration on the website as needed. The portal has a search engine for providers, covered services, claim history, and educational information.

Benefits and prior authorization information is listed in the provider manual as well as in the THP's member handbook.

THP's holistic process of managing the care of its members is designed to ensure that all services under the members contract are monitored for appropriate and timely utilization. THP assures that the children, youth and families receiving services under this contract overall healthcare, including dental, will be monitored for appropriate use, and for quality outcomes intended to ensure the overall health and well-being of the network member.

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A photograph of a male doctor with glasses and a stethoscope around his neck, smiling as he examines a young child's arm. The child is holding a brown teddy bear. The scene is set in a clinical environment with a window in the background. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

CARE MANAGEMENT

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Care Management

THP is aware of the Department's negotiated settlement with the Department of Justice over Olmstead violations with children and youth. THP will develop a network of Wraparound Facilitators across the state that will serve all children at risk, regardless of their eligibility for participation in the SED waiver, using alternative payment methodologies. Clinical services required in the negotiated settlement will be developed and implemented by THP once the Department achieves an approved implementation plan. THP will collaborate and cooperate with the Department's approved Subject Matter Expert in implementing and monitoring the components of the implementation plan. THP will also work with the network of Wraparound Facilitators to develop and implement the Child and Family Teams, Mobile Crisis Response teams, Behavioral Support Services, and expand access to Therapeutic Foster Care Homes. THP already reimburses for Assertive Community Treatment but will encourage further access to the 18 to 21-year-old population. THP also already provides in home therapy services to its Medicaid population with enhanced reimbursement for in home services.

THP Care Management is divided into four (4) distinct areas, each with a specific clinical focus aimed at appropriate navigation of members through the healthcare systems in order to ensure that each member receives the right care, at the right place, at the right time and the right cost. The three areas include:

- **Medical Management** including utilization management, catastrophic case management, disease management, concurrent review, referrals and preauthorization. Staff in this area includes registered nurses, social workers and physicians, all with varied clinical backgrounds and expertise.
- **Behavioral Health Services** including utilization management, case management, referrals and preauthorization, and concurrent review. Staff in this area includes registered nurses with behavioral health expertise, social workers, a clinical psychologist, and physicians, including a psychiatrist.
- **Pharmacy Services** including formulary development and management, preauthorization, drug utilization review and specialty pharmacy management.
- **Clinical Analysis and Research** including clinical reporting, technology research and assessment, predictive modeling, provider profiling, gaps in care analysis and outcomes tracking.

The Health Plan's Care and Complex Case Navigation Program is the care delivery model used to coordinate and manage care across the care continuum. Care navigation is a collaborative approach to provide and coordinate healthcare services to a defined population. The Health Plan catastrophic navigation program identifies a population that includes those members who have had a major health event or diagnosis that requires the extensive use of healthcare resources. The Care navigator's member population includes those members with extended acute hospital stays, discharge follow-up issues, problems identified on the Health Risk Assessment, medical, nursing or behavioral health needs, and/or problems with social determinants of health. Navigators actively engage with their members to identify and facilitate care options and care services to meet their individual health needs

with the goal of decreasing fragmentation and duplication of care and enhancing quality, cost effective clinical outcomes.

The framework for the Navigation Program is "member centric" and involves assessment, care planning, implementation and evaluation. The program is collaborative and multidisciplinary in nature and involves the member, family, caregivers and healthcare providers. Coordinating care helps with the efficient use of healthcare resources. Vital factors are quality of care, continuity of care, and appropriateness and timeliness of interventions.

The navigators provide telephonic management and serve as the communication liaison between the member/caregivers, physicians and other healthcare providers. They arrange for services required at time of discharge, arrange for appropriate community resources, negotiate cost effective rates for supplies and services or rates for out-of-plan services when necessary.

The Care and Complex Case Navigation Program is goal oriented. The navigator/catastrophic nurse navigators strive to help the members achieve optimal wellness or functionality. They teach self-empowerment and self-management through support and education.

Goals include:

- Help members regain and improve health.
- Improve the member's quality of life.
- Achieve the best possible clinical outcomes.
- Improve self-management of diseases or conditions.
- Reduce unplanned hospital admissions and ED utilization.
- Improve medication adherence.
- Educate the member and caregiver about preventive care.
- Ensure that care is provided in the appropriate setting.

The Utilization Management Program ensures the provision of appropriate healthcare, including behavioral health services to its members, while addressing the effectiveness and quality of the care. The delivery of healthcare services is monitored and evaluated to identify opportunities for improvement. The program provides for a systematic process to promote the access of medically appropriate care in a timely, efficient manner across the network through care/case management, pre-authorization/referrals, and admission/concurrent review and disease management programs.

The primary goal of the Utilization Management Program is to measurably improve the utilization of care and services to THP members in a way that is financially responsible and responsive to their individual healthcare needs. This goal is achieved by meeting the following objectives:

- To promote and provide appropriate allocation of healthcare services to THP members.
- To perform utilization processes with minimal disruption to the delivery of care and services, including clinical information gathering, documentation review, and communication of utilization management decisions.

- To identify members for social service referrals, case, care or disease management programs.
- To assess Utilization Management Program performance by soliciting input from members and practitioners through surveys annually.
- To develop interventions based on input received from members and practitioners to improve the quality of services to all customers.
- To educate practitioners on the scope of the Utilization Management Program and Medical Management Services.

The Health Plan promotes the management of care and services and facilitates access to care for our members. We identify any gaps in care and provide resources to enrollees to improve their healthcare status. The Health Plan proactively identifies and enrolls members with complex/catastrophic diagnoses, multiple healthcare needs, and/or chronic conditions into specialized programs that provide early interventions, education, and coordination of care and effective communication of an individualized care plan. Program activities are coordinated with quality improvement activities and initiatives through active collaboration.

The Behavioral Health Unit staff includes registered nurses and licensed social workers. The Health Plan members may directly access services from network behavioral health practitioners and providers.

The Health Plan provides 24-hour service through their afterhours nurse available to assist members with questions about accessing services. Customer Service staff, during regular business hours, may provide members information about provider or service availability with the network and direct the member to the Behavioral Health Unit staff for additional assistance if requested.

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CM001	The Vendor should coordinate continuity of care between healthcare providers, child welfare providers, behavioral health providers, and THP Navigator(s) with an integrated care plan for all children.
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THP's Case Navigation system is highly flexible, enabling THP to work collaboratively with DHHR, healthcare providers, child welfare providers, behavioral health providers, families, and other stakeholders using an integrated care plan for all children with the ultimate goal being a fully inclusive record and documentation that includes all information for the child in a portable and accessible format. THP will develop a Fully Inclusive Record (Health Passport) that is:

- **Access driven** - landing and dashboard pages based on needs and permitted access;
- **Interoperable with the FACTS plus system** - DHHR and THP will work together to assure the transfer of information/records
- **Inclusive of DHHR Care Plan information.**

The integration of data and resources will enable THP to coordinate care between the various providers and stakeholders to ensure there is continuity of care and to avoid duplication and disruption in care and services needed for the wellbeing of the child.

- Through collaboration with the state, KVC Health Systems, and other foster care and partner agencies the THP will provide access to an integrated warehouse of information including various assessments, health records and the Family Service Plan (FSP), as it carries great importance in establishing the Individualized Service Plan (ISP) for the foster child. Understanding and addressing the family situation/dynamics and
 - ensuring that both the child and family are obtaining services toward the same goal is essential.
- THP believes it can provide a robust and flexible system that allows approved stakeholders to access and track all aspects of care and management of the ISP. This system would be:
 - Streamlined with templates for agency reporting requirements
 - Web-based
 - Consistent in form and format
 - Able to develop ISP plans through the web-based system or accept from providers in their format for conversion to a consistent format that allows for reporting on progress/goals, etc.
 - Based on systems, forms, and processes developed with the input of a stakeholder team that includes DHHR, THP, KVC Health Systems, and other partners

We believe that this represents a major commitment on the part of THP, WV DHHR and all of the various stakeholders. The result will be a collaborative record that will provide the information and resources to ensure the best outcome for the child.

Since all stakeholders in a very complex foster care system are required to produce and maintain care plans of one sort or another for the child, the MDT case plan will be considered to be the "master plan" and will be available on the website, along with the care plans of all the stakeholders. The MDT Case Plan will incorporate the Child and Family Plan as well. The THP Navigator will continuously review the plans to ensure that they are consistent and of

sufficient quality to optimize a positive outcome for the child and family. The Navigator will also assist the MDT to monitor and record progress in completion of the objectives of the master plan and to recommend amendments as necessary.

CM002 The Vendor should share information required for continuity of care with the member and their family or caregiver(s).

THP has a comprehensive, integrated care coordination model and approach enhanced through strategic alliances with community partners. In the DHHR Foster Care System, the MDT plan is considered to be the “master plan” and as such, the Navigator will assist the MDT to produce the best possible plan utilizing all information that the Navigator can make available to the team. Under the DOJ agreement, each child will also have a Child and Family Plan that governs most of the services and supports provided to the child in the community. The navigator will ensure that he/she works closely with the Wraparound Facilitator to coordinate the Plans.

The HP care model incorporates a comprehensive concept of care that includes:

- **Developing Treatment Plans** – THP takes a comprehensive approach to treatment planning, administered by our Medical Management Department, that encompasses all relevant factors and conditions. The Navigator will create an immediate plan for internal use as soon as THP is notified that the child is joining the population. This plan will eventually yield to the master plan developed by the MDT within 30 days. In the meantime, the navigator will assist the DHHR case manager to collect information and develop an initial case plan. Members, their families, and their providers maintain active roles in the process, while our case managers ensure that the member is aware of all available alternatives. We use EPSDT standards when developing treatment plans for members less than 21 years old. Treatment plans are coordinated with DHHR case managers and other members of the MDT and facilitated by the Wraparound Facilitator when one is contracted. Our treatment planning approach ensures effective communication and collaboration between in-network providers, the foster care system, and any out-of-care providers.
- **Updating Treatment Plans**—as transitions in care or changes in status occur, the Care Navigator is responsible for ensuring the Treatment Plan is updated to reflect any necessary alterations. This will occur at crucial intervals or at minimum, at each MDT (those being held as needed, minimally each 90 days). The Care Navigator will coordinate with the MDT on the needed changes to ensure a collaborative approach to addressing the needs of the member. The plan is updated by or with the collaboration of the Care Navigator (depending on the child's legal circumstances and the stakeholders involved) and shared with the team and the member as age appropriate and his/her caregivers.
- **Monitoring Treatment Plans** – We employ an electronic tracking system to monitor the provision of services to ensure that members' treatment plans are reviewed at appropriate intervals, that goals are met, and that treatment plans are revised and updated as needed. For members with special needs, treatment plans are reviewed and updated no less frequently than every 90 days or as care needs change.

The navigator has the responsibility of coordinating care between all providers that are active in the enrollee's care plan. Because medical records exist throughout the entire healthcare system, it is imperative for the navigator to coordinate the care information for continuity. The navigator communicates with the member, his/her caregivers, their DHHR Caseworker, Wraparound Facilitator and providers as needed to ensure the information is shared in order to coordinate care. If needed, the care navigator will contact the member or member's parent/guardian and PCP/Provider to request a conference call to share information so that the member's care can be coordinated in a timely and efficient manner. By acting as the liaison, the navigator ensures that the necessary tasks are completed in a timely, accurate and professional manner.

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 principal coordinating physician, and the child and caregiver(s).

THP will work with DHHR to create training for all levels of partners to ensure that everyone understands the implementation and ongoing process. THP will work with the foster care providers to ensure that they understand expectations and roles. THP will offer community educational forums and invite local and state community partners to make sure they also understand their roles and how they can become involved in helping WV children. THP will use social media and the THP website to advertise resources and information that partners can use.

The Child and Family Planning process is designed to bring all providers to the table to agree upon a strengths-based plan of care for the child. The PCP is an integral part of that team. To the extent the PCP is able to be involved, the Wraparound Facilitator and Navigator will ensure that this occurs. THPs provider outreach team will work with PCP offices to explain the Child and Family Planning process and demonstrate to the PCP how to access the child's "drop box" of PHI which will include the Plan.

Provider education will focus on the role of the PCP or principal coordinating physician in the development and implementation of the integrated care plan. While the care navigator at THP will maintain a constant presence in the development and updating of the care plan, it is a collaborative effort carried out by the PCP, the member, the caregivers, the case managers and the other stakeholders, coordinated by the Wraparound Facilitator. This plan will also be incorporated into the MDT plan.

The Navigator will monitor medical records and discuss progress with the member family and member (as age appropriate), sharing concerns telephonically with the office of the PCP or other professional as necessary, with member permission.

The ultimate goal of each care plan is to obtain willingness on the part of the member and caregivers to participate in his or her care plan and the mutual goals that have been established. The care navigator works with the member and caregivers to address healthcare needs, personal healthcare preferences, address community resources, and

provide education and collaboration with other members of the care team, including the PCP or other medical advisor.

Provider Education will be part of THP's overall educational program and will consist of:

1. Complete documentation of Foster Care/MCO program will be contained in provider manual. Various aspects of THP resources will be defined and processes for providers to follow detailed.
2. Ongoing outreach by THP Provider Outreach representatives will take place in provider offices to educate them on the program to ensure they understand the specifics in dealing with the Foster Care children in WV.
3. Web based training materials and periodic updates will be available to the provider
4. Provider Newsletter updates will include mention of provider manual resources
5. As part of new provider ON BOARDING, foster care will be addressed as well as when issues are identified that indicate additional training is needed.

CM004 The Vendor should evaluate and report member progress in meeting goals identified in the individualized service plan (ISP).

THP maintains an individualized service plan (ISP) and related information in COMET, THP's electronic care navigation system. The systems allow for electronic tracking of the member's progress and enables the Care Navigator to work with the member, the providers and the stakeholders to assist the member in meeting care plan goals. The system is available to all members of the care team who are employed by THP. The Health Plan's electronic Care Navigation Tool eliminates silos of information and allows for integration of various facets of information utilized in the Care Navigation processes including:

- Workflow;
- Care coordination;
- Communications; and
- Clinical and social assessments, care plan development, etc.

As the ISP is updated, changes are provided to relevant parties including member or care giver, PCP, caseworkers, etc., utilizing the "drop box" methodology as appropriate.

The ISP outlines prioritized target goals for issues identified during the member assessment process. The ISP works toward the achievement of those goals and reviews and analyzes progress toward the stated goals while refining the ISP as the status of the member changes. The plan is continuously analyzed and updated by THP Care Navigators based on interactions with the Multidisciplinary treatment team (MDT).

The ISP will be available in the member's "drop box" which will be available to all approved/authorized stakeholders.

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.

Currently THP has access to DXC's (DHHR Fee For service claims administrator who pays pharmacy claims) website, which enables THP to:

- Check claims
- Monitor fills and
- Review prescribed medication

THP receives an electronic data feed from DXC daily and those claims are loaded into THP systems so as to be available to THP professional staff for review.

THP conducts a comprehensive medication reconciliation at initiation of a case and at every transition of care, including review of any psychotropic medications which may be prescribed. This process:

- Allows for at least an annual review of medication for the target population
- Reviews medications during transitions and prior to every MDT or IDT meeting
- Provides pharmacy oversight for discrepancies

THP has enrolled in WVHIN, the state's electronic health record. This allows notification of member care at the time it occurs, including information on admission, discharges, ER visits etc.

Utilizing this system, for the enrolled provider, THP is freed from the requirement to wait for claims data or other standard notification processes. This information will be incorporated into THP care navigation processes.

- An email notification is received real time for each member seen in the emergency department or admitted to the hospital.
- The advocate logs into the system to identify the members who received services.
- THP advocates reach out to each member following an episode to offer assistance in follow-up appointments, transportation, medication, etc. and
 - Reviews utilization history for inpatient and outpatient visits
 - Monitors ER visits to increase outreach and
 - Has available the medication reconciliation performed in the emergency room or other participating office(s).

THP will work with DHHR/BMS to develop a strategic relationship with the pharmacy manager (RDT) to facilitate smooth exchange of information between the parties as necessary. Objectives of the relationship will be:

- One on one contact working with RDT
- Integration of RDT representatives into the team reviews to address pharmacy issues and pharmacy compliance
- Ensuring complete data files with all elements from DXV to allow for better integration of data into THP system—tools from ESI are not currently able to 'mine' the data needed for

MTM and other reporting---ultimately would like to make this data available to the practitioners as well to assist in MTM concerns.

THP navigators currently receive a list of members prescribed psychotropic and anti-depressant medications from pharmacy.

- The navigator reviews the list to identify members under the age of 18
- An outreach call is made to educate parents/care giver on medication follow-up.
- An assessment is done for initial fills for psychotropic medication to determine if member has had outpatient services or an inpatient admit prior to initiation of the psychotropic medication. This is based on APC-CH and APP-CH HEDIS measures.
- There is an assessment completed for members who are prescribed anti-depressant medication to determine if the member is following up with the prescriber and to educate the parent/guardian.
 - Allows discussion of follow-up visits, side effects, physician visits, expected outcomes, side effects, and importance of maintaining drug regimen
 - THP is continually working to improve its performance on HEDIS measures APC-CH: Use of multiple concurrent antipsychotics in children and adolescents. Related: measure APP-CH: Use of first-line psychosocial care for children and adolescents on antipsychotics in order to protect and promote member health.
- In addition, THP has established workflows for identification and care management of children prescribed ADHD medications and psychotropic medications that have been in place since 2017, developed in response to the HEDIS measures for the Medicaid population already in THP's membership pool. THPs multiple staff pharmacists are available to act as primary members of the treatment team for these two populations in particular. Member advocates have been provided with a THP screening tool to review with parents and guardians in order to provide parent education and develop follow-up goals for navigators. Children and parents needing enhanced care management and assistance are referred to the navigation program for follow-up contact. Pharmacists are available to the navigators at any time for consultation.

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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 Healthcare Issues for Children and Adolescents in Foster Care and Kinship Care manual, including, but not limited to, the following:
CM007	The application process for providers
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
CM009	Communication with members and/or their caregivers/families, as appropriate, about patient-centered medical homes for applicable populations
CM010	Annual reporting processes

THP views the PCMH concept as an approach to patient-centric and engaged care that is the bedrock of quality primary care—whether by a primary care, internal medicine, or pediatric specialist; FQHC; or other integrated delivery system. The PCMH is not simply an accreditation standard to be attained but a holistic approach to the care and service of THP members.

- Children in foster care, as a vulnerable population, have not been well served by the current healthcare delivery system, including PCMHs. THP recognizes this challenge and will tailor its PCMH to comply with recommendations of the American Academy of Pediatrics' "Healthcare for Children and Adolescents in Foster Care Manual," as well as the Academy's more recent 2015 technical report¹ on "Healthcare Issues for Children and Adolescents in Foster Care and Kinship Care." These evidence-based reports call for the development of a Pediatric Medical Home with seven attributes:
 1. Accessible
 2. Comprehensive healthcare
 3. Compassionate care
 4. Care that is continuous over time
 5. Care that is coordinated
 6. Culturally competent healthcare
 7. Family focused.²

Effective care coordination, especially for children with special healthcare needs, increases access to specialty care and is of greater impact in a PCMH setting.²

- THP will develop a preferred provider network that incentivizes providers with increased payments (such as a capitation, patient management fee, or bundled reimbursement) to

¹ Szilagyi MA, Rosen DS, Rubin D, Zlotnik S. et al. Healthcare Issues for Children and Adolescents in Foster Care and Kinship Care. *Pediatrics*. 2015;136(4):e1142-e1166. doi:10.1542/peds.2015-2655.

² Boudreau AA, Goodman E, Kurowski D, Perrin JM. et al. Care Coordination and Unmet Specialty Care Among Children With Special Healthcare Needs. *Pediatrics*. 2014;133(6):1046-1053. doi:10.1542/peds.2013-2174d.

offer specialized services aligning with the Pediatric Medical Home attributes listed above. Wherever possible, THP will also assign and/or refer members to these preferred providers.

- THP leverages the PCMH concept in its existing value-based agreements. Indeed, these value-based agreements include a PCMH model as the key to better quality care and cost savings.

Recognizing West Virginia's position as a leader in community health centers, THP will encourage greater use of school-based health centers (SBHCs) to better integrate care for the foster child population with the education system. By partnering with the West Virginia Primary Care Association, which absorbed the West Virginia School Based Health Assembly, and Community Care of West Virginia, which has the balance of the state in terms of SBHCs, THP will create specialized payment models that incentivize community health centers to offer greater services at their SBHCs. This will yield quality improvement and cost savings benefits for all children covered by Medicaid, as evidenced by [systemic economic analyses of SBHCs](#)

Additionally, THP intends to pilot an alternative payment methodology for community based case management that will create Wraparound Facilitators who will work closely with the HP navigators and with the DHHR case worker to perform "boots on the ground" case management including working with various immediate stakeholders such as biological parents, foster care parents and kinship guardians to implement the recommendations of the MDT. Primarily the "Wraparound Facilitator agencies will be BH or child welfare providers who will contract with THP to provide on-site case management services, establishing immediate rapport with the member and his/her "family" (whomever that may include) and ensuring that the member has means and opportunity to attend all appointments and to smooth transitions from one placement to another. The "Wraparound Facilitator will also act as a conduit of information about the member, ensuring that the BH provider and the PCP are aware of any changes in the treatment approach or the member's behavior between appointments, and communicating regularly with the navigator to facilitate any needed information, authorizations, or other medical, socially necessary or BH products/services/supports. THP believes that this fragile population requires "eyes on" case management at regular intervals and the "Wraparound Facilitator will be expected to perform this service at regular intervals, increasing in frequency as the member situation demands. See case scenario for further information/description.

One of the chief responsibilities of the WF will be to chair and organize the Child and Family Planning team in order to create the child's individual service plan.

THP will recruit "Wraparound Facilitator" agencies or professionals utilizing fax and email blasts to network members and through presentations at various provider groups including WV Behavioral Health Providers Association, the WV Child Care Association and the FFTA monthly meetings. Any willing provider who can meet the credentialing requirements will be welcome to join the network. THP will recruit foster care placement agencies in particular to participate in this process so that children in shelters or residential placements can be linked with a Wraparound Facilitator prior to leaving the facility, creating a "friendly face" after discharge

for the child/youth. If a member has a pre-existing relationship with a "Wraparound Facilitator" provider agency, that relationship will be given preference if the member/family desires.

When possible, the member will retain their Wraparound Facilitator across treatment modalities unless the child transitions to a different geographic area. Should this occur, the "Wraparound Facilitator" will work with the child/family to transition to the new "Wraparound Facilitator" using face to face encounters and the IDT and MDT process. Additionally, the BH provider, if there is one, will assist in preparing the child for transition. If the child is involved with a SBH provider, that relationship will not change unless the child's geographic relationship requires it. Should this occur, the navigator and the "Wraparound Facilitator" will ensure that initial appointments are made/kept with a newly designated provider and that the child/family are accompanied to the initial and subsequent appointments.

Members and families will receive information about the PCMH and the "Wraparound Facilitator" program upon enrollment and identification as a member of the target population. This information will be provided in the enrollment packet and verbally by the navigator. Members and families will be given a choice of provider agency whenever such a choice exists.

As an alternative payment model, careful data will be collected regarding the efficacy and efficiency of the program. Data will include reflection of member satisfaction in addition to clinical and financial data. Additionally, any data collection required by the DOJ negotiated settlement will also be collected and submitted as required.

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.
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.
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.

THP navigators are alerted to admission of a member of the target population to any type of inpatient facility as soon as it occurs. Prior to discharge, it is the navigator's responsibility to participate in any IDTs held by the facility and to communicate with the facility discharge planner to ensure that outpatient services are arranged prior to discharge or alteration in level of care and that the following activities occur:

- The responsibility of the Navigator is to discuss transitional needs, aftercare appointments, other needed services and medication changes.
- The transitional Navigator participates in care team meetings to discuss placement needs, homecare services, prior authorization needs, socially necessary services, medications,

educational needs, court involvement, reunification plan, permanency plan, and ongoing case management needs.

- Upon discharge, a review will be incorporated into the care plan to document the transition, addressing the various needs and how they are being met. Information of scheduled appointments, prescription changes and other care needs are documented in the system with reminders set so the Navigator can verify that services were obtained.
- Mini Rounds are conducted weekly with the UM nurses to discuss any barriers to discharge, discharge needs, and supportive treatment needed.
- THP requires appointments for outpatient provider follow-up within seven days of a discharge or transition for medication reconciliation, and to ensure that prescriptions are filled. Providers are educated on this requirement in THP's behavioral health and provider/physician manual; at workshops and conferences, as well as included in the quarterly provider newsletter. THP Navigators follow-up with members to ensure appropriate follow-up occurs and assist by contacting the provider when necessary.

As part of the transition process, THP care navigators will collaborate with hospitals, psychiatric residential treatment facilities (PRTFs), residential providers, behavioral providers, and/or others to ensure outpatient services have been established prior to the member leaving an inpatient facility or changing levels of care. Navigators follow-up after discharge to reinforce the discharge plan through:

- Education of members on their discharge plan, follow-up care and appointments, medication changes, self-management of chronic conditions and other considerations based on the updated care plan
- Facilitating communication among the member, the PCP, the Network Providers, and other specialty Providers, and the member's support network as identified by the member;
- Collaborating with staff of other agencies, community service organizations, and providers who are involved in the member's healthcare to promote service delivery and improved outcomes;
- Ensuring the PCP has received updates on the transitional care and has appropriately scheduled follow-up with the member
- Navigators and Wraparound Facilitator will focus on children/youth in residential levels of care in particular to ensure that THP is represented on residential treatment teams so that discharge planning is always discussed at each team meeting. Social necessity needs, behavioral health follow up goals, educational transitions and plans for medication adherence will be an integral component of discharge planning. Identified needs will be facilitated by the child's navigator. If socially necessary services can be put in place prior to discharge, the navigator and Wraparound Facilitator will implement (for example, parent/guardian preparatory training/education). Additionally, the ability of the Wraparound Facilitator and the navigator to establish rapport with the child and when possible, family, prior to discharge will be invaluable.
- Monitoring medical and pharmacy information and appropriately updating the care plan and/or coordinating follow-up care including ensuring a medication reconciliation has

been completed and new medications have been acquired and discontinued medications have been appropriately discarded

- Documenting activities related to changes in the care plan as a result of the transition
- Ensuring information on the transition has been shared with the MDT and is incorporated into the MDT case plan.

If the child has a Wraparound Facilitator, the Wraparound Facilitator will visit the child in the facility (with guardian permission) and the Wraparound Facilitator will work with the clinical team at the facility and in an outpatient program to ensure that the transition to an alternative level of care is smooth and that the needs of the member are clearly addressed within the facility or program.

If the child does not have a Wraparound Facilitator, the navigator will work with the member and family to engage a Wraparound Facilitator and that Wraparound Facilitator will then become familiar with the case and begin working with the child and the family while he/she is still in the facility.

The Wraparound Facilitator and the navigator will work collaboratively with community-based care providers, both medical and BH, to ensure that Child and Family Services Plan and the MDT case plan are properly implemented and that the member's needs are addressed in an integrated manner.

The navigator will contact the discharge planner from the facility on day of discharge if possible, to ensure that the member was given a supply of medications or a prescription for medications prior to leaving the facility. THP records contain an on-going list of medications prescribed while in the facility and further receives a post-discharge summary of medications prescribed at discharge. If contact with the discharge planner is not possible, the "Wraparound Facilitator" and navigator will work with the family to ensure that prescriptions are filled and that no barriers exist to obtaining properly prescribed medications. When necessary, the navigator may contact DHHR pharmacy department for assistance in waiving any interfering pharmacy policies or procedures that present a barrier to filling of prescriptions.

CM014 The Vendor should engage in the Individualized Care Planning process for foster care members.

The THP care coordination system is central to ensuring members receive the level of care they need. Oftentimes Foster Care enrollees demonstrate higher rates of acute and chronic physical and behavioral health needs. Care coordination is an essential key to managing those needs.

THP's patient-centered system of care is a valuable tool to promote members' long-term well-being. THP navigation systems utilize industry-recognized processes while maintaining a holistic approach with a personal touch. Our disease and case management programs are a significant component of the THP care coordination system.

THP will establish a standardized case management documentation structure that will be developed collaboratively by THP, its provider partners including "Wraparound Facilitator"

agencies, and DHHR representatives. The report components will be stored in the stakeholder accessible "drop box" and will include:

- Key elements of ISP/FSP (reunification plan) and the Child and Family Services Plan (ISP — goals, measurements, initial assessment (7 day) results, CANS results, CAFAS results, and other relevant assessments and feedback
- Medical records as they become available
- Treatment Plan with updates each month on progress on goals
- Evaluation updates—monthly with quarterly updates
- Timeframes for updating/redoing assessments (i.e., CANS and CAFAS)
- Results of updated assessment

THP will work with the DHHR case worker and the "Wraparound Facilitator" to update ISP documentation on a regular basis. This evaluation will reflect progress toward meeting ISP objectives and any amendments in the plan approved by the MDT. A process for amending plans will be in place which will take into account all of the various plans created by the provider and DHHR partners, particularly the MDT. The navigator and the "Wraparound Facilitator" will attend all MDT meetings as a key participant, providing updates and information to the MDT as needed in order to complete the ISP process.

THP Provider Engagement Representatives will work with stakeholders and providers regarding reporting needs. Summary reports will be provided by THP to the DHHR Caseworkers and other stakeholders as appropriate.

CM015	The Vendor should collaborate with caseworkers to support members experiencing home removals and changes in placement based on Department foster care requirements.
CM016	The Vendor should collaborate with caseworkers to minimize the need for removals and changes in placement.

THP expects that the DHHR case worker will notify THP of enrollment of the member as soon as that enrollment occurs so that THP can immediately begin to mobilize the initial services needed to successfully transition the child to a new and possibly initially frightening environment. To facilitate that notification, THP will provide a contact person and THP contact information for the DHHR case worker, available 24/7.

Part of that initial discussion between the THP intake worker and the case worker will be identification of immediate needs for medications, equipment, screening appointments, school placements, and the permission from the DHHR guardian to begin making the necessary navigation contacts to put those services and supports into place. The navigator will begin implementation of the initial case plan immediately. THP will collaborate with the DHHR case worker to ensure that all time lines are met as required by DHHR policy, prior to the initial MDT. The navigator will also collaborate with the identified caretaker agency/family on a frequent basis until the initial plan of assessments and immediate needs are addressed.

"Wraparound Facilitator"- The family/foster family/guardian is considered to be an integral aspect of the interdisciplinary team in any setting - inpatient, residential and outpatient. The navigator, foster care agency, facility team and/or "Wraparound Facilitator" will work together to ensure that the family is able to attend IDT meetings either in person (preferably) or telephonically.

- THP will facilitate information gathering from multiple sources and ensure that treatment plan information is coordinated as part of the transfer/transition of the child. The electronic record shall be maintained by THP and made portable to follow the child, allowing access to pertinent information for approved stakeholders via "drop box" methodology.
- As part of the management of the child, navigators will look at specific services to prepare the child/family for transitions such as:
 - Socially necessary services
 - Support from Counselor/therapist
 - Education system involvements
 - Group and individual member meetings for planned placement changes
- THP will coordinate with the MDT to create a comprehensive transitional plan
 - THP and partners can work with the case worker on a child and family specific plan
 - THP shall track aspects of plan in COMET software to ensure plan is followed in a timely and effective manner and to allow for necessary adjustments to the plan based upon established goals and objectives of the plan.

THP recognizes that frequent changes in placement are counter-productive to member stability and as such will provide any services or supports within its repertoire to prevent placement changes from occurring. This may include respite, mobile crisis services, parental/foster parental coaching and education, in home therapies and other services. Contact with the DHHR case worker will be imperative during periods of instability for the member.

CM017	The Vendor should identify and track new members with high physical or behavioral health needs to assure continuity of care, for applicable populations.
CM018	The Vendor should monitor members' physical or behavioral health needs and respond to changes in acuity over time, for applicable populations.

THP uses analytic software that builds episodes of care from claims data, and refreshes the data on a monthly basis, to identify individuals with complex or serious medical conditions. THP's system targets medical conditions and risk scores are identified each month and sent to Medical Management for assessing and developing interventions. Examples of conditions that are identified by the software include, but are not limited to, autism spectrum disorder, cystic fibrosis, personality disorders, and congenital anomalies. Additionally, case navigation reports are reviewed to identify members in need of care management based on complexity of need. Reports can be generated to include engagement of member, intensity of engagement, case open date, case closed date, program type, and level or participation.

For instance, the list of members receiving services for children with special healthcare needs can be sorted to include the date the case was opened/closed, the type of programs that they are enrolled in, and the assigned navigator. In addition to sorting the members enrolled in the program, the list of members can be added to our CAVE analytics program to further identify the needs of the member based on the care need index and the predictive score.

Once identified, the member is assigned to a care navigator to determine the intensity of services needed and to provide assistance in getting the treatment required to resolve any identified issues. Ongoing evaluations of member needs are done by utilization of information from past claim history, census information, service pre-authorizations, and any other related clinical information received from practitioners and facilities. If a member is found to need services, an active case is opened in COMET and the appropriate case navigator is assigned.

An evaluation is completed to determine any further needs the member may have. The assessment includes the overall status of the member's health, a clinical history, which includes current and previous medication, activities of daily living, social determinants of health, and the need for any socially necessary services. Our integrated data system allows the navigator to set automatic reminders for reassessment and ongoing evaluation of the member's needs, which will prompt a review and applicable revision of the plan of care.

In addition, THP tracks compliance with EPSDT service provision requirements including a Periodicity Schedule of preventive services and standards of care in the following areas:

1. **Initial visit:** The initial EPSDT screen may be performed by any appropriate THP provider partner, be it at the hospital, at home or in any other setting. Based in part upon the results of the procedure conducted through the hospital or home setting under the auspices of the MDT, the periodicity of preventive pediatric visits that follow schedule recommended by the AAP or the accelerated visit schedule.
2. **Preventive pediatric visits** according to the West Virginia's Periodicity Schedule up to age twenty-one (21).

In accordance with results of the EPSDT outcomes, THP will employ processes to ensure timely initiation of treatment as recommended at the earliest possible date.

All additional assessments, medical, behavioral health, and psychosocial, will be conducted per DHHR policy and the results placed in the "drop box" and collated for the MDT. As the assessments are conducted at regular intervals, results can be compared and utilized for creation of amendments to the case plan and the ISP. Additionally, the "Wraparound Facilitator" and the navigator are in frequent contact with the member, the caretaker family and the DHHR case worker in order to identify newly emerging needs or unsuccessful treatment approaches that may necessitate changes in the ISP or recommendations for amendments in the ISP to the MDT. The THP case plan can be modified as needed on a daily basis by the navigator who can also request that the provider agency convene an IDT to discuss changes in the agency treatment plan.

CM019 The Vendor should use telemedicine, telehealth, and telemonitoring services to improve quality and/or access to care.

All THP providers are encouraged to provide telemedicine access to care per BMS policy for Medicaid recipients. THP would work with the state to further extend the availability of telemedicine to Foster Children to help ease the burden created by travel and accessibility for this vulnerable population.

THP believes there are several opportunities for use of telemedicine that could potentially benefit the foster care population. Among them are encouragements of telemedicine for:

- behavioral health needs that cannot be met in the local community
 - psychiatric/psychological consultation—tele psychiatry program
 - crisis assistance
- urgent care needs—real-time urgent care
- remote monitoring
- specialist evaluations
- medication reconciliation
- access to geographically scarce specialty services via Project ECHO resources

WVUM as a collaborating partner with THP has significant resources for telemedicine and continues to develop and implement new programs facilitating more efficient and effective delivery of care in WV.

The Department of Behavioral Medicine and Psychiatry, in conjunction with WVU Mountaineer Doctor Television (MDTV), currently operates 32 telepsychiatry clinics throughout the state of West Virginia. These clinics provide child and adolescent, adult, and addiction related psychiatric services to clients in fifteen counties with extensive catchment areas extending past county borders. Addiction related services also include provision of much needed care to pregnant mothers. Services have expanded to include the education of rural clinic providers and psychiatry residents. Future plans for further expansion include provision of services to nursing homes, rural schools and teletherapy which are all designed to minimize usage of limited patient and local resources and maximize treatment potential for the future.

WVUM also is engaged in Project ECHO programs that provide consultative services to providers across the state.

THPs provider partner KVC's MyLink is a robust, HIPAA-compliant video conferencing program that provides children in foster care and others served by the child welfare system increased access to therapeutic and crisis intervention services, and also delivers state-required training to foster parents in the home. Children and families in Kentucky and West Virginia were the first to complete pilot testing of the new program, and both distance learning and therapeutic sessions using MyLink are now fully implemented. Kansas and Nebraska were the latest states included in the expansion, and a pilot group of foster families participated in continuing education sessions from the convenience of their homes using the new technology. They provided invaluable feedback on the experience in order to help KVC sort out any technical issues.

KVC staff nationwide are already finding unique ways to use MyLink to leverage better care for children in foster care. In West Virginia, staff in a court room used an iPad equipped with MyLink to connect with a student from their school so that the child could appear in court without having to be excused from school. Therapists also reported that MyLink provided an added opportunity to connect with children and youth in care and practice emotion regulation skills, check in and monitor prescribed medications and continue building daily rapport with children and families.

All of these opportunities represent the potential for expansion and improvements in access to care that THP intends to encourage and facilitate with our provider partners and with other network partners across the state.

CM020 The Vendor should use Internet and/or web-based services to improve quality and/or access to care.

THP's website is designed to be informational and to facilitate the dissemination of member and provider information. The website has been in place for several years and is successfully operational.

For the foster care program, our website will contain DHHR approved materials as well as password access to THP's clinical practice guidelines and policies and procedures to support compliance by our provider network in accordance with all applicable laws, rules and regulations set forth by DHHR, West Virginia, and the Federal Government. Our website is compliant with the Americans with Disability Act, as specified in §508 as well as compliant with Language Access. In addition, our website will contain the following information placed prominent and readily accessible:

- Our location, hours of operations and contact information
- A link to the DHHR website
- Electronic Enrollee Information (e.g. Member Handbook, Provider Directory, Brochure of Covered Services)
- Instruction on how to obtain information in paper form without charge and within the designated period of time in accordance with DHHR policy.

THP systems provide Portal access for members which shall provide information on:

- Claims and Claim status
- EOBs
- Authorizations
- Member eligibility and benefits
- Wellness

In the case of the foster care program, a "drop box" technology will be added with access limited to approved stakeholders. Examples of documents that may be found at this location will be:

- CANS

- CAFAS
- Medication reconciliations
- Results of various assessments
- Copies of service plans
- Relevant notes or summaries from providers
- FACTS PLUS document
- Notes from MDT
- Court orders
- Other documents as identified in collaboration with DHHR.

CM021 The Vendor should identify and implement opportunities to use video conferencing to improve quality and/or access to care.

THP will leverage the use of internet and/or web-based services to improve quality and/or access to care primarily through services of our providers and strategic partners.

- **THP** provides education to providers through Web based seminars which will be used to provide education to the provider community on The Health Plan's role as a Foster Care MCO. THP will also use video conferencing to promote various evidence-based and trauma sensitive methods of care.
- **KVC**, a partner with THP, currently provides access to HIPAA compliant Video and WebEx systems. Each of their 9 offices is equipped with a video conferencing hub as well as access via telephone. Staff members have access to their own private video room and are able to send an encrypted link to their room for use by families and community partners alike. This equipment can be used not only for holding MDTs or other service meetings but for therapy sessions and booster sessions when a client is in crisis. Resources such as I-Pads are typically made available to Foster Families to enable participation in such services. Through its relationship with KVC, THP will be able to provide access to these resources and will also be able to work with other Foster Care Providers in the state to provide the same.
- **West Virginia University Medicine, a partner with THP** is able to utilize internet technology for educational purposes with providers and members in addition to providing traditional telemedicine patient encounters. Their extensive telemedicine network allows residents and physicians from across the state to have access to conference and clinical consultation with faculty on campus.

THP has the ability to provide member and provider webinars on topics of interest.

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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.
CM023	The Vendor should determine the composition of the Intensive Care Management (ICM) team for participating members, for applicable populations.
CM024	The Vendor should develop plans specific to each case for members participating in Intensive Care Management (ICM) teams, for applicable populations.

THP uses analytic software that builds episodes of care from claims data, and refreshes the data on a monthly basis, to identify individuals with complex or serious medical conditions. THP's system targets medical conditions and risk scores are identified each month and sent to Medical Management for assessing and developing interventions. Examples of conditions that are identified by the software include, but are not limited to, autism spectrum disorder, cystic fibrosis, personality disorders, and congenital anomalies. Additionally, case navigation reports are reviewed to identify members in need of care management based on complexity of need. Reports can be generated to include engagement of member, intensity of engagement, case open date, case closed date, program type, and level of participation.

For instance, the list of members receiving services for children with special healthcare needs can be sorted to include the date the case was opened/closed, the type of programs that they are enrolled in, and the assigned navigator. In addition to sorting the members enrolled in the program, the list of members can be added to our CAVE analytics program to further identify the needs of the member based on the care need index and the predictive score.

Once identified, the member is assigned to a care navigator to determine the intensity of services needed and to provide assistance in getting the treatment required to resolve any identified issues. Ongoing evaluations of member needs are done by utilization of information from past claim history, census information, service pre-authorizations, and any other related clinical information received from practitioners and facilities. If a member is found to need services, an active case is opened in COMET and the appropriate case navigator is assigned.

An evaluation is completed to determine any further needs the member may have. The assessment includes the overall status of the member's health, a clinical history, which includes current and previous medication, activities of daily living, social determinants of health, and the need for any socially necessary services. Our integrated data system allows the navigator to set automatic reminders for reassessment and ongoing evaluation of the member's needs, which will prompt a review and applicable revision of the plan of care.

Upon enrollment, the foster child will be immediately assigned a member advocate, who will work with the guardians, caretaker/facility staff and DHHR case workers to ensure the child obtains a Comprehensive Health Assessment and Developmental Assessment. Based upon the results of the assessment, the specific care needs of the child will be determined, and the child will be assigned to a Navigator based on his/her care needs for assistance with the coordination of care. Based on the results of these assessments, The Health Plan navigator will be able to work with the providers and DHHR Case Managers to assess the member's medical and behavioral health status, utilization of services including preventive, home health, ER,

inpatient, durable medical equipment (DME), caregiver and support systems, activities of daily living, social needs, and lifestyle risk factors. Living arrangements and caregiver questions help identify the level of involvement and what special considerations may be required in developing a care plan for the child.

Additionally, THP will develop a network of community-based Care Managers ("Wraparound Facilitator") across the state who will provide "boots on the ground" supports and monitoring to coordinate with the navigator and the DHHR case worker.

THP will have access to an internal Interdisciplinary Care Team (ICT) to assist and advise with the individual member's healthcare and services. The team is the responsibility of the Clinical Navigator. The team's mission is "whole person" care and the participants vary based on the unique needs of the member. The team can include the navigator, The Health Plan medical director, the pharmacist, a THP specialty nurse, the "Wraparound Facilitator" and the THP social worker. The team will be available to the MDT as needed.

This team is not designed to replace the MDT or any other teams required by DHHR policy such as the foster care agency IDT and the Child and Family Care Team. The member and/or caretaker/guardian and DHHR case worker are an integral part of the team and the resulting plan is "person centered" meaning it is guided by the preferences of the member and his caretakers to the maximum extent possible.

Member materials or reports are discussed at the Member Care Team meetings and shared with the MDT and the Child and Family Care Team as appropriate. The navigator can print and provide copies of the clinical assessment, care plan, goals, barriers, and medication lists from tracking systems to distribute to team members, as necessary. Any recommendations to the PCP or BH/specialty care provider can be passed on as necessary.

Individualized Care Plan

The navigator is responsible to make sure that all relevant member assessments have been collected. The areas that are evaluated include:

- A general health component that gathers current diagnoses, medications, need for adapted education or need for home health
- A mental health and psychosocial history, including alcohol/substance abuse, smoking, and behavioral issues
- Caregivers, disciplinary techniques and level of communication
- Cultural and linguistic needs including primary language, need for translation services, and religious or cultural preferences
- A need for physical, occupation or speech therapy or other specialized services
- Current Behavioral Health Services
- Appropriate prescription drug use for disease and age, along with compliance
- Barriers to care such as visual, hearing, cognitive, and transportation
- Family environment
- School Assessment, IEP, and other education considerations

Information from the comprehensive assessment provides greater detail about the member and their needs. After this assessment is completed, the assigned navigator will formulate an individualized longer-term care plan to replace or supplement the immediate care plan already in place to address the member's healthcare needs. The plan will prioritize and coordinate the member's needs and serves as the thought leader and organizer of the THP and "Wraparound Facilitator" care team. The navigators are licensed staff assigned to the member based on an area of expertise pertinent to the member's needs. Foster care children will most often be managed by nurses or BH staff in the behavioral health unit due to the need to deal with the traumatic issues many of these children have faced.

A draft care plan is reviewed and evaluated by the ICT and once approved, passed on to the MDT and Child and Family Care Team as input. The key components of the care plan are problems, interventions, and goals. The navigator works with the member and his/her caretakers and advocates addressing knowledge and understanding of their condition/disease and community resources so they can work together to develop goals, interventions, and identify problems or barriers.

To address problems and barriers and achieve the desired goals, a number of interventions can be established to help address various issues. Some examples of possible interventions include:

- Scheduling of routine follow-up to PCP or specialists
- Obtaining needed preventive services such as routine exams, immunizations and EPSDT services
- Providing support services
- Meeting transportation needs
- Obtaining referrals for ancillary services or tertiary care
- Ongoing treatment for substance abuse or behavioral health services
- Educating member and caretakers on care needs

Interventions and objectives for treatment/support are established with documented status updates and timelines. Goals, interventions, and problems are set up to be ongoing and changing. As the needs change, the care plan is flexible and can be adjusted to respond to those changes.

Of special concern are those especially vulnerable children with complex chronic health or ongoing severe behavioral health conditions. These members are identified by the navigator, as well as through the member's caretakers and PCP. As special needs and considerations of these members are identified, the navigators have access to varied staff including social workers, and community resources to evaluate and meet the needs of this delicate population. The SED waiver will be leveraged to add services for those children/youth identified as eligible for the program. The standards of care contained within the negotiated agreement with the DOJ will be implemented per the DHHR implementation standards, once developed.

The navigator shares the care plan with the member, any applicable caregiver, the ICT, PCP, or specialist, the DHHR case worker, the Child and Family Care Team and the MDT any time there is a change to the plan. The care plan is communicated telephonically, by facsimile, by mail, or secure email once the preferred method of communication is established. Any clinical information received from physicians, providers, or facilities is gathered to complete documentation required to support the care plan.

Members, providers and other stakeholders are always encouraged to offer input and modification to the plan of care.

Coordination of care efforts require The Health Plan to seek and accept information and communications from a wide variety of resources and through a number of different avenues. Some of the key information and avenues of communication include:

- Reports on admissions and inpatient reviews provided by the hospital/skilled nursing facility on members who have been admitted to their facilities.
- Electronic medical records information transmitted electronically by providers for key documentation components that The Health Plan may wish to monitor. This often includes lab results that help to evaluate disease progression and compliance. In instances when this information may not be available electronically, it can also be extracted from the practitioner medical records or provided by the practitioner via established plan reporting mechanisms. When received the information is tracked systematically as part of the history.
- Claims information including prescription drug information fed into the various systems and evaluated to determine needed interventions. Some examples include immediate notifications in the Pharmacy Department of possible drug adverse events, changes in drug therapy, readmission reports signaling possible setbacks in care that may require intervention upon discharge, etc. This information is provided through reports, as well as, system alerts.
- Reports and system alerts reminding staff of scheduled and/or needed member interactions are generated through the various information systems and ensure that appropriate follow-up occurs on a timely basis. Reports indicating any backlog or follow-up issues are routed to supervisory staff in the event of overlooked communications.
- Referrals and care authorization processes are handled through a variety of means such as telephonic, facsimile, mail and direct entry through secure web access. These requests come from a number of resources including providers, members and other stakeholders.
- Reminder calls are made to remind members and/or their caretakers of appointments, preventive care needs and to provide education on benefits and services.

Members with urgent needs after hours and on weekends have access to The Health Plan "Nurse on Call." The Nurse on Call is a nurse at The Health Plan who can provide information on plan benefits and can assist the member in accessing needed care and services after hours. Pharmacy services is also available after hours and is staffed with local technicians from The Health Plan who can assist in resolving conflicts in getting medications at the pharmacy. Behavioral Health nurses are available 24 hours a day, 7 days a week via telephone to assist

with any after hour needs. All of these services are accessible to the DHHR case worker as needed.

In addition, THP will ensure development of the statewide mobile crisis response teams required by the negotiated agreement per DHHR standards. These teams will be available telephonically and when necessary, in person.

Internal computer systems at The Health Plan are set up to allow members to designate alternate communication needs and establish alternate contacts. In this way, members are able to designate a second contact for mailing of information and phone calls in the event that the member or DHHR case worker wishes to have the member's information routed to a caregiver or family members, in addition to themselves. Members are also able to designate language preferences, communication handicaps and the need for adaptive materials. The system also tracks instances when a member has a designated medical power of attorney or has authorized an individual to access and discuss their medical information. All staff members at The Health Plan are able to access interpretative services for members and their caregivers that include language translation, as well as, hearing and/or visually impaired services, large print materials, Braille, and audio, upon request of the member.

The care plan elements address the member's knowledge and understanding of their condition/disease (in an age appropriate manner), locate community resources, provide education, develop goals and interventions and identify problems or barriers. The care plan identifies needed services to be arranged or coordinated including:

- Periodic assessment of growth and development, including assessment of physical, mental and developmental health
- Comprehensive vision, dental and hearing services
- Necessary medical services (diagnostic and treatment)
- Routine follow-up to specialists or primary care physicians
- Preventive services (EPSDT)
- Obtaining referrals for ancillary services or tertiary care
- Ongoing treatment for substance abuse or behavioral health services

Goals can be identified and documented as short-term and long-term with a start and complete date with case notes added, as needed. Interventions and problems are established with the identification of the goals, with status documented. The Health Plan Navigators review the individualized care plan on a regular basis and work with the stakeholders to appropriately navigate the member toward the established goals. As changes are needed, the ICT is reconvened, and the care plan reevaluated with the results of the evaluation made available to the DHHR case worker and the MDT.

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CM025	The Vendor should conduct ongoing gap analyses to determine the types of services and resources not available in the State.
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.

THP will work with the WV BHPA, the WVPCA, the Foster Care Association, the WV Child Care Association, local FRNs and other provider groups to address potential gaps in services and promote community-based resources through creative partnerships such as those enjoyed with WVUM and KVC.

The WVUM partnership provides a key resource to help in filling gaps—utilizing this partnership the Plan is able to locate and recruit needed providers and services to underserved local communities. THP can work with WVUM to make certain services available through E technology when in person services cannot be obtained.

KVC has experience in Kansas in forming and developing needed services—KVC has gone so far as to develop an inpatient psychiatric hospital for children when services were not available through a local resource.

These are just examples of the resources available to the Plan as it identifies and addresses service gaps across the state.

Data tracking will allow for identification of needs using THPs available tools and any specified by DHHR:

- Reports on services going out of area to ascertain needed services
- Provider and member outreach to identify provider issues with locating services
- Case management input in identifying services that are difficult to locate for members
- Geomapping to look at availability of services throughout the state in hopes of enabling regional development where needed

THP believes it is better positioned than our competitors to identify and correct service gaps because we live here, our case management team knows the services and options available and THP is well positioned to manage the resource development.

THP can use tracked information and data from Care Plans to look at barriers and issues to meeting goals through reports, navigator and "Wraparound Facilitator" interviews and data, and other data resources.

THP will convene public/private meetings with various stakeholders and will reach out to provider and advocacy groups to perform specific surveys to identify needs and gaps in care resources. Additionally, the data collected by DHHR prior to the issuing of the RFP will provide valuable input into the identification process. The report completed by DHHR entitled the West Virginia Child and Family Services Plan also contains valuable information provided by stakeholders as to service gaps that tend to trigger placement failures.

THP is also willing to consider methods of working with the state and foster care agencies to incentivize and encourage potential families to become foster care parents. Clearly there is a need for mature, balanced families willing to enroll in the foster care programs and payment and benefits for those families is currently rather low. Expansion of access to specially trained Therapeutic Foster Care Homes will be a priority issue.

The Commission to Study Residential Placement of Children has carefully evaluated and conducted numerous surveys in order to identify the causation for children being sent out of state to residential placement. Results and recommendations of the commission will be carefully considered in order to identify service gaps and if possible, the HP will request ability to attend and provide information as available to the commission in its deliberations.

CM027 The Vendor should leverage population health management risk stratification tools to support stratification of members into risk tiers for care coordination services.

THP's Care Coordination and Case Management program is a tiered model designed to address a wide and diverse range of member healthcare needs. Our Model is a comprehensive, integrated program utilizing industry recognized processes and procedures modeled with components of care model that was specifically developed for medically underserved and low-income populations.

THP care services has a range of disease management program activities that have been established based on the prevalence of conditions within traditional Medicaid populations.

THP has criteria for identifying enrollees appropriate for Case Management services beginning with data from the enrollee's Health Risk Assessment (HRA). In addition to the HRA, other data is gathered, quality reviewed, and reports are generated on an ongoing basis to identify members with potentially high-risk, high-cost medical conditions.

At every opportunity/encounter, members are educated in self-care strategies, illness prevention, and wellness activities. THP's Program is specifically tailored to improve the health outcomes of each participating enrollee. The frequency of interventions and staff assigned to members vary based on each member's particular need. The range of care coordination and case management activities vary in frequency or intensity based on each member's particular need for each tiered level.

For members at the highest tier level, for example children with special healthcare needs, THP assigns an RN or a Licensed Independent Clinical Social Worker.

THP utilizes an electronic system to track, profile, report and manage members receiving care coordination and case management. Our system tracks assessment completion, care plans, ongoing interventions, telephone contacts, face-to-face or home visits.

The analytical software incorporates all claims from medical, pharmacy, and behavioral healthcare, to develop episodes of care to create an understanding of medical conditions that are tied to each individual and prevalence of these conditions within the population. This

allows targeted programs to support the needs of the high risk and most prevalent conditions. The software also creates risk scores to help understand the individual's needs, along with a severity of illness indicator. The first is a Predictive Score that provides an expected future trending on each individual based on current patterns of care. The second score, the Care Need Index (CNI), incorporates the predictive score along with key performance indicators, such as gaps in care, severity of illness of medical conditions, fragmented care, and utilization of ED and frequency of admissions/readmissions.

Every child being enrolled due to removal from parental custody is highly likely to require intensive care management, at least until stable placement and/or reunification is achieved and the member is removed from the judicial docket. The navigator will evaluate each new case for case management triage in order to identify the level of case management intervention and assistance likely to be needed. Results of various assessments will also be considered and the "Wraparound Facilitator and the Child and Family Care Team will be consulted in making that determination after initial stability is achieved and urgent member needs addressed. A member can be moved up or down the continuum of CM care at any time depending on need.

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).
CM029	The Vendor should incorporate data about social determinants of health into its care coordination services.

NCQA specifies evaluation of social determinants of health in every case management assessment at higher levels of intensity. THP navigators incorporate this assessment into every initial CM assessment. Initial and ongoing data gleaned as the navigator and "Wraparound Facilitator" interact with the member and member family system will be retained to allow for tracking and trending of progress

THP will make use of the Accountable Health Communities model to identify the gap between clinical care and community services.

THP has the capacity to utilize ICD 10 codes to identify social factors (Z55-Z65) and will provide education to providers to ensure that:

- They incorporate Z coding into billing and
- That they evaluate and identify social determinants of health for each member and member family.

The THP navigator will work with the DHHR case worker and the foster care agency staff to assess the home of the biological parents to determine if the child has a safe place to return to following foster care and residential placement;

THP will collaborate with the MDT to ensure that the court has the information it needs to make informed decisions based on the presence or lack of resources.

THP navigators will attempt to ensure that housing, food, transportation, utilities, and safety are addressed initially and subsequently, in collaboration with the "Wraparound Facilitator" and the DHHR case worker.

THP will work with DHHR to develop appropriate trainings regarding identification of social determinants of health for stakeholder groups and will build or utilize a standardized sample tool for providers and others to use.

THP utilizes Change Healthcare (InterQual) in UM decision making. Change Healthcare now provides Health Risk Assessment tools that allow for the evaluation of social determinants of healthcare. This will help in establishment of care plans and understanding of barriers and obstacles to care and treatment. The THP process will allow sharing of this information with the interdisciplinary team and MDT for care plan development

THPs member-specific "drop box" centralized record containing this information will aid providers, social workers, foster care entities and other a greater understanding of the member needs.

THP is a local in-state entity that has a thorough understanding of local and regional concerns and how they can best be addressed in our communities since our care managers live and work in those communities.

The Health Plan utilizes the following resources to identify and understand social disparities:

<https://www.census.gov/quickfacts/fact/table/US/PST045218> for information of population, race, housing, families and living arrangement, computer and internet use, education, health, income and poverty.

County Health Rankings and Roadmaps: <http://www.countyhealthrankings.org/> for quality of life, health behaviors, social and economic factors. For disease specific prevalence: <https://www.cdc.gov/> and https://dhhr.wv.gov/hpcd/data_reports/

Data for Food Insecurity in WV and the US gathered by Food Research & Action Center http://www.frac.org/maps/food-security/tables/tab1_foodinsecurity_2015_2017.html

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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.

THP shall work in collaboration with the Multidisciplinary Team (MDT) in the development of the Individualized Service Plan (ISP) and the Family Service plan (FSP) to ensure care and services are coordinated across all systems.

The negotiated agreement with the DOJ mandates the development and implementation of Child and Family Care Plans coordinated by the WF. The team is a group of people, chosen with the family and connected to them through natural, community, and formal support relationships, that develops and implements the Individualized Service Plan. The navigator will participate in the ISP as a matter of course.

The foster care system is a very complex system with multiple "moving parts" all of which have some version of a "care plan". The role of the HP navigator is to collect all the available care plans, post them in the "drop box" and ensure that they are collated and provided to the MDT. The navigator works with the member (as age appropriate) and the caretaker to develop an initial THP case management plan to identify and address member needs. The "Wraparound Facilitator" will collaborate in this process if one is available.

Working with the MDT, THP will design engagement processes that will ensure ongoing input from all the child welfare providers, behavioral health providers, medical providers, care managers, youth service workers, educators, court representatives and family representatives as appropriate. THP recognizes that the voices from each of these stakeholder groups is vitally important and will work with the MDT to ensure that a fair and equitable engagement process is designed that routinely captures and respond to service needs of individuals and families. THP envisions designing and establishing an advisory process that involves community-based providers, social workers and other relevant stakeholders to the input to processes aimed at supporting the work envisioned under this contract. The focus of this work will always be aimed at improving the outcomes of children and families.

Based upon the input from the MDT, The Health Plan care coordinator shall document the plan of care electronically through THPs Case Navigation systems. The case navigation system is an internally developed software tool which allows for tracking of all patient management considerations in one integrated tool. The navigation system eliminates silos of information and allows for integration of various facets of information utilized in the Care Navigation process including workflow, care coordination, communications, clinical and social assessments, care plan development, etc. Referrals, admission reviews, assessment, claims and other external data can be incorporated into the tool for access by members of the MDT based on needs-based access criteria. The integrated navigation system is the key tool used to support the activities of the care team. Through this system THP can perform and track the following:

- Reminders for follow-up calls, contacts, meetings, etc.
- Notification of various team members of needed interventions
- Performance of comprehensive assessments

- Incorporation and tracking of external assessments such as CANS, CAFAS
- Generation and mailing of letters, pamphlets, and educational materials,
- Creation and tracking of the care plan
- Gather, update and evaluate patient medication lists and claims
- Document clinical reviews
- Documentation of routine contacts, phone calls, meetings, correspondence and other contacts
- Incorporation external information such records from DHHR FACTS system
- Tracking and coordination of foster placement information and key contact resources.

CM031 The Vendor should develop and implement access to care standards and methodology.

The Health Plan has defined standards in place for access to care and availability to care. These standards ensure that The Health Plan meets the needs of our members by assessing member to provider ratios, as well as demographic distribution of Primary Care, Behavioral Healthcare and Specialists. Practitioner and provider availability and accessibility is monitored annually against defined standards

The guidelines monitor the practitioner compliance for:

- Emergency Services: Availability 24 hours a day, 7 days a week
- Urgent Care: Within 48 hours
- Non-Urgent/Sick Care: Within 48 hours
- Routine, Non-Urgent/Preventive Care: Within 21 days of request

Practitioners and providers who do not meet the standards with a score of 90% are required to submit a corrective action plan to improve services to our members. Where accessibility does not meet the defined standards, The Health Plan Provider Network Department is notified for collaborative strategy initiation.

Annual audits for distance to practitioner and provider locations is completed with defined targeted performance goals. These guidelines require PCP's to be located within 30 minutes travel time, basic hospital services located within 45 minutes travel time, and tertiary services located within 60 minutes travel time. The Health Plan also conducts an annual "After-Hours" Access audit. The Health Plan completes calls to offices after normal business hours, or on weekends or holidays to determine that practices have an after-hours access process in place to meet The Health Plan's standards.

Guidelines for accessibility in the practitioners' office location are also defined by The Health Plan. These defined guidelines are monitored to ensure that our contracted practitioners' offices provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities.

CM032 The Vendor should develop and Implement care guidelines for working with youth who may have been exposed to adverse childhood experiences (ACEs).

THP recognizes the impact of adverse childhood events on the increased risk of negative outcomes throughout the child's life. These negative outcomes continue throughout adulthood and the number of traumatic events that the child experiences increase the risk of heart disease, depression, cancer, smoking, substance use, and obesity.

The multitude of traumatic events that children experience that are assessed in the ACES process includes, but is not limited to physical and emotional abuse, sexual abuse, witnessing domestic violence between parents or other family members, divorce, incarceration of parents, discrimination and bullying, economic stresses in the home. This kind of exposure affects the way children learn to cope with various situations and also has a large impact on development as the child grows. Learning disorders and behavioral problems manifest as a result of childhood negative experiences.

Early intervention is the key to minimizing the negative impact of traumatic childhood events and relies on formulation of a plan to address the needs of the child and the family. It is important to treat the family unit in consideration of the possibility of reunification and the decision of the court system with regard to permanency for the child.

When children are removed from the home, they are screened for trauma and PTSD symptoms by the placement agency, if there is one. An example of the screening tool used is the UCLA PTSD screening tool. The tool is a self-report of the trauma experienced and the symptoms that the child is currently experiencing. This tool is intended for children and adolescents between the ages of 7-18 with an adapted version used for children age 6 and under. In addition to the PTSD screening tool, THP will utilize the questionnaire for ACES and will utilize the results of that screening for reference during the intake assessment process. THP will coordinate treatment for the member in order to begin to address any trauma related behavioral health or health problems and any family dynamics needing improvement. Additionally, THP will work with its Physician Advisory Committee to incorporate the ACES questionnaire into physician practice guidelines where appropriate to help recognize issues in a proactive manner.

THP recognizes that behaviors and health issues are often the result of the trauma experienced in the member's life. We will coordinate services directed at increased coping skills, improved school performance, decreased behavioral and substance use problems, and correct identification of the precipitating factors that precede the removal of the child. Additionally, THP will focus on the coordination of services aimed at the prevention of removal of a child from the home. This will allow members to work on improved relationships and while coordinating services for the entire family unit.

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 Health Plan recognizes the impact that trauma has on the development of children and adolescents. These experiences cause long-term consequences that affect the health of the child throughout their lives. Low performance in school, behavior problems, and difficulty in establishing long-term relationships are a direct result of the trauma that has been experienced. In addition, these children and adolescents are more likely to end up in the juvenile legal system with delinquency and truancy problems. The ineffective coping skills that are developed have a chronic effect on the mental and psychical health of the member.

Children and adolescents begin to have problems with behavior when they can no longer cope with the amount of stress that they are experiencing in their lives. This intense feeling of hopelessness is displayed in many different ways. Children and adolescents often act out in anger toward others or themselves in contrast to adults who may react by withdrawing and decreased interaction with others.

The DSM identifies diagnoses related to trauma that include but are not limited to, PTSD, anxiety, oppositional defiant disorder, and ADHD.

THP coordinates care for the whole person and understands that human behavior, coping skills, and problems associated with trauma can be treated in a variety of ways with many different modalities of care. Accordingly, THP will 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 provider community is an essential aspect of this structure and THP will engage providers in systematic ways to introduce ACES and to promote evidence-based methods of identifying and remediating the byproducts of chronic childhood stress.

Through the screening and assessment process, early intervention coordination, and prevention strategies utilized for children in foster care, these children can lead healthy and happy lives. Breaking the cycle of trauma is a focus as well as treating the individual as a whole. Capitalizing on the strengths of the individuals will allow for the development of a plan of care that will not only provide treatment to members but will also have an impact on the prevention of trauma and thereby reducing the potential for removal from the home.

According to the National Council for Behavioral Health, "Trauma is a near universal experience of individuals with behavioral health problems. According to the U.S. Department of Health and Human Services Office on Women's Health, 55-99 percent of women in substance use treatment and 85-95 percent of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood.

The Adverse Childhood Experiences study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente, is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being.

Almost two-thirds of the study participants reported at least one adverse childhood experience of physical or sexual abuse, neglect, or family dysfunction, and more than one of five reported three or more such experiences."

THP considers provision of trauma informed care to be vital to the success of treatment with the Medicaid population of endangered children, and as such, will evaluate providers during the credentialing process to ensure competence in this area. As deficits are identified, THP will utilize its partnership with provider resources such as the Prestera Center, KVC and WVUM, to develop educational opportunities for parents and providers on topics of interest, particularly trauma informed care in various modalities. Examples might be free trainings after DXC workshops, informational materials, fax and email blasts and WebEx sessions. THP will explore the possibility of bringing in nationally known experts on this topic and others to speak to parents and other stakeholders including providers. THP's website will contain links to projects such as the National Council's three-year initiative to introduce PCP and other medical providers to concepts of trauma informed care.

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.

Participating PCP's and pediatricians complete a Health Check exam to identify the needs of members related to dental services. THP staff monitors completion of the examination and sends reminder notices to the PCP and the member when the screening is due. The PCP is requested to return the notice to THP to indicate if the exam was or was not completed, if the member kept or missed the appointment, or if any referrals were made as a result of the exam.

This information is entered into the HEART system tracking tool that auto updates for when the next screening is due based on the periodicity schedule. Wellchild exams are tracked up to the 21st birthday.

If a suspected problem is noted during the PCP exam for any dental issues, the process of referral is coordinated by the PCP and THP staff to ensure that the member receives the care needed.

THP collaborates with the "Wraparound Facilitator" and the foster care placement agency to arrange for and provide transportation to required dental examinations and treatment per DHHR policy. Results will be made available in the child's THP "drop box", accessible to any approved member provider.

THP subcontracts with Skygen USA to provide dental services to our members. Skygen will work with the PCP and THP to identify any specialized dental care needed for children with special healthcare needs. Skygen takes a case-by-case approach to ensuring these members receive the specialized care that they need. Depending on the need of the member and the type of disability, specialized providers may need to be identified and contracted to meet the needs of the population. This is reviewed between THP and Skygen on a regular basis to ensure there is sufficient access within the network to specialized services.

CM035 The Vendor should provide a care coordination model with stratified services for eligible members according to clinical, social, or other criteria.

The Health Plan will assess all foster care members and families for care coordination needs upon identification and enrollment using a hub and spoke model concept to appropriately stratify based on identified needs and diagnoses. All of the target population of members are considered to be eligible for care navigation services until an assessment is completed and the MDT agrees that no services are necessary.

The Health Plan Care navigator will be at the center of the hub in a command center type of setting. He/She will be responsible for ensuring communication across the various care team settings. He/She will collect assessment data gathered in the field by the DHHR/CPS, the "Wraparound Facilitator", medical providers, behavioral providers and various community agencies and resources (spokes or affiliates) for storage in a centralized repository. She will complete or assign any required assessments or functions not identified as satisfactorily completed and share information with all involved parties in an agreed upon format and make all information available to the MDT and the DHHR case worker. She will analyze the synthesized data with input from the various stakeholders to appropriately stratify members to a primary THP navigator.

The Health Plan Primary Navigator may be assigned based on the focused individualized needs of each identified member and family. A member may stratify to a primary navigator based on the most immediate need - medical, behavioral or social. Members may be co-managed with consults to other THP navigators based on secondary and tertiary needs, but the primary navigator will coordinate care across the spectrum to be inclusive of all parties in the multidisciplinary team with communication, record sharing and shared care planning as her prime directive as the care team hub. She will communicate at set intervals, determined by needs assessment, with all stakeholders in the care team and provide updates to goal attainment or setbacks and ensure interventions are carried out by all assigned parties as identified in the care plan.

The Health Plan's Foster Care Coordination Department is organized into units focused on behavioral health, medical management, pharmacy management and social needs. Within each of these specialties criteria are defined for Complex or Care Navigation. The Health Plan's Complex Case Navigation Program is designed for individual members requiring assistance on a long-term basis. Members are identified to be at high risk due to high cost care needs, catastrophic diagnosis, illness or injury and or complex care delivery issues. Individualized member driven, clinical analytic based, provider shared care plans are developed and implemented with input from the team, focusing on facilitating member service access, eliminating gaps in care and educating members/caregivers for improved care independence and self-management skills. Medically Complex Diagnosis Criteria include:

- Transplant
- Catastrophic Neuromuscular Disease
- Brain Injury

- Cystic Fibrosis
- Spinal Cord Injury
- Major Burns
- Immunodeficiency
- Ventilator Cases in the Home
- Major Congenital Anomalies
- Preterm Birth
- Complex Cancer
- Children with Special Healthcare Need
- Hemophilia
- Genetic Abnormalities
- Trauma

Behaviorally Complex Diagnosis Criteria include:

- Schizophrenia
- Attempted Suicide or Homicide
- 30 Day Inpatient LOS members
- Major Depressive Disorder
- Psychosis
- Bipolar Disorder
- Eating Disorder
- Substance Use Disorders

It is assumed that most children will require an intensive level of case management at least initially upon removal from a placement, be it familial or otherwise and members will be carefully evaluated accordingly.

Care Navigation is a care coordination stratification in which a member receives necessary short term, episodic care and services support in an efficient and timely manner. Members are identified in real time and by clinical analytics. Care Navigators engage members and related providers and develop a care plan identifying utilization issues, gaps in care, analytics driven Care Need Index and Predictive Scores and that information is made available to providers. Care Navigators perform a telephonic or collect a detailed assessment from affiliate providers with each member and identify member goals for care. They plan and implement interventions to achieve these goals across the team setting ensuring members receive the right care, in the right place, at the right time and at the right cost. Members are discharged from Care Navigation when goals are achieved, and needs are resolved. Members are eligible for Care Navigation for multiple episodes of care.

Care Navigation's focus is prevention, continuity and coordination of care, and education to improve or maintain functional and clinical status.

Medical Care Navigation

Some triggers for medical care navigation include:

- Self-referral, physician referral, DHHR case worker referral, family referral, group referral or request with any identified need.
- Identification based on a trigger diagnosis with any identified risk factor (*diagnosis specified in complex care are exempt as these go to Complex Case Navigation). Sent in real time by Inpatient, Pre-authorization or Clinical Services Staff.
- Readmissions within 30 days. Identified in real time by Inpatient Navigator/internal reporting with focus on those with readmit for same diagnosis and identifiable risk factors increasing likelihood of further readmission.
- Clinical Analytics. Reports identifying specific at-risk populations based on various defined parameters and individualized criteria, stratified by Care Need Index and Predictive Scores for targeted intervention (i.e. Children with Special Healthcare Needs, Medically Frail Medicaid).
- Risk identified by Governmental HRA or Outreach (Medicare/Medicaid)
- Enrollment in a Clinical Trial
- Discharge Outreach identified with needs beyond scope of Inpatient Navigation.
- Redirection for Out of Network or Transitional Care.
- High cost stop loss/reinsurance identified post service.
- Core Wellness Identified.
- Any other identified need such as uncomplicated transition of care or change in placement

Behavioral Healthcare Navigation

Some triggers for behavioral healthcare navigation may include:

- Multiple Co-Morbidities or high risk co-morbidity with short term, non-bio-based
- Self-referral, physician referral, DHHR case worker referral, family referral, group referral or request with any identified need
- Behavioral Health Diagnosis, identified by depression survey or referral, not suitable for complex case navigation, such as positive responses on a member HRA or PHQ-9
- Enrollment in Clinical Trials
- Identification through Discharge Survey
- All members seeing out of out-of-network providers
- Redirection/Transition of members for OON to IP providers
- Crisis Encounter follow-up
- CSU or SUD residential follow-up
- Antidepressant Medication Management follow-up
- Autism
- PTSD
- ADHD follow-up
- Any other identified need such as uncomplicated transition of care or change of placement

Members identified as having primarily social needs will be navigated by The Health Plan's Social Work Team. Criteria will mirror that currently followed by Kepro/BMS to prevent any disruption to current service provision.

The framework for the Hub and Spoke Care and Complex Case Navigation is "member centric" and involves assessment, care planning, implementation and evaluation. The Navigation Program is collaborative and multidisciplinary in nature and involves the member, family, caregivers, healthcare providers, socially necessary service providers and community-based resources. Coordinating care through team-based navigation helps with the efficient use of healthcare resources and ensures efficient delivery of service promoting positive outcomes. Important are quality and continuity of care, promotion of education and self-management through timely intervention across a unified care navigation team.

The Health Plan navigators provide telephonic management and serve as the communication resource (hub) connecting all stakeholders. They arrange for and/or coordinate and communicate with all stake holders for all services. THP intends to build a network of community-based care managers ("Wraparound Facilitator") to assist with "on the ground" case management needs. The Wraparound Facilitator is also responsible for coordinating the Child and Family Care Team. The navigation program may include services required across the care continuum (inpatient, crisis stabilization, discharge planning, outpatient, in the community via outside resources, etc.). The navigator can negotiate cost effective rates for supplies and services for out-of-plan services when necessary and facilitate movement of records across a complex system to facilitate smooth care transitions.

The Care and Complex Case Navigation Program is integrated by employing a variety of structures and strategies to ensure constant and efficient communication between all stakeholders, members, physicians, providers, and caregivers. Much of the communication process is coordinated through the use of Information Systems Components which include:

- An automated internal full service electronic medical record and care planning system named COMET (Care Organization Management Evaluation Tool).
- An overall operating system for eligibility, claims, referrals, hospital review and member surveys called HEART.
- Customer Service call and documentation Application
- West Virginia Health Information Network
- Pre- manage
- West Virginia University Hospital's electronic medical record, Epic
- Access to Molina

COMET is a THP developed software tool which allows for tracking of all patient management considerations in one integrated tool. COMET eliminates silos of information and allows for integration of various facets of information utilized in care or complex case navigation and disease management such as workflow, care coordination, communications, clinical and social assessments and care plan development. COMET allows for the building and sharing of a collaborative care plan via assessment, diagnosis, planning, implementation and evaluation

stages. It allows for the setting of reminders for self and delegated tasks as well as serving as the repository of assessments and notes and will be the foundation of communication.

The Health Plan will work with all stake holders to collect and synthesize all relevant data across all care settings to formulate integrated care plans that are shared and communicated through all phases of care via the hub and spoke model outlined and diagramed above and available to approved stakeholders in THP's "drop box".

CM036 The Vendor should screen members for stratification into care coordination services upon enrollment.

Once the contract is initiated, THP navigators will begin to contact DHHR case workers and member caretakers and guardians to perform initial assessments on those members that are relatively new to the foster care program, with the assumption that new members are likely to be less stable. Additionally, THP will analyze claims data available to identify members that are high cost or who have numerous BH/medical/social necessity claims in order to begin the THP assessment process.

THP has policies and procedures to ensure that each new enrollee obtains an initial screening within 90 days of enrollment. In the case of foster care members, THP will perform many screenings much more rapidly, as described above. THP acknowledges that DHHR reserves the right to specify or limit which screening tool or questionnaire(s) THP can use for the initial screening. THP's Care Coordination and Case Management program is a tiered model designed to address a wide and diverse range of member healthcare needs.

Criteria for identifying enrollees appropriate for Case Management services begin with data from the enrollee's Health Risk Assessment (HRA). In addition to the HRA, other data is gathered, quality reviewed, and reports are generated on an ongoing basis to identify members with potentially high-risk, high-cost medical conditions.

That said, all children in the target population will receive assignment of a Wraparound Facilitator unless the member and his/her legal guardian opt out of the program. THP intends to develop a network of Community Based Care Managers that will assist THP navigators to address member assessments and needs in a face to face interaction. THP Navigators will identify and contract with a WF for each member as needed and approved by the DHHR case worker.

THP ensures that each enrollee assigned to our Plan has an ongoing source of care appropriate to his or her needs. We are committed to helping our member reach their optimal level of health and well-being while maintaining a "holistic approach and personal touch."

Our Member Analysts (Enrollment Coordinators) track membership and enrollment, identify discrepancies and refer cases to appropriate Case Managers or Care Coordinators who identify and coordinate the care required for the member's specific health condition. It is expected that many of the target population will require case management services.

CM037 The Vendor should monitor screening timelines for member care coordination stratification.

THP will conform to identified timelines as specified for placement agencies, DHHR rules and regulations, and MDT statute. The foster care system is very complex with many rules, policies and identified timelines. The THP navigators will be familiar with those timelines and will assist DHHR case workers and placement agencies to meet deadlines in an appropriate fashion through the THP case tracking system in COMET.

THP performs its own comprehensive assessments to determine if members have needs that can be met by current case management plans. These assessments will initially be prioritized as described above.

Additionally, members newly enrolled have very clear deadlines for initial medical, behavioral, psychological and dental assessments that will be adhered to scrupulously, utilizing the THP network of provider partners and the "Wraparound Facilitator's" "on the ground" resources. The THP navigator will ensure that initial and follow up screening appointments are arranged, transportation is provided as needed, and that if for any reason the appointment is missed, rescheduling occurs. The navigator will call providers to monitor the member's compliance with appointments and when there is a "Wraparound Facilitator" involved, the "Wraparound Facilitator" will accompany the member to the appointment and report back.

The navigator will ensure that the EPSDT is performed and that recommended follow-up assessments and treatment are provided at the earliest opportunity.

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

Members enrolled with THP are instructed to select a Primary Care Provider (PCP) to act as their overall coordinator of care. Members who do not choose a PCP upon enrollment or choose a PCP that is not eligible are assigned an eligible PCP.

THP monitors for issues with assigned PCP's based on the monthly roster received from the State and through internal reporting. These reports will indicate situations when assignment of a PCP by the plan may be indicated including but not limited to:

- The listed PCP is not accepting new patients;
- The PCP is no longer THP effective;
- The provider number is incorrect;
- No provider is listed at all;
- The PCP has terminated or left the area.
- An alternative professional may be more appropriate to serve as primary coordinator of care, although a PCP will still be identified.

All members must have an identified professional in charge of their care. If the member does not have a PCP, THP staff will first determine if the member is a re-enrollee. If so, the same PCP will be reassigned. If not, the member claims will be reviewed to determine the provider who is caring for the member. A list of all eligible providers is maintained in the HEART system to ensure that any assignment is appropriate. If the member is more appropriately care managed by a behavioral health or other specialist, the navigator will work with the identified coordinator of care to become familiar with their obligations as the primary care provider and coordinator.

THP educates all PCPs on their responsibility to coordinate care for THP members. This includes procedures to facilitate communication between behavioral health and other specialty providers and PCPs to enhance continuity and coordination of care.

THP will coordinate necessary services or procedures for members who join THP with services or procedures members already had rendered or that were scheduled prior to coming on THP. These services include behavioral health services. Members are reminded that the PCP should have medical records from other providers in order to coordinate the member's care. THP will share information necessary with other MCO's or other entities to prevent duplication. All sharing of information and coordination of care must follow HIPAA guidelines to protect the member's privacy of his/her protected health information.

While the PCP is the primary coordinator of care, THP also assigns members to an appropriate THP staff healthcare professionals (i.e. care navigator, complex case navigator or chronic disease navigator) to assist with their healthcare needs. The referral to THP navigation services is coordinated through COMET from resources such as inpatient nurse navigators, preauthorization nurse navigators, outreach, members and physicians.

Assignment also occurs through systematic and thorough review of clinical analytic reports by the nurse manager(s) in the Medicaid Unit in the Medical or Behavioral Department. The Risk Reports stratify members according to their care need index and predictive score. Individual member coordinated care reports are produced that reveal gaps in care, severity of illness, number of admissions and ED utilization to further help identify members that would benefit from THP navigation resources.

Reviews for referrals are created in COMET and received by the designated navigator to be evaluated with a subsequent case created, flag assigned, and assessment and care plan developed. Reviews can also be received in a queue and the navigators take member assignments from the queue.

The members' healthcare needs are coordinated by the navigator establishing a partnership with the members and their care givers, their PCP and/ or other treating physicians. Care plans are developed and shared with these stake holders as well as any updates to the member care plan.

CM039 The Vendor should use clinical, social, or other criteria to assign members to a care coordinator within a timeframe that the Department approves.

THP has detailed policies regarding criteria used to assign member to a care coordinator. However, once the DHHR case worker notifies THP that a child has been removed from a home or other placement, a navigator will be immediately assigned to arrange and coordinate the initial assessments and emergency actions necessary to optimize success in the new placement.

Criteria for the care/complex case navigation programs standardizes and proactively facilitates the process for identification of appropriate members for enrollment into the program. Members with a variety of complex conditions are afforded the opportunity to participate in the program. Eligibility is not limited to one complex condition. Multiple sources/avenues for referrals are utilized.

Immediately upon enrollment, a health risk assessment by THP is completed to identify member healthcare needs. Additionally, Information from the CANS and CAFAS and related social service assessments can be incorporated to address all aspects of care and service. Based on the results of these assessments along with any information provided directly, a "permanent" Navigator is assigned (which may be the initial navigator), and the member is followed according to their individual acuity of care. Some aspects that may be incorporated to ensure assignment of the navigator with the most appropriate clinical background include:

- Specific diagnoses, treatments and/or procedures
- Complexity of illness
- Assessment of social determinants of health
- Specialized care needs such as specialty drugs, special care programs, facility placement
- Request for assistance from the DHHR case worker

When a member is identified for care navigation, they are set up in COMET to identify the member and his/her various needs. COMET ensures that the member is assigned a navigator and followed up for care needs on a regular basis. Staff throughout the organization are able to identify the care navigator(s) responsible for managing the members care. COMET ensures that the care navigator is forwarded information on the member as care needs are identified.

For example, a member in the behavioral health program for ADHD management who is actively engaged in the program with intensive needs is flagged in COMET. When any THP staff pulls up the member screen this information is provided and allows for easy and accurate identification of the member status.

Although follow-up is required anytime a care notification or concern is identified, the minimum timeline for member follow-up in care management is based on the intensity level assigned to the member. The time line for member follow-up is as follows:

- Intensive services -daily to monthly
- Moderate services- every 1-5 months
- Infrequent- every 6-8 months

- Annual – every 9-12 months

Children removed from a home or placement (and the stakeholders for that child) will receive more frequent telephonic contact from the navigator and a "Wraparound Facilitator" will be identified to perform face to face visits with the child as frequently as necessary. Those contacts will continue until the child is stable in his/her current placement.

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.

There is a searchable health library on the THP website. The educational materials that are listed are approved by the physician's advisory committee. This committee is a collaborative committee established to provide insight and guidance on decision making. The committee is comprised of board certified, contracted practitioners from appropriate specialties. The physician advisory committee reports to the Medical Director oversight committee who then reports to the Executive management committee.

The education materials are approved by the marketing director for appropriate content prior to being placed on the website for member use.

If the member does not have electronic access, the nurse navigator or advocate can mail the education material to them or discuss the information telephonically during case navigation.

Members appropriate for outreach are identified by stratification during enrollment, care analytics, and the referral process, however DHHR case workers will be contacted for all children removed from a placement.

Educational correspondence is written in sixth grade language to ensure that the member is able to easily understand the material provided.

Education is provided on disease management, mental health strategies, and general health.

CM041 The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Healthcare Needs (Title V) program clinics, providers, or other professionals.

Members already enrolled in the CSHCN Program are immediately identified in THP systems so that Care Navigators and advocates can coordinate with the program on the care needs of the child. THP navigators have regular dialogue with the CSHCN program and coordinate care activities, making sure that CSHCN staff are aware of transitions in care and specific care needs. THP has worked with CSHCN for a number of years with the TANF populations and have found that strong coordination between THP and the program provides the member with additional support for their needs.

The Health Plan has a staff of Member Advocates trained to obtain the initial Health Risk Assessment for all newly enrolled Medicaid Members. These Member Advocates conduct a"

Welcome Outreach" orientation and education within 90 days (initial call is, usually, within 30days) of enrollment in The Health Plan. Education regarding benefits, importance of establishing and maintaining a PCP, appropriate use of the emergency room, importance of EPSDT/Well Child Visits, and, Enrollment in WIC and Right from the Start is provided during this call. Inquiries re: chronic illnesses, use of out-of-network providers, or any other issues the member may have in obtaining care are also made with follow-up call for any gaps in care identified (i.e. UTD immunizations/well child visits). The Member Advocates will contact the Care Navigators personally for any serious, acute need identified upon first call, enabling early identification of members who may qualify for the Children with Special Healthcare Needs program. Additionally, the electronic HRA stratifies the Members, based on their answers to the questions. Clinical services have criteria that identifies Members most at risk, and potentially appropriate for the Case management, Disease Management, and Behavioral Health Programs. Referrals are received in Clinical Services for another call and further stratification with a more in depth HRA. THP makes 3 calls, and sends 3 post cards over the first 30 days in order to engage the Members. (Members can request Case Management at any time, as well, through Customer Service.)

Members already enrolled in CSHCN are automatically enrolled in Complex Case Management. THP policy is to review the Member's case and contact them or the parent/guardian within 7 days of receiving the review. During that call, the advocate or navigator will review services, assess the Member and refer for any additional services/programs (i.e. Birth to 3, Social Services, CSHCN, WIC, Smoking Cessation, Disability Outreach, Behavioral Health, Dietician, Logisticare, or any other community resources that may enhance the welfare of the Member). The established plan of care is reviewed as it pertains to the THP Benefit Plan. Attempts may be made to redirect any services that are out of plan, as appropriate. THP has the ability to do single case agreements for established care that can't be safely transitioned to a network provider.

All of these factors are evaluated during the 90-day transition period. The Members are followed by Nurse Navigators, Social Workers, or program specific Member Advocates (or a combination of more than one) according to the acuity of the Member's needs. A Mutual agreement for plan of contact with Member/Caregiver, and/or Providers, is made and documented in the Members Care Plan and/or COMET. The Navigator will provide education, and direction, and facilitate any needed socially necessary services for the family in order to optimize member success.

CM042	The Vendor should perform screening, assessment, and/or utilization analysis to identify and provide services for members with special needs.
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THP analytical software has the capability to create disease specific reports, as well as allow data mining that will assist in identifying enrollees with special needs and chronic conditions. Data files and reports are generated based on medical conditions such as diabetes, congestive heart failure, asthma, seizure disorders, major depression, etc., and incorporated into the clinical services workflow, assigning the enrollees to a care or disease management

nurse. A care need index and care summary are produced, identifying the conditions and utilization patterns of the enrollee, ER utilization, severity of illness, comorbidities, and gaps-in-care related to quality measures. The nurse uses this summary to develop a care plan and assist the member in achieving goals related to the medical condition(s). Upon enrollment in care and disease management programs, flags are created internally to track ongoing intervention and outcomes related to the medical conditions. . A copy of the HRA tool is available within this document.

Members are identified and referred via COMET in real time from preauthorization nurse navigators, inpatient nurse navigators, or outreach staff via HRA's or initial new member calls. These members would have diagnoses specific for disease management, complex case navigation or care navigation.

Members or their family and physicians may refer or enroll via The Health Plan website. Pharmacy claims may be used a resource to identify members that require high cost drugs e.g. for hepatitis C or cystic fibrosis.

Additionally, members are identified by:

- Health risk screenings performed by THP outreach
- Direct referral by PCP or specialists
- Referral from THP care and case managers
- Referral from DHHR case workers
- Member self-referral including e-enrollments
- System generated weekly reports of hospitalizations coded with a primary or secondary diagnosis, as well as, concurrent hospital review staff referrals
- Data from health management or wellness programs
- Information from EHRs
- Depression screening

Members are evaluated during enrollment and during care navigation for eligibility for special healthcare programs. The HRA is completed and any complex issues are identified. If the member is currently receiving services through the special needs program, the navigator ensures that the services are continued.

When a member is referred for care navigation services, the navigator contacts the member and completes the comprehensive assessment in COMET. THP utilizes the coordinated care assessment and care planning tool from Change Healthcare (InterQual). This is an evidence-based assessment and care planning tool that is evidence based and updated with the latest information available. It is compliant with NCQA standards and allows for an individualized, member specific plan of care that is focused on the priority goals established during the assessment process.

In collaboration, the behavioral health department also assesses members for special healthcare needs. If a member meets the criteria for the program with either physical or functional limitations the navigator completes the screening tool. Upon completion the screening tool is sent to the WV CSHCN program for evaluation.

The navigator is able to assist with the coordination of medical care, supplies and equipment, location of transportation, and community resources.

The navigator will review the intake assessment provided by the DHHR worker to identify specific needs for the child. The CAFAS and CANS will also be reviewed upon receipt from the assigned worker so the THP can coordinate services and ensure that the child is receiving the services that they need.

THP completes a health risk assessment telephonically or the HRA can be mailed for completion by the member upon request. During the HRA special healthcare needs are identified. Examples of the screening include, but are not limited to, Asthma, CSHCN, Diabetes, potential need for SSI disability, severe behavioral health problems, and high potential for removal from a placement and pregnancy.

An example of THP's HRA can be found on the following pages.

(BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK)



MEMBER NAME	
MEMBER HID#	
Who is your primary care physician?	
What is your phone number?	
What is your email address?	

Please answer all questions by checking each box:

GENERAL HEALTH RISK ASSESSMENT

Do you have diabetes?	☐ Yes ☐ No
Are you pregnant? If yes, due date is: _____	☐ Yes ☐ No
Do you have asthma?	☐ Yes ☐ No
Do you have chronic lung disease such as emphysema or COPD?	☐ Yes ☐ No
Do you have Heart Failure or have you had a heart attack or open heart surgery in the last 3 months?	☐ Yes ☐ No
Do you have any of the following heart/blood pressure problems?	
Other heart surgery in the past 3 months	☐ Yes ☐ No
Heart surgery scheduled	☐ Yes ☐ No
New pacemaker or defibrillator	☐ Yes ☐ No
High blood pressure not controlled with medication	☐ Yes ☐ No
Do you use any of the following home medical equipment?	☐ Yes ☐ No
If answered yes, please check the ones that you use	
☐ Prosthetic devices	☐ Pulse oximeter
☐ Trach care	☐ Suction machine
☐ CPAP or Bi-PAP	

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Do you have any of the following medical conditions/concerns that we should be aware of?

Have you had or are you receiving care for a transplant? (e.g. heart, lung, kidney, pancreas, liver, bone/stem cell, LVAD as bridge to transplant) ☐ Yes ☐ No

Nerve or muscle disease that is progressively getting worse? ☐ Yes ☐ No

Answer YES if multiple sclerosis, myasthenia gravis, muscular dystrophy, ALS.

Answer NO if arthritis, fibromyalgia, neuropathy.

Brain injury that has left you disabled for which you are still receiving care or treatment? Answer NO if you have or had a concussion or old injury that no longer needs treatment. ☐ Yes ☐ No

Cystic Fibrosis? Answer NO if you have COPD or cystic breast disease. ☐ Yes ☐ No

Spinal cord injury requiring ongoing care/treatment? ☐ Yes ☐ No

Answer NO if you had back surgery in the past that you are recovered from, back pain, disc disease, surgery to put rods in your back.

Large burns or currently receiving care related to a recent trauma/accident? ☐ Yes ☐ No

Any immunodeficiency disorder requiring care or treatment? ☐ Yes ☐ No

Use of a ventilator at home (you would have a tracheostomy)? ☐ Yes ☐ No

Answer NO if you use CPAP, Bi-PAP, nebulizer or oxygen.

Birth defect, congenital anomaly, genetic disorder that requires ongoing care, treatment or monitoring? (e.g. congenital - spina bifida, cleft lip/palate, heart defect, club foot), (e.g. genetic - down syndrome, Alpha-1 antitrypsin deficiency, Fragile X, PKU). ☐ Yes ☐ No

Hemophilia or severe blood disorder requiring ongoing care, treatment or monitoring? ☐ Yes ☐ No

Answer NO if you have anemia or are taking Coumadin or Xarelto.

Under age 21 and currently receiving care or treatment for cancer? ☐ Yes ☐ No

Do you currently receive services from the Children with Special Health Care Needs Program? ☐ Yes ☐ No

When did you last see your practitioner for a well visit?

☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ >12 months ☐ Not established with MD

SMOKERS

If 12 years or older, do you smoke? ☐ Yes ☐ No

If yes, do you plan to seriously quit smoking in the next 30 days? ☐ Yes ☐ No

Do you plan to quit in the next six months? ☐ Yes ☐ No

Are you exposed to second-hand smoke? ☐ Yes ☐ No

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ADVANCE DIRECTIVES

If 18 years or older, do you have advance directives? If yes, please check ☐ Yes ☐ No
type: ☐ Living Will ☐ Medical Power of Attorney

Do you want us to mail you an advanced directives flyer (free for members)? ☐ Yes ☐ No

PHARMACY

Do you take any medications that are available without a prescription? ☐ Yes ☐ No
(e.g. Ibuprofen, Aleve, Prilosec, Claritin, St. John's Wort, Co Q 10, etc.)

If yes, does your practitioner know that you are taking these medications? ☐ Yes ☐ No

If no, please tell your practitioner about these medications because there may be interactions or it could be a covered benefit.

Do you have problems getting or paying for your prescriptions? ☐ Yes ☐ No

BEHAVIORAL HEALTH

Do you have any of the following behavioral health conditions/concerns that we need to be aware of?

Major Depression Disorder ☐ Yes ☐ No

Bipolar Disorder ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No

Thought disturbances/Hallucinations/Psychosis ☐ Yes ☐ No

Eating Disorder ☐ Yes ☐ No

Post Traumatic Stress disorder ☐ Yes ☐ No

Obsessive Compulsive Disorder ☐ Yes ☐ No

Panic/Anxiety disorder ☐ Yes ☐ No

Age 3-8 with a diagnosis of autism ☐ Yes ☐ No

If you answered yes to any of these questions, please tell us the name of the office, practitioner or counselor that you see for your treatment and care.

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PHQ2

Over the past 2 weeks, how often have you been bothered by any of the following problems? Check the answer that best describes how you feel.

Little interest or pleasure in doing things:

☐ Not at all ☐ Several days ☐ More than one-half of the days ☐ Nearly every day

Feeling down, depressed, or hopeless:

☐ Not at all ☐ Several days ☐ More than one-half of the days ☐ Nearly every day

CAGE-AID QUESTIONNAIRE

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Do you drink alcohol? ☐ Yes ☐ No

Have you ever experimented with drugs? ☐ Yes ☐ No

If you answered yes to the above two questions, please answer the next four questions.

In the last three months, have you felt you should cut down or stop drinking or using drugs? ☐ Yes ☐ No

In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? ☐ Yes ☐ No

In the last three months, have you felt guilty or bad about how much you drink or use drugs? ☐ Yes ☐ No

In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs? ☐ Yes ☐ No

Thank you for taking the time to answer these questions. You may receive a follow-up call or you may get a letter requesting more information. If you have questions, please call The Health Plan's toll-free phone number at 1.877.221.9295.

Please return this in the enclosed, postage-paid, self-addressed envelope to:

The Health Plan
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Wheeling, WV 26003

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CM043 The Vendor should perform screening and assessment to identify and provide services for members with behavioral health needs.

Children removed from placement are required to have a comprehensive behavioral health assessment within 30 days per DHHR policy. Additionally, the negotiated settlement with DHHR and DOJ will require the Department to identify a standardized set of assessment tools for each child in the target population, most likely to include the CANS assessment tool as well as others. THP will ensure compliance with the specified assessments and timelines.

Regardless, THP intends to ensure that each child is screened by a behavioral health provider within 7 days and more immediately if necessary, based on behavior or trauma. THP intends to develop a network of provider partners willing to provide priority access to children in the foster care population for both screening and comprehensive BH evaluation.

A copy of the Health Plan's High-Risk Assessment tool (HRA) is available in this document.

The purpose of THP behavioral healthcare navigation is prevention, continuity, coordination of care, and education to improve or maintain functional and clinical status.

Behavioral health nurse navigators can receive referrals for navigation in several ways- post inpatient psychiatric discharge, potential PRTF placement, review with appropriate diagnosis, referral from another department, identification by THP reporting tools, by member/guardian, DHHR case worker or physician request, to mention a few.

Claims information is reviewed to determine various needs of the members. Depression screening tools aged appropriately are also utilized upon admission and periodically as needed, based on the individual member. Monthly, auto generated reports received from information in the HEART system are also reviewed to determine member needs based on the use of psychotropic medication, autism diagnosis, antidepressant medication, and ADHD medication.

Information from the health risk assessment is entered into the HEART system. As applicable, if there are behavioral health issues/diagnoses that are triggered, a referral auto generates to the BH navigator queue for review. The BH navigator reviews the information received and also pulls any applicable history to determine the needs of the member. Screening tools are used to further review the needs of the member by engagement of the parent/guardian/caregiver related to behavioral issues, school performance, and adjustment disorders.

THP staff also receive auto generated notification of any member seen in the ER department from participating facilities through medical record exchange programs with PreManage and The WV Health Information Network (WVHIN) for any specific behavioral health and substance abuse diagnoses. If a member is treated in the ER, the advocate makes an outreach call to the member to determine if the member needs have been addressed and if a follow-up appointment has been scheduled with a BH provider. If the member does not have an appointment with a provider, the advocate will coordinate with available providers to set up an appointment with the goal of 7 days post ER visit. If the member is in need of continuing

support the advocate will open a case and continue to follow the member and provide support by reaching out periodically according to the member's identified needs. If there are issues that require a more comprehensive program, the advocate will make a referral to the complex or care navigation behavioral health nurse. The nurse will reach out to the member and complete a comprehensive assessment as needed.

All members who have been admitted to an inpatient MH, PRTF, or CSU receive ongoing monitoring by the inpatient BH nurse navigator. The BH social worker collaborates with the discharge planner by reaching out upon notification of admission to assist in any services that will be needed by the member upon discharge. When the member is discharged, a case manager is assigned to continue to coordinate services for the member.

Readmission reports are auto generated through the HEART system to determine if members are in need of services. The report is reviewed by the navigator on a monthly basis to identify trends. If the member has been readmitted numerous times, the advocate determines if there are barriers to follow-up care or if the member is in need of a higher level of care on an outpatient basis.

All members newly enrolled receive a health risk assessment. In addition to the assessment, a depression screening is completed. If the member triggers a positive score for depression, a more detailed survey is auto generated to the member for completion and to determine if case navigation needs are present. The HEART system auto generates a monthly report of all surveys that were sent to the member during the previous month. The report is reviewed by the member advocate to determine if the more comprehensive questionnaire was received. If the survey was not received, the advocate makes an outreach call to the member to determine if the survey was received and/or if the member needs help in answering the questions. The advocate can enter the results in the HEART system while speaking with the member on the phone and send a referral to a behavioral health nurse immediately if needed.

For Foster Children, upon notification of children removed from the home, a behavioral health nurse navigator will be assigned to the member to assess needs based on the initial assessment completed by the DHHR caseworker. The navigator will reach out to the DHHR caseworker to determine who may discuss the needs of the member and to identify what services are already in place. Consideration will be given to court ordered services and THP staff will coordinate those services as ordered. Collaboration with previous providers will ensure that the member continues to receive necessary services without interruption.

Diagnosis specific assessments are completed by the navigator based on the member needs. From these assessments, a plan of care will be developed which will include information received from participation in MDT meetings. During the MDT meeting, the navigator will coordinate all services related to behavioral health needs based on the clinical information collected during screening and assessments.

An example of THP's HRA can be found in CM042.

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.

Health Risk Assessments (HRA) are sent to all new Medicaid members or their guardians (including members with special healthcare needs) upon enrollment through the Welcome packet within five days. The HRA includes a postage paid return envelope. Members/guardians are instructed to complete and return the form in the postage paid return envelope provided. Once the Advocate receives the information from the member or caregiver the data is entered into THP system. Based on the member's response the document is forwarded to the appropriate clinical team for follow-up. Telephone contacts are attempted by THP Member Advocates to complete the HRA in the event the HRA is not returned or is incomplete. If a member/guardian cannot be reached by phone after the first attempt, post cards are sent encouraging them to call our THP toll free line where an advocate will assist them.

The Health Risk Assessment includes screenings for functional and social risk factors. If a member has certain medical conditions, the appropriate electronic assessment is completed:

- If a member is found to be pregnant during the completion of the HRA, a prenatal assessment is completed.
- If a member has diabetes, asthma or children with special health care needs, an electronic notification is generated from the HRA and sent to disease management where the clinical staff will complete a more detailed assessment.
- If it is determined a member has special healthcare needs, the assessment is immediately routed to a Care Navigator for follow-up.

Information on all assessment is evaluated and routed to the appropriate care management staff for evaluation and further assessment if warranted.

Members already enrolled in CSHCN are automatically enrolled in Complex Case Management. THP policy is to review the Member and contact the member/guardian within 7 days of receiving the review. During that call, THP will review services, assess the Member and refer for any additional services/ programs (i.e. Birth to 3, Social Services, CSHCN, WIC, Smoking Cessation, Disability Outreach, Behavioral Health, Dietician, Logisticare, or any other community resources that may enhance the quality of life for the Member). The established plan of care is reviewed as it pertains to the THP Benefit Plan. Attempts may be made to redirect any services that are out of plan, as appropriate. THP has the ability to do single case agreements for established care that can't be safely transitioned to an in- network provider. This will be evaluated during the 30-day transition period.

The Members are followed by Nurse Navigators, Social Workers, or program specific Member Advocates (or combination of more than one) according to the acuity of the Member's needs.

As appropriate, the results of the HRA will be made available in the "drop box" created for each complex member that permits access to approved stakeholders for sharing of information.

CM045 The Vendor should provide targeted education programs and identify who will receive these programs.

A variety of education and outreach programs will be established for youth, young adults and care takers to ensure understanding of the resources that are available and the instructions for accessing them.

THP will collaborate with child placement agencies to facilitate and enhance the educational services the agency is able to provide for foster parents. Such training is likely to include:

- Trauma informed care for children and youth
- Mental health first aid
- Effective child discipline techniques
- General foster care parenting techniques
- Basic developmental processes for children
- Effective care of common medical issues
- IDEA and parent or guardian rights under IDEA

Similar programs will be provided to biological or kinship parents and delivered by THP staff or contracted social necessity or behavioral health providers.

THP is partnering with several large provider agencies to develop and provide targeted trainings. These partners include WVU Medicine, the Pretera Center and KVC. Other strategic partnerships will be developed as needs are identified.

Transitional assessments for Youth & Young Adults will be developed in conjunction with DHHR Chafee staff if needed. Individualized and group trainings can be developed for that population to aid youth in life skills development as necessary. Life skills may include resume design, job interviewing skills, banking and finance, consumer math, accessing community resources and others. The purpose of this program is to address any gaps in training and transition assistance not covered by placement agencies, socially necessary services, and Chafee services.

THP will continuously assess training needs in its foster care and at risk populations and will work with DHHR and community partners to make additional targeted trainings available as the need arises.

CM046 The Vendor should use specialized care coordinators for certain care conditions, including, but not limited to, experienced pediatric or cardiac nurses and behavioral health specialists.

THP has historically provided disease specific care management to its specialty populations. Medical and behavioral healthcare managers are experienced in their fields and supervisory staff assign cases based on the strengths and backgrounds of various care managers, particularly when it comes to members with behavioral health presenting problems and challenges. THP processes for identifying these populations are described in earlier sections using the HRA tool. THP provides the option of navigator "consultants" to the primary navigator in situations in which the member, for example, displays both significant behavioral health and health challenges. The primary navigator is responsible for the contact and assistance with the member/guardian and the consulting navigator will work with the primary navigator to provide assistance and consultation regarding the member's specialty care needs.

CM047 The Vendor should develop and maintain qualifications and training for Vendor staff who will be involved in coordinating care.

Per NCQA standards and THP policy, THP ensures that appropriately licensed health professionals are engaged to perform utilization management, care management, and other member services.

- Registered nurses maintain licensure as well as continuing education, credentialing, and certification. Certified complex case navigators are assigned for complex cases and maintain certification in case management to ensure they are knowledgeable on the most current best practice standards.
- Registered nurses hired in the medical and behavioral health departments are hired as per their qualifications required in the job description and for the population that they will serve.
- Nurses hired with specialty experience are screened during the recruitment process to ensure that they possess the knowledge and education required (for example diabetic nurse educators/navigators).
- Behavioral health pre authorizations are reviewed by staff with at least a BA in the mental health field or a registered nurse with experience in caring for pediatric patients with behavioral health issues. If a question arises regarding the member's meeting medical necessity for the requested service, the case is forwarded to a medical reviewer with a physician's license for further review and peer to peer consultation as needed.
 - Registered pharmacists are available to the navigation team and to the MDT at any time. THP employs six registered pharmacists.
- Monthly reviews are performed by supervisors and managers to ensure that the coordination of care meets THP standards of excellence. Ongoing education is provided as necessary as a result of the review process.
- Monthly staff meetings are held to educate staff on changes in policy and procedures or to communicate changes in best practice related to case navigation.

- An interdisciplinary team of THP physicians, nurses, pharmacists, psychologists and licensed social workers is also on hand for consultation to any staff person or supervisor.

CM048 The Vendor should develop and implement steps for care coordinators to establish relationships with their assigned members.

Establishing a relationship with a member is a basic tenet of care navigation. Member engagement is key in forming a relationship with the member to facilitate recovery and self-management. A member experience survey is conducted annually by mail. Responses regarding care manager interactions are always positive and meet established goals. It is not uncommon for members to mention their care or complex case navigator by name in their returned survey.

The first step in establishing a case is a telephonic contact with the member. When a child enters foster care, the initial engagement will be with the DHHR worker and the placement agency. The care or complex case navigator has researched the member's history as available and reached out to treating physicians for information. Information regarding court requirements and signed releases will also be obtained. Having knowledge of the member's healthcare needs, court ordered requirements, and diagnoses helps build a trusting relationship.

If the navigator is unable to reach the member after three telephone calls, repeated postcards are sent asking the member to reach out to the navigator.

Since most members of the target population will have DHHR case workers, the case worker can assist THP to reach the member and establish telephone contact. THP will also verify telephone numbers and addresses with treating physicians and providers

The member contact is initiated for introductions, program explanation and member agreement for participation. Contact information for the care or complex case navigator is provided.

Effective communication is essential to coordinate care for members. The care or complex case navigator serves as the communication liaison for all stakeholders.

The care or complex case navigators gather and review all information to develop a care plan. This assures that the care or complex case navigator has an in depth understanding of the member's diagnosis and care needs and barriers to reaching goals are identified.

The care or complex case navigator collaborates with the member, family, MDT, "Wraparound Facilitator" and care team to develop the THP care plan and to coordinate various service plans in order to facilitate the MDT master plan. The navigator maintains collaboration and communication with the member, family, physicians, healthcare providers and other stakeholders to facilitate review of the THP care plan and to initiate monitor progress and initiate amendments as necessary. The member, family, MDT and physician are involved in all aspects of the care plan. The care or complex case navigator maintains regular communication with the member, MDT to gather information on the current status of the

member and determine impact, if any, to the care plan. The care or complex case navigator maintains current communication with the physician, placement agency, DHHR worker, MDT, and healthcare providers to discuss issues and make adjustments to the care plan as appropriate.

The care or complex case navigator communicates with providers during transitions of care to identify needs or barriers to care and will research appropriate providers for services when those services are not available from network providers.

Care plans are based on evidence-based guidelines, if available, and any deviations from the standard of care are addressed. The care or complex case navigator performs an assessment of the member's progress toward obtaining goals of the care plan.

The frequency of contact and level of management is tied to the member's acuity as determined by risk stratification i.e. care need index, predictive score, gaps in care or if the member is being removed or transferred from placement, receiving a course of significant treatment or is hospitalized.

Additionally, THP will develop a statewide network of community-based care managers ("Wraparound Facilitator") to assist in contacting the member and developing rapport.

A four-character member flag is created for each individual member. The first character indicates the program i.e. Behavioral, Complex, Disease Management, Navigation, D-SNP or Pharmacy. THP may develop a flag specific to the foster care population with this contract. The second character indicates the diagnosis or event criteria specific to the member. The third character indicates the level of member participation, active, opt out or do not call, unable to contact, or completed or discharged. The fourth character indicates the level of management, intensive, moderate, infrequent, annual, not enrolled, following, completed or discharged.

The levels of management establish the parameters for member contact as follows:

- Intensive management requires daily, weekly or monthly follow-up;
- Moderate management requires follow-up every 2 to 5 months;
- Infrequent management requires follow-up every 6 to 8 months;
- Following management requires monitoring of pre-authorizations and admissions, contact with treating physicians for those members the opt out or cannot be contacted;
- Completed or discharged management indicates the member has met goals, disenrolled or expired;
- The member flags are updated or modified to reflect the member's needs or condition changes or level of participation or management.

In the event a member is unreachable or opts out of the care management program, the care or complex case navigator will continue to outreach to the provider both to obtain updated contact information for the member and to maintain an up to date care plan. These members' care is continually followed, and new outreach attempts are made to the members around key target events, such as admissions, discharges, emergency department visits, etc.

Regardless of member engagement, the THP navigator will continue to assist the DHHR case worker and other specialty providers to meet the needs of the member and family.

It is unclear in the negotiated agreement who will be responsible for evaluation of the wraparound facilitators. THP will comply with any data requirements or monitoring specified by the Department.

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 Health Plan, through a hub and spoke model, will collaborate with community-based care managers ("Wraparound Facilitator") to identify and stratify the needs of the members, including, but not limited to, face-to-face contact. This will be done via routine case management operations and screenings such as direct telephonic or facsimile communication with the member's providers and the member's themselves. When the need for a face-to-face contact is identified, coordination of the visit will be initiated by The Health Plan navigators and The Health Plan's "Wraparound Facilitator". Our partnership with strategic providers throughout the state will provide a unique opportunity for collaboration which will enhance and improve the care and services provided to the foster care population.

The frequency of and need for face-to-face contact will be determined by a number of things including, but not limited to:

1. WVDHHR Foster Care Policy
2. Terms of the implementation plan developed by DHHR
3. Crisis Intervention
4. Situations related to safety of the member and/or other residents of the household
5. New or adjusted placement
6. As requested by a department worker

The goal of all face-to-face contact (scheduled and as needed) is to ensure safety and coordination of care for the member. All contacts will be documented. Additionally, the objective of all as needed face-to-face contact (new placement, crisis, safety intervention, etc.) will be to stabilize and improve the member's status to the extent that they are well maintained via the standing face-to-face contact requirements as defined by WVDHHR Foster Care Policy (monthly, quarterly, etc.). Efforts will be made to ensure Face to Face encounters are coordinated with various entities to avoid duplication where possible.

The "Wraparound Facilitator" will be contractually obligated to visit the member at least twice during the first week in any new placement and at least weekly thereafter and will submit brief reports to the navigator summarizing the visit and member progress. Reports may be made available in the "drop box". More frequent visits can be made as necessary.

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.

When a member is identified for care navigation, a navigation flag is auto generated in COMET to identify the member and the member's various needs. The flag is a 4-character identifier to indicate the type of program the criteria for the navigation, the participation level of the member, and the level of care.

1. The first character indicates the programs available which are Behavioral, Complex, Disease Management, Navigation, DSNP, and pharmacy. An additional flag will be developed for this target population.
2. The second character indicates the indication for the assigned program and is specific to the first character.
3. The third character identifies the member's level of participation.
4. The fourth character is the frequency of the follow-up for the member.

As an example, a member in the behavioral health program for ADHD management who is actively engaged in the program with intensive needs is flagged as BH1A. This indicator is an identifier associated with the member case and is viewable in COMET when any THP staff pulls up the member screen. This allows for easy and accurate identification of the Member needs.

The time line for member follow-up is as follows:

- Intensive services -daily to monthly
- Moderate series- every 1-5 months
- Infrequent- every 6-8 months
- Annual – every 9-12 months

Additionally, THP will develop a network of community-based care managers ("Wraparound Facilitator") who will be contacting the member at least weekly until the member disenrolls/leaves the court's docket, or at any other interval specified by the DHHR implementation plan.

CM051 The Vendor should collect statistics, according to a set frequency, on Care Coordinators' progress toward establishing relationships with members.

Through data analytics THP summarizes engagement reports and information related care management tasks. Additionally, CAVE analytics allows for review of member engagement with navigators which includes the type of outreach, the type of program enrollment, the initial engagement date, and the date of the case being closed. From this information an analysis can be done to determine if the efforts in the THP navigation program are successful.

Clinical analytics provide insight retrospectively and prospectively, identifying and prioritizing opportunities to engage enrollees in care navigation and disease management programs, utilizing predictive scoring and clinical decision support software and other analytical

processes, to assure effectiveness and efficiency of services and the evaluation of care navigation interventions and processes.

Key performance indicators are developed by each navigation unit to identify goals and to incorporate measures established by accreditation and other governmental organizations, as well as evidence-based guidelines.

The level of engagement and customer satisfaction results related to navigation services are monitored. Data is reviewed by each navigation unit to show trends over time, compare performance, and outcomes of populations served.

Based on navigation guidelines and regulatory standards, engagement is monitored on a monthly basis through the completion of documentation reviews performed by the managers and supervisors. This process involves review of the date the review or referral is received compared to the date the review was either accepted or declined. If the review is accepted a case is opened. All navigation encounters documented in the member's electronic medical record are time stamped automatically by the HEART system. During the interrater review, compliance with completion activities related to member engagement are noted. Informational reporting can be done through COMET to include the reason for member engagement success by coding the case status as follows:

- Active to show that the member is engaged
- Opt out/do not call when the member/guardian has refused navigation
- UTC to indicate that efforts to contact the member have been unsuccessful within 30-90 days if the member has not responded to telephone calls or mailed correspondence requests.
- Completed or discharged for members who have met the program goals and objectives
- Discharged with goals unmet to indicate the member did not actively engage
- Under review for program to indicate attempts are being made to collect necessary information during the initial 30-day engagement process.
- Various monthly reports are run from COMET for statistical analysis as part of the audit process.
- Member satisfaction surveys for case management services are conducted annually with analysis of results to determine effectiveness of the program.

For the purposes of this program, the navigators will continue to be involved in the member's service provision until such time as the DHHR case worker and MDT authorize the case to be closed, regardless of member/guardian active participation.

Additionally, the "Wraparound Facilitator" program will have an identified set of objectives that will be evaluated per DHHR policy regarding alternative payment methodologies and the negotiated implementation plan.

CM052 The Vendor should monitor and evaluate care coordinators in regards to establishing relationships with members.

The care/complex case navigation monitoring will be performed Bi-monthly on all new Navigators during their first year, and then monthly thereafter. The reviews are performed by the manager/supervisor using the monitoring tool application in the HEART system.

- Monthly monitoring cases are selected randomly on active and closed cases. Cases for care/complex navigation are reviewed for consistency, correct interpretation, application of criteria/guidelines, member's benefit and appropriate case navigation.
- Navigators are educated on any inconsistencies found in the monthly monitoring. Monthly scores will be reviewed with the navigator and counseling will occur for a quarterly score of 90 percent or below. Counseling and disciplinary action plans will be generated when needed and will follow The Health Plan Disciplinary Action Policy in the employee handbook.
- Ad Hoc review may be performed at any time as part of a performance evaluation.

Monthly monitoring results, counseling and disciplinary actions will be reported by each manager/supervisor to the Director/Assistant Director of Medical Management, or Director of Behavioral Health, as appropriate.

DHHR case workers will be provided with contact information for THP staff and supervisors and are encouraged to speak with THP supervisors should they feel that a particular navigator, "Wraparound Facilitator", or THP policy is interfering or underperforming in facilitating member recovery/stability. This will be treated through normal THP processes as a quality of care concern or in some cases, as a complaint.

CM053 The Vendor should identify members in need of treatment plans.

All members referred by DHHR case workers will have an initial plan of care that will dictate the collection of all available information and the identification and addressing of immediate member needs for medical treatment, supplies and screening evaluations. The initial plan will evolve over time and become much more extensive based on incoming information and input from the MDT.

All Members are assessed through THP Health Risk Assessment (HRA) for their needs and the appropriate navigation program.

Via the negotiated agreement with DOJ, THP expects that other assessment tools and implementation timelines will be added to the requirements for THP and the WFs. THP will comply with the negotiated implementation plan.

Additional information is collected from the initial placement assessment, the CAFAS, CANS, and MDT meeting. Once the needs are identified, a more extensive plan of care can be developed with input from the various providers and stakeholders.

The care plan will be developed to address the needs of the child based on the reason for removal, the needs of the child for any medical or behavioral health needs and will be in collaboration with the MDT team. Components of the care plan will include the assessment, problems, objectives, interventions, goals, and evaluation of progress.

The Health Plan will collaborate with the DHHR Caseworker, Foster Care organizations, Socially Necessary providers, "Wraparound Facilitators", caretakers and other appropriate parties to obtain a complete and appropriate plan of care for the child. This will include all information related to placement, socially necessary services, medical issues and care needs, identification of social determinants of health, medical equipment, medication, guardianship, school progress, and other components that will be addressed for the duration and after the placement of the child.

The care/complex case navigation program includes all information and interventions necessary for a member or practitioner to improve the delivery and management of healthcare services and promote quality, cost effective outcomes.

Examples of stratified services included in the care plan include but are not limited to the following.

- Those currently hospitalized or recently discharged from the acute care setting
- Low functional performance level
- Health Risk Assessment history of the disease
- Newly enrolled members with diagnosis
- Those newly diagnosed with specific disease state
- Frequent hospitalizations or ER visits related to the disease state
- Those with high predictive score on predictive modeling tool
- Positive depression screening
- Removal from placement

When possible, the case plan developed by the DHHR worker will be obtained and uploaded to the centralized location in HEART. Information pertinent to the care of the member will be loaded onto the drop box landing page with problems, goals and objectives available to view by providers and other stakeholders so that the member is receiving collaborative services and the goals and objectives are addressed in a multi-disciplinary team approach.

1. The member's clinical history is obtained which includes disease onset, treatment history and medications from system history, PCP or specialists.
2. An individualized care plan is developed for care and complex cases including prioritized goals that consider the member's and caregiver's goals, preferences and desired level
3. Care plans include an adequate number of direct access visits to specialist practitioners to accommodate implementation of the treatment plan as appropriate based on line of business and related preauthorization requirements.
4. Barriers to meeting goals or adhering with the care plan are documented and addressed.

5. Follow-up and communication schedule is developed with the member and documented in COMET with reminders.
6. When a member is telephonically engaged (not at a "following" level) a self-management plan is developed with the member and/or caregiver and communicated to the member and made available to the appropriate providers.
7. Interventions including education and facilitation of member referrals to appropriate resources are initiated and follow-up process to determine whether members act on referrals is put in place.

The care plan is re-assessed, and interventions/barriers are revised as the member's needs and acuity may change over time with care transitions. Outcomes of interventions are reviewed for progress towards goal attainment.

The MDT care plan is considered to be the umbrella plan that governs the development of all other plans until the child leaves the court's jurisdiction. The navigator is responsible for collecting and coordinating all available active care plans for the member to ensure consistency and avoid duplication.

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.
CM055	The Vendor should share care plans with a member's primary care provider (PCP) at a set frequency.
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.

THP shall work in collaboration with the Multidisciplinary Team (MDT) to develop clinically appropriate treatment plans that address coordination of primary services, specialty services, ancillary services, and a Family Service plan (FSP) and Individual Service Plan (ISP) to ensure care and services are coordinated across all systems. The MDT care plan is considered to be the umbrella plan that governs the development of all other plans until the child leaves the court's jurisdiction. The navigator is responsible for collecting and coordinating all available active care plans for the member to ensure consistency and avoid duplication.

The Child and Family Plan team will produce a strengths-based plan for implementation in order to meet the needs of the child and family, coordinated by the Wraparound Facilitator.

Working with the MDT, THP will design engagement processes that will ensure ongoing input from all the child welfare providers, behavioral health providers, medical providers, care managers, Wraparound Facilitators, youth service workers, educators, court representatives and family representatives as appropriate. THP recognizes that the voices from each of these stakeholder groups is vitally important and will work with the MDT to ensure that a fair and equitable engagement process is designed that routinely captures and responds to service

needs of individuals and families. THP envisions designing and establishing an advisory process that involves community-based providers, social workers and other relevant stakeholders to the input in supporting the work envisioned under this contract. The focus of this work will always be to improve outcomes for children and families.

Based upon the input from the MDT, The Health Plan navigator will document the plan of care electronically through THPs Case Navigation systems. Our integrated navigation system is the key tool used to support the activities of the care team. Through this system THP can perform and track the following:

- Set up reminders for follow-up calls, contacts, meetings, etc.
- Notification of various team members of needed interventions
- Performance of comprehensive assessments
- Incorporation and tracking of external assessments such as CANS, CAFAS
- Generation and mailing of letters, pamphlets, and educational materials,
- Creation and tracking of the care plan
- Gather, update and evaluate patient medication lists and claims
- Document clinical reviews
- Documentation of routine contacts, phone calls, meetings, correspondence and other contacts
- Incorporation external information such records from DHHR FACTS system
- Tracking and coordination of foster placement information and key contact resources

THP will share care plans with the member's primary care provider (PCP) at a set frequency, at least initially and at each treatment juncture (update, change in level of care, hospitalization and so forth). THP will develop a strategy for sharing care plans with the member's PCP outside of the established schedule and the strategy will be approved by DHHR.

The member's PCP will have access to the member's "drop box" and will be alerted by THP navigators to addition of new documents with PCP and guardian permission.

CM057 The Vendor should track the completion of care plans.

All care and case management operations are completed, documented and tracked within The Health Plan's proprietary system, COMET. Within COMET, care plans can be developed to document goals, progress and next steps and added to the "drop box" to make them accessible to the stakeholder. In addition, the system will create reminders for outreach and deadlines for completion. All care navigators are scored and evaluated on the progress/completion metrics reported out of COMET. If a navigator does not achieve 90% or greater completion rating, then additional training is provided to help the navigator to improve the outcomes for their members. Navigators are reviewed regularly, twice monthly during their first year and monthly thereafter.

These functions are also audited by The Health Plan's Interrater Review Reliability Monitor, which is a systematic and objective review process done by the manager/supervisor of the department that evaluates the clinician's case navigation ability. This tool also audits The Health Plan's clinicians for their ability to consistently and correctly interpret and apply review guidelines and criteria for pre-authorization and inpatient reviews.

The Interrater review tool is housed in THPs HEART system where compliance reporting and educational opportunities are tracked. Included in this tool are reviews for the timely completion of assessments and care plans that are completed in COMET. Review for the timely completion of the care plan includes the determination if the care plan was modified as needed based on individual assessment, if the goals and interventions were personalized, and if the care plan was dated with updates as applicable and shared with the MDT.

The Interrater review is performed Bi-monthly on all new Navigators during their first year, and then monthly thereafter. The reviews are performed by the manager/supervisor using the monitoring tool application in the HEART system.

Ad Hoc review may be performed at any time as part of a performance evaluation.

Monthly monitoring results, training/counseling and disciplinary actions will be reported by each manager/supervisor to the Director/Assistant Director of Medical Management, or Director of Behavioral Health, as appropriate.

CM058	The Vendor should provide episodic and/or catastrophic care coordination interventions.
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The Health Plan's Care and Complex Case Navigation Program is the care delivery model used to coordinate and manage care across the care continuum. Navigation is a collaborative process of providing and coordinating healthcare services to a defined population. The Health Plan catastrophic navigation program identifies population including those members who have had a major health event or diagnosis that requires the extensive use of healthcare resources. The Navigator's member population includes those members with extended acute hospital stays, discharge follow-up issues, problems identified on the Health Risk Assessment, medical, nursing or behavioral health needs. Navigators/catastrophic nurse navigators actively engage with their members to identify and facilitate care options and care services to meet their individual health needs with the goal of decreasing fragmentation and duplication of care and enhancing quality, cost effective clinical outcomes.

The framework for the Care and Complex Case Navigation Program is "member centric" and involves assessment, care planning, implementation and evaluation. The Care and Complex Case Navigation Program is collaborative and multidisciplinary in nature and involves the member, family, caregivers and healthcare providers. Coordinating care helps with the efficient use of healthcare resources; controlling costs is not the only goal. Important are quality of care, continuity and ensuring appropriate & timely interventions.

In developing The Health Plan's Care and Complex Case Navigation Program, evidence-based tools were used including clinical guidelines. Clinical guidelines are incorporated to remove clinical variation from healthcare delivery. They support high quality care and reduce healthcare costs by supporting the effective, efficient delivery of care to achieve desired patient care outcomes. The care/complex navigators use the guidelines as a roadmap to obtain high quality care.

In developing criteria to proactively identify eligible members that had a major health event or diagnosis that is life changing and therefore requiring care coordination, and extensive use of healthcare services The Health Plan utilizes clinical data sources. Data sources reviewed are high cost claims reports, admission reviews and pharmacy claims. The navigators/catastrophic navigators may receive referrals via COMET from plan pre-authorization nurses, nurse navigators, and social workers. Members are provided an opportunity to participate in the Care and Complex Case Navigation Program.

DHHR case worker referrals will be an approved source of entry into the catastrophic program. Causes for referral may be multiple failed placements and pending institutionalization as an example.

The care or complex case navigators provide telephonic management and serve as the communication liaison between the member/caregivers, physicians and other healthcare providers. They arrange for services required at time of discharge, arrange for appropriate community resources, negotiate cost effective rates for supplies and services or rates for out-of-plan services when necessary.

The Care and Complex Case Navigation Program is integrated by employing a variety of structures and strategies to ensure constant and efficient communication between all stakeholders, members, physicians, providers, and caregivers. Much of the communication process is coordinated through the use of our internal Information Systems Components which include:

- An automated Navigation/Catastrophic Navigation System named COMET.
- An overall operating system for eligibility, claims, referrals, hospital review and member surveys called HEART.
- Customer Service calls and document tracking system called ENTREINDEX.

COMET is a THP developed software tool which allows for tracking of all patient management considerations in one integrated tool. COMET eliminates silos of information and allows for integration of various facets of information utilized in care or complex case navigation and disease management such as workflow, care coordination, communications, clinical and social assessments and care plan development.

The key components of the care plan are the problems, interventions and the goals. The navigator/catastrophic nurse navigator works with the member to address knowledge and understanding of their condition/disease/injury, address community resources, provides education as they develop goals and interventions, identify problems or barriers to obtain

care and services. To address problems or barriers to achieving goals or accessing services a number of interventions can be developed to help. Examples include:

- Scheduling of routine follow-up to specialists or primary care physicians after hospitalization.
- Obtaining necessary preventive services such as flu shots or pneumovax.
- Arranging homecare or support services.
- Obtaining referrals for ancillary or tertiary care.
- Education on diagnoses or injury.

The Care and Complex Case Navigation Program is goal oriented. The navigator/catastrophic nurse navigators strive to help the members achieve optimal wellness or functionality. They teach self-empowerment and management through support and education. Goals include:

- Help members regain and improve health.
- Improve the member's quality of life.
- Achieve the best possible clinical outcomes.
- Improve self-management of diseases or conditions.
- Reduce unplanned hospital admissions and ED utilization.
- Improve medication adherence.
- Educate the member and caregiver about preventive care.
- Ensure that care is provided in the appropriate setting.

Clinical Services is divided into four (4) distinct areas each with a specific clinical focus aimed at appropriate navigation of members through the healthcare systems ensuring each member receives the right care, at the right place, at the right time and the right cost. The four areas include:

1. Medical Management including utilization management, catastrophic case management, disease management, concurrent review, referrals and preauthorization. Staff in this area include registered nurses, social workers and physicians all with varied clinical backgrounds and expertise.
2. Behavioral Health Services including utilization management, case management, disease management, referrals and preauthorization, claims processing, and concurrent review. Staff in this area included registered nurses with behavioral health expertise, social workers a clinical psychologist, and physicians including a psychiatrist.
3. Pharmacy Services including formulary development and management, preauthorization, drug utilization review and specialty pharmacy management.
4. Clinical analysis and research including clinical reporting, technology research and assessment, predictive modeling, provider profiling, gaps in care analysis and outcomes tracking.

Members identified as having catastrophic illnesses or injuries are referred to complex case navigators for their healthcare needs via COMET. Members identified as having diagnoses appropriate for disease management are referred to the chronic disease nurse navigator via

COMET. Reviews can be completed by customer service representatives, outreach representatives, nurse inpatient and pre-authorization navigators via COMET.

THP has a multidisciplinary team of medical professionals who can provide consultation to providers and the MDT as needed.

CM059 The Vendor should identify providers that do not perform coordination activities and take action to improve coordination.

The Health Plan's Provider Engagement team will be working hand in hand with the Navigators to educate primary care providers on coordination activities and to monitor their involvement in each case as it progresses. Provider Engagement will handle the task of ensuring all PCPs are well educated in the dynamics of caring for foster care members and understand their responsibility to serve as their liaison to any resources that can be helpful within THP. In addition, THP's clinical navigators will inform the Provider Engagement team of any provider identified as needing improvement. The team will meet with the provider and provide appropriate education. THP will track and trend to identify ongoing issues with providers and will review and evaluate additional action for providers who are consistently non-compliant with THP clinical standards of care per THP contracting and credentialing guidelines.

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 Health Plan Medical Department employs full time MSW level social workers with community and hospital experience to help coordinate and access community resources for members. Any member not yet assigned to a care or complex case navigator can be referred to one of the social workers via a review in COMET. Members assigned to a care or complex case navigator are referred to one of the social workers in the same manner as community resource needs are identified.

The social workers maintain a Resource Directory of all known community resources. They are responsible for on-going education of The Plan Customer Service, Behavioral Health Unit, and Medical Department staff regarding available community resources. The Health Plan social workers, care and complex case navigators, inpatient nurse navigators and chronic disease nurse navigators ensure that members and providers are made aware of community resources that might enhance treatment plans and assist in accessing such resources. The members' current use of community resources or needed services are part of the assessment completed by the navigator. This activity is documented in COMET software program. Community resources include the following:

- Meals on Wheels
- Food Pantries
- Health Right

- Coordinated Council for Independent Living
- National Alliance on Mental Illness
- Salvation Army
- Alcoholics or Narcotics anonymous

The Medical Department navigators, in-patient navigators, behavioral health navigators/referral coordinators are educated regarding such services on an on-going basis, so that they may in turn; offer such services to members and providers as appropriate.

In order to provide a truly local resource for care coordination, THP intends to develop a network of Community Based Care Managers ("Wraparound Facilitator") through our contracted BH and child welfare agencies. The "Wraparound Facilitator" will be knowledgeable of local resources and will provide "boots on the ground" case management on a regularly scheduled and ad hoc basis, assisting the member, family and DHHR case worker in obtaining and properly utilizing community resources.

Our staff work with various groups to identify and develop community resources. Some of those efforts include:

- Accountable Health Communities/can build upon existing WV 2-1-1 resource
 - Will be able to address health related social needs
 - Reduction of cost
 - Able to reach all WV counties
- Information Help Line
- Family Resource Network
 - Currently have staff participation in local and regional meetings
 - Identification of general networking opportunities
 - Community needs assessment is being developed in some FRNs
- Providers and Other Partners including WVUM and KVC have resources to meet social needs
 - Currently we are participating with WVUM on a project with the goal of improving health outcomes for members. We are engaged in weekly telephonic meetings to discuss members who have difficult cases or those with whom we have been unsuccessful in engaging. WVUM has facilities throughout the state with the ability to provide resources and assistance to all 55 counties.
- Our Autism Advocate is a member of the Family Ways Community collaborative and Foster Care Subcommittee and the Ohio County Family Resource Network General Networking and Disabilities Committees. She brings extensive experience, education, and knowledge in community collaboration. She was a developmental healthcare consultant for the Children's Hospital of Pittsburgh.
- In addition, we collaborate on a monthly basis with the director of the CSHCN program to discuss members who may be eligible for services and to determine if members receiving services are having their needs met. Part of the discussion involves determining if members are having the EPSDT assessment completed and if there are needs that are unmet. If determined that members are in need of services that have been unidentified, our

navigators coordinate those services and educate the families on resources available. This includes WIC for children ages 0-5 years old.

Finally, THP will work with current Foster Care providers to ensure appropriate training is provided to meet children with special healthcare needs. As placements occur, we will work collaboratively with the Foster Care providers to identify those children with those specialized needs and more importantly, to help them ensure appropriate placements in homes with capacity to handle those needs (IE: Tier II and Tier III homes when required). Further, we will ensure consistent training and education on resources available to support the needs of this population.

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A photograph of a male doctor with glasses and a stethoscope around his neck, smiling as he examines a child's brown teddy bear. The child is on the left, looking towards the bear. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

COMMUNITY STAKEHOLDER ENGAGEMENT

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Community/Stakeholder Engagement

This section covers THP's approach to community/stakeholder engagement, including responses to required elements of the RFP, to ensure the effective transition to managed care for the foster care population and those at-risk of entering the system. Although this section of the foster care RFP contains the fewest technical requirements and the lowest page limit, THP views the outreach and education discussed in its responses as essential to an orderly, positive transition. Accordingly, THP urges DHHR to recognize the importance of community/stakeholder engagement work, as well, to the overall success of the foster care transition.

In preparation for this RFP response, THP met with and participated in numerous meetings with individuals and stakeholders groups, such as Circuit Court Judges, guardians ad litem, social workers who serve foster families, leaders of kinship care programs, foster care placement agencies, and current or former foster parents, among others. The Community Engagement Director and THP's Provider Engagement Managers listed in the RFP staffing plan were leads for this outreach. The lessons learned from those meetings are woven into the responses to individual RFP questions; however, it is helpful to summarize those here, as they frame THP's approach to community/stakeholder engagement. Note that this is not an exhaustive list of lessons learned, rather points THP believes are most responsive to the foster care RFP.

- Lesson Learned 1: The managed care organization (MCO) must demonstrate its value to stakeholders, including those served in the foster care system. Otherwise it could be viewed as an interfering third party.
- Lesson Learned 2: A common hope concerning transitioning the foster care system to an MCO is improved accessibility for medical and behavioral health services, provider panel expansion, and timeliness in appointments.
- Lesson Learned 3: Not all stakeholders feel positively about an MCO—some of this stems from moving to an unknown system, while other feelings are derived from misunderstandings. Education and engagement, especially early in the transition process, is crucial.
- Lesson Learned 4: Engagement and buy-in of the judicial branch, particularly Circuit Court Judges, is vital to successfully serving the foster care population and their families/caregivers. The MCO must play a lead role in helping courts receive required reports and ordered care/socially necessary services timely and aiding the family and others in the comprehension of relevant reports.

THP will invest in community/stakeholder engagement for the foster care transition, especially ramping up resources in the first 1.5 years of the contract. This commitment matches THP's belief in superior provider and member service. Furthermore, THP will be an active partner with DHHR in pursuing grants, programs, technical assistance, or other initiatives that support better communicating benefits of managed care, implementation of the Children with Serious Emotional Disorder Waiver, and/or compliance with the Family First Prevention Services Act.

CS001 The Vendor should coordinate care across child-serving systems, including, but not limited to, the educational system, community services, and after-school programs.

To address the incorporation of the educational system, community services and after-school programs, THP shall leverage the experience of its strategic partner KVC Health Systems. In its current role in several states, KVC works directly with the DHHR case worker (or equivalent staff) and with school systems to guarantee that educational needs of the child are met. Often children move from one school system to another when a placement changes, so it is important to collaborate with school systems to ensure that needed records are received. Historically, foster parents store these records as part of their Youth Home Record so they can be easily accessed.

KVC assesses and advocates for the child during its assessment process to determine if outstanding or unmet educational needs are suspected. KVC cooperates closely with Legal Aid of West Virginia's Family Advocacy, Support & Training program if the team feels that a child's educational needs are not being met in the current setting and seeks to satisfy unmet needs. KVC foster parents and case managers work together to ensure that any tutoring, after-school programs or extracurricular needs are satisfied locally.

THP will incorporate KVC's experiences when working with other foster care providers and other members of the Multi-Disciplinary Treatment Team to ensure that educational components and community service needs are included in the care planning process. Furthermore, THP shall facilitate the use of its **Care Organization Management Evaluation Tool (COMET)** for storage and maintenance of records relevant to educational needs and services.

Finally, a key role of KVC, in partnership with THP, will be the establishment and implementation of a Foster Care Advisory Forum. Through this forum, THP will collaborate with stakeholders to develop best practices that can be shared throughout the delivery system with regard to the educational system and community programs. THP can also identify needed services and supports and partner with communities/local organizations to offer those resources.

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.

- Establish relationships through regular and full participation in MDT meetings
- Communicate with partners at DHHR in Charleston, WV, and at county-levels

As outlined in its staffing plan, THP will base a Medicaid Foster Care Liaison at DHHR to ensure a unified, frontline approach to engagement. This liaison will coordinate communication and engagement at the state-level along with THP's Community Engagement Director. THP Provider Relations Directors/Provider Engagement Representatives will interface with the Community Engagement Director and liaison to conduct outreach on a county/regional basis with CPS workers and to facilitate access to needed services and information from THP.

- Education and ongoing outreach by THP to CPS workers
 - Educate on the MCO role and how it interacts with CPS

- Collaborate with existing "education early" programmer that is in place with foster care agencies to educate and collaborate with CPS workers (i.e., encourage relationship building not just with THP but also with various agencies, providers and other stakeholders)
- Provide orientation to CPS workers on a regular, on-going basis via local meetings to build personal relationships and rapport
 - New CPS workers
 - New or revised programs
 - Majors changes to key standards of care or policies/processes
- THP will collaborate with Regional Clinical Review Teams to offer resources and input to facilitate information sharing
 - Offer access to relevant THP systems for CPS workers to facilitate tracking and data sharing
 - Engage in direct communication with CPS workers when THP has knowledge of a critical development concerning the foster care child Example: When a child is in the emergency department or hospitalized, THP may have early knowledge due to PreManage information that is transmitted to THP. THP is capable of notifying the CPS worker, along with the foster care case manager and clinical case workers, to ensure prompt follow-ups.
- Once a child is in a permanent placement, THP will conduct an after-action review to determine lessons learned and leverage data and outcomes to establish best practices—with an eye toward identifying regional or county trends.
- THP will participate in collaborative prevention efforts with various resources, including:
 - Developing training and programming regionally
 - Supporting or creating community educational resources
 - Engaging stakeholders to develop needed programming and resources

Previously KVC and the West Virginia Chapter of the Family Focused Treatment Association worked together with DHHR leadership to create training on how foster child placing agencies operate in West Virginia. This training is part of new employee orientation for frontline CPS workers and explains agency roles, DHHR roles, and the workflows for paperwork and child placement. This training is provided by the foster child placing agencies, and each county/region has designated trainers. THP, through its partnership with KVC, will work with the various foster child placing agencies to ensure this process continues throughout the state and is enhanced to incorporate the managed care role.

Lastly, KVC has experience in a number of states utilizing the Safe and Connected framework and Structured Decision-Making model to staff initial foster care placement matching, minimize placement disruption, offer family case planning, and streamline adoption cases. THP and KVC, in concert with DHHR, will incorporate similar processes in West Virginia as a method of coordinating needs of the child while also improving access to needed services.

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.
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THP and its partners understand the strength that we have is in numbers. It is important for us not only to communicate with the CPS worker about intake information but concerning the ongoing visitation needs, permanency planning and monthly updates for the child.

Through its experience in other states, KVC has developed an integrated framework that supports the inclusion of the entire team around the plan for the child. This framework, KVC's Safe & Connected™, is an integrated child welfare model that brings everyone together in a structured and unified way. The program emphasizes organizing information to promote critical thinking and collaboration with the family and other stakeholders. Additionally, the program creates a comprehensive assessment of risk in service to the outcomes of improved child safety, wellbeing and permanency.

THP will work with KVC and DHHR to implement Safe & Connected™ or a similar strategy in West Virginia. We will also capitalize on our ability to serve as the information hub for the communication process, enabling case workers to prioritize the child and less on managing data resources. By assisting the CPS worker with quicker follow-up with stakeholders and in project management, the worker can focus on the primary goals of placement and permanency.

As an added benefit to stakeholders, KVC can offer various trainings, site supervisions and continuing education units that are crucial for achieving social work licensure and maintaining credentials. THP's Community Engagement Director and KVC will engage with the state's three master's-level social work schools— Marshall University, West Virginia University and Concord University—to discuss potential partnerships with students currently in the pipeline or those who recently graduated. This benefit is a testament to building partnerships among THP and its strategic partners, DHHR and those in the wider child welfare community. Moreover, these benefits can help usher in a new social worker workforce in West Virginia and retain these individuals in needed positions, both inside and outside of DHHR.

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.
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CS005	The Vendor should inform the court of alternative services that best meet the child's needs, as deemed appropriate by the Department.
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In preparation for this RFP, THP conducted key informant interviews with circuit court judges and those involved with the judicial system to elicit their insights about the managed care transition and the present foster care system. **A sample summary from a meeting with an active circuit court judge is provided at the end of this response.**

The judges and other key informants provided feedback to THP about how an MCO can support them during the foster care adjudication process. However, another important lesson was learned during this interview process: not all judges support or understand what role the MCO can play during adjudication.

THP believes direct, continual outreach to the judicial system is essential to managing the foster care population effectively and assuring evidence-based treatment. THP will leverage its robust Provider Engagement Representative network—adding and improving it as needed—to conduct routine check ins with circuit court judges, their staff, and guardian(s) ad litem.

Education and training on a regular, on-going basis

- Connect with various members of the judicial system to educate about the role of the MCO and how THP can assist in the adjudication process
- Guardians ad litem often have huge caseloads, and THP can help by sharing knowledge and reporting activity to make guardians aware of changes with their clients
- Raise awareness among judges about resources from THP and its partners that he/she can leverage during the adjudication process
- Engage in regular outreach to ensure guardians ad litem have open communication at all levels, including with the MDT

Specific training for judges

- Target newly elected or appointed judges for training regarding the foster care system and process, especially the role of the MCO, and child welfare best practices
- Work with Court-Appointed Special Advocates to engage judges in structured conversations and focus groups concerning ways to improve the foster care adjudication process
- Attend court advisory meetings and provide education when appropriate

Adjudication, placement and mandated services vary widely among circuit courts and even individual judges. THP will provide education and support to judges to enable consistent, prompter decision making that ensures a feedback loop to the judge concerning what is or is not working generally for foster care children.

Establish a presence at judicial conferences and gatherings, especially the annual West Virginia Supreme Court Improvement Program Trainings and Guardian Ad Litem Program/Trainings that offer continuing education on abuse, neglect and child welfare.

Develop a webinar series for continuing education of judges and guardian(s) ad litem for delivery on a quarterly basis. THP will gauge interest in creating a Project ECHO-like model (see response to QU002 for more information on the model) for judges, their clerks, and guardian(s) ad litem on foster care issues/cases. Through this model, THP may provide didactic components on evidence-based guidelines regarding psycho-trophic medications or key behavioral therapies, Family First Prevention Act requirements, trauma-informed care and adverse childhood experiences but gear content toward the legal rather than medical community.

Data and information sharing

- Provide information that is needed concerning the clinical needs of the child and status of established care plan via a Health Passport
- Ensure the judiciary establishes the MCO as a resource

THP will track outcomes from a judicial perspective to understand bottlenecks and help court systems improve and expedite processes. Examples of questions THP will seek to answer:

- Why some adoptions take so long
- Are there delays in termination of parental rights
- Are there delays in accessing care or needed services
- Are there problems gathering all information and data needed by legal system
- Hot spotting outlier court systems, then targeting outreach and support accordingly

A summary of the interviews can be found on the following pages.

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The Honorable
Judge [REDACTED]
May 31, 2019 | 9-10 a.m.

Interview Notes

1. When you hear the phrases "managed care" and "managed care organization," what immediately comes to mind? AND What is your greatest worry about moving the foster care system to managed care?

Whether or not another third-party is going to be interfering in this process. It also conjures up the HMO stigma (e.g., withholding care or bad service). Initially, when the legislation was unveiled, Judge [REDACTED] said the judiciary was "up in arms" about it—mostly because of the aforementioned stigma and the prospect of change/new way of doing things that is unfamiliar or unknown.

2. What do you think is working well about West Virginia's foster care process/system?

During his [REDACTED] years on the bench, Judge [REDACTED] has witnessed extremely dedicated and good foster families. Likewise, he has seen foster families "game" the system. Guardians ad litem are also dedicated professionals both to the children and the children's families, he said.

Judge [REDACTED] encouraged The Health Plan to reach out to [REDACTED] attorney who serves as a guardian ad litem and represents families in court proceedings, to solicit her input on the foster care system. [REDACTED] leads a Court Advisory Board that convenes local stakeholders to address the needs of children in foster care, as well as child victims of abuse/neglect. The next Court Advisory Board meeting is scheduled for [REDACTED] in the jury room of Judge [REDACTED] court.

Lastly, Judge [REDACTED] encouraged The Health Plan to connect with [REDACTED] assistant [REDACTED] prosecuting attorneys, as they are leads on delinquency and related cases. Judge [REDACTED] noted that the foster care process typically begins with cases originating in their office for school delinquency/truancy, removal from the home due to illicit substances, etc.

3. What do you think needs to be improved about West Virginia's foster care process/system? AND If you had the ability to change one process/procedure when adjudicating a foster care case, what would it be and why?

Throughout the discussion, Judge [REDACTED] emphasized two key failure points in the foster care process: timeliness of reports and care and comprehension/actionability of the reports.

Reports such as the Child and Adolescent Needs and Strengths (CANS) and the Child and Adolescent Functional Assessment Scale (CAFAS) are not delivered to



the court timely, Judge [REDACTED] said. Some of this delay is due to limited availability of specialists (i.e., psychologists), he said. These delays cause the court proceedings to not be compliant with legal/adjudication timeframes. Once the reports are filed, though, Judge [REDACTED] said it is difficult to decipher their meaning or elicit actionable conclusions.

- o **Recommendation:** Judge [REDACTED] suggested that a one-page cover letter with an action summary, the evidence-base for that action(s) and guidelines used would be of great value to him and other judges—particularly those who are new to the bench and/or not from a psycho-social background. Wherever possible, using plain English and reducing jargon would be best, he said.

Judge [REDACTED] added that the West Virginia Department of Health and Human Resources uses a generalized Family Service Plan template that is not applicable to every biological family in a foster care proceeding. This creates confusion with the family, as the family members feel overwhelmed with the enormity of the requirements (approximately 30-page document) or cannot read or comprehend what is expected. Judge [REDACTED] requests CPS workers to draft a one-page letter summarizing the expectations of the Family Service Plan and to share it with the biological family.

Direct quote from Judge [REDACTED]: "I hear so many times that kids don't go to school because they have some type of health problem." A related issue is the parent cannot schedule the child for a medical appointment or cannot complete the Medicaid enrollment paperwork. Bullying is also a leading reason for truancy, he said.

4. What is your greatest hope about moving the foster care system to managed care?

Having dialogue with an MCO (i.e., The Health Plan) will be helpful to transitioning this process that will change in 2020. Judge [REDACTED] also provided names of colleagues that might be receptive to meeting with The Health Plan.



CS006	The Vendor should establish relationships with applicable Department agencies and State advocacy groups, including, but not limited to, the following:
CS007	Child advocacy centers (CACs)

THP will ensure that its staff work closely with Child Advocacy Centers (CACs) and the West Virginia Child Advocacy Network (WVCAN) as part of the assessment and treatment planning process. The specialized resources these organizations offer enhance the delivery of needed services to the child and his/her caregivers. Additionally, the specific expertise and sensitivity around sexual abuse cases is necessary to guarantee care is handled in the most appropriate manner. By working with DHHR, law enforcement and the CACs to establish the best plan for assessment and treatment of the child, improved outcomes can be achieved. For instance, KVC often refers cases for specialized assessment to CACs, and CACs frequently refer cases for therapy to KVC. This process should be emulated by other foster care placement agencies if it is not already common practice.

THP supports CACs, as well as their mission, and recognizes that their work is crucial to the healing of sexual trauma. Furthermore, THP values having CACs as members of the MDT and will facilitate their active participation on the team.

CS008	Court appointed special advocates (CASAs)
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THP prioritizes engagement of Court-Appointed Special Advocate (CASA) volunteers for their role in increasing stability and establishing rapport with the child and his/her caregivers and biological family. Once notified that a child has a CASA volunteer, THP will coordinate with the MDT to incorporate the volunteer as a member of the team, as well as include them in treatment decisions when appropriate. THP's Community Engagement Director and Provider Engagement Directors will reach out to the various CASA organizations throughout the state to establish and promote relationships for the benefit of foster children.

CS009	The West Virginia Child Abuse Network, as defined by applicable State Code, as defined by the Department.
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THP is well aware of the services and resources available through WVCAN and already has established relationships. As part of its foster care implementation process, THP will utilize many of the materials and resources available through the West Virginia Child Abuse Medical Program, a project of WVCAN, to provide resources for our staff, providers and other stakeholders.

Relatedly, WVU Medicine, one of THP's key provider partners, offers training for nurses who may care for victims of sexual assault. WVU Medicine's Sexual Assault Nurse Examiner Program trains registered nurses to provide victim-centered and trauma-informed care to victims of sexual assault.

CS010 The Vendor should establish communications with foster parents based on Department foster care guidelines.

THP will collaborate with foster care agencies and DHHR to establish effective communications with foster parents. Recognizing the responsibilities and time constraints of the foster family, THP will provide communication options through a web-based portal and a mobile portal where foster families can access client information, as permitted by DHHR and relevant laws/regulation. Foster families will be able to access health data, appointment data, resource information and updates to information about client care. THP will collaborate with foster care agencies as they maintain contact with foster families via telephone, twice monthly visits to the home (when children are placed) and regular newsletters and social media postings. THP and KVC will engage other foster care agencies throughout the state to develop a phone and e-mail list in case of an emergency, such as natural disasters or non-weather-related crises.

THP offers a health library on its website and through its mobile applications. These resources provide literature and documents relevant to the populations that THP serves. As THP identifies topics and materials appropriate for foster families, it will post these on the website for easy access. THP will notify foster families about new or important changes to resources via the mechanisms mentioned in the previous paragraph. Any web-based resources can be made available in print form, as well.

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.

THP will partner with the West Virginia Home Visitation Program at the Bureau for Public Health (BPH) as a part of bridging services when families are being reunified. Programs such as Right From the Start and the Maternal Health Outreach Worker will be utilized by parents reunifying with infants. THP will link families with these services and encourage foster care agency case managers to participate in initial meetings to ensure a smooth transition. THP care navigators and foster care agency case managers will also assist families with accessing home-based Early Head Start services so that children have the resources needed to begin school successfully.

THP will outreach directly to families to encourage and aid with enrollment in the West Virginia Home Visitation program. THP's DHHR-based liaison will cultivate relationships with the program's administration and with its regional coordinators throughout the state to grow the reach of the program.

In addition to direct outreach, THP will engage with providers, caretakers, advocates and other stakeholders to educate on the value of the program and raise awareness of the resources available. THP's experienced staff have worked closely with the West Virginia Home Visitation Program for several years and understand how valuable it is to families. THP will continue to incorporate these services into its care management programs, encouraging and monitoring the use of such services.

- THP commits to training stakeholders on services available through BPH programs and the various topics that its programs can address, including:
 - Healthy pregnancy
 - Infant sleeping
 - Crying
 - Breastfeeding
 - Discipline strategies
 - Child development
 - Parenting support
- Information on programs shall be maintained and made available through THP's website and in printed reference materials distributed to families. Some of the programs to be highlighted on the website and in printed materials include:
 - Parents as Teachers
 - Birth to Three
 - Healthy Families America
 - Head Start Programs
 - Right From the Start

CS012 The Vendor should engage community-based child welfare organizations to help provide family-centered treatment that goes beyond traditional medical care.

THP will partner with all foster care providers, as well as other community-based child welfare partners, such as Right From the Start, CASA organizations and Mission West Virginia, to ensure services are wrapped around families. These organizations will be invited to participate in MDT meetings, as they are directly linked with families. This strong linkage promotes continuity of care. THP will strive to make foster families and biological families comfortable with these partners so they can access their resources once foster care/DHHR-involvement concludes.

THP actively participates in Family Resource Network (FRN) meetings throughout West Virginia. Through THP's involvement, it is able to identify opportunities for partnerships with community members and public/private organizations. FRNs facilitate easy identification of resources in local communities. THP's care navigators rely on FRNs to catalogue resources that meet many of the socioeconomic needs of our members.

CS013 The Vendor should provide initial (during implementation) and ongoing training for advocates and other stakeholders.

THP will work with DHHR to create training for all partners to ensure that everyone understands the implementation and ongoing process. During implementation and no less than annually thereafter, THP will offer community educational forums and invite local and state community partners to facilitate understanding of their roles and how they can become involved in helping West Virginia foster children. THP will also regularly update social media and its website to promote resources and information that partners can utilize.

THP shall provide direct outreach to new members, parents and caregivers when a child enters the foster care system (i.e., onboarding). The outreach process will involve early contact to make sure the child/caretakers are aware of:

- Key points of contact, including care navigators, foster care case workers, CPS workers, guardian(s) ad litem, educational resources/contacts, etc.
- How to obtain assistance
- Role of various contacts (e.g., MCO role, foster agency role, etc.)
- Materials that are available to members and what they will receive from THP (e.g., ID cards, benefit brochures and educational documents)

Educational documents providing an array of information will be made available and distributed through multiple means on at least a quarterly basis:

- Follow-up documents will be mailed after completion of initial outreach calls (or if not able to reach, in lieu of) to document information discussed during the call
- General foster care materials will be developed with input from various stakeholders to ensure consistent materials are available to all parties and are available for distribution through multiple channels:
 - Direct mail (upon request)
 - Web resources
 - Distribution by care navigators, foster care case workers, CPS workers, educators and others who may be involved (e.g., CASA volunteers, guardian(s) ad litem, etc.)
- Materials on relevant topics and based on professional evidence-based guidance (Relevant examples: trauma-informed care, adverse childhood experiences and Mental Health First Aid)
- Materials incorporating resources currently available from DHHR, provider resources, community resources, foster program resources, as well as materials that will be newly developed as needs are identified

Provider education will be part of THP's overall educational program and will consist of:

- Complete documentation of the foster care program in its provider manual with various aspects of THP resources defined and processes for providers to follow
- Ongoing outreach by THP Provider Relations Directors and Provider Engagement Representatives will take place in provider offices and via telephone to educate them on the facets of the foster care implementation; this is will also be reinforced during site surveys
 - Targeted engagement during the implementation phase (i.e., first 90 days of the contract) will facilitate identification of providers with special capabilities to meet the needs of foster children
- Web-based training materials and periodic updates for providers
- Provider newsletter updates along with provider manual resources
- As part of new provider onboarding, foster care will be addressed and additional training/education will be provided, if warranted

Specialized educational programming and materials will be developed for other stakeholders, including:

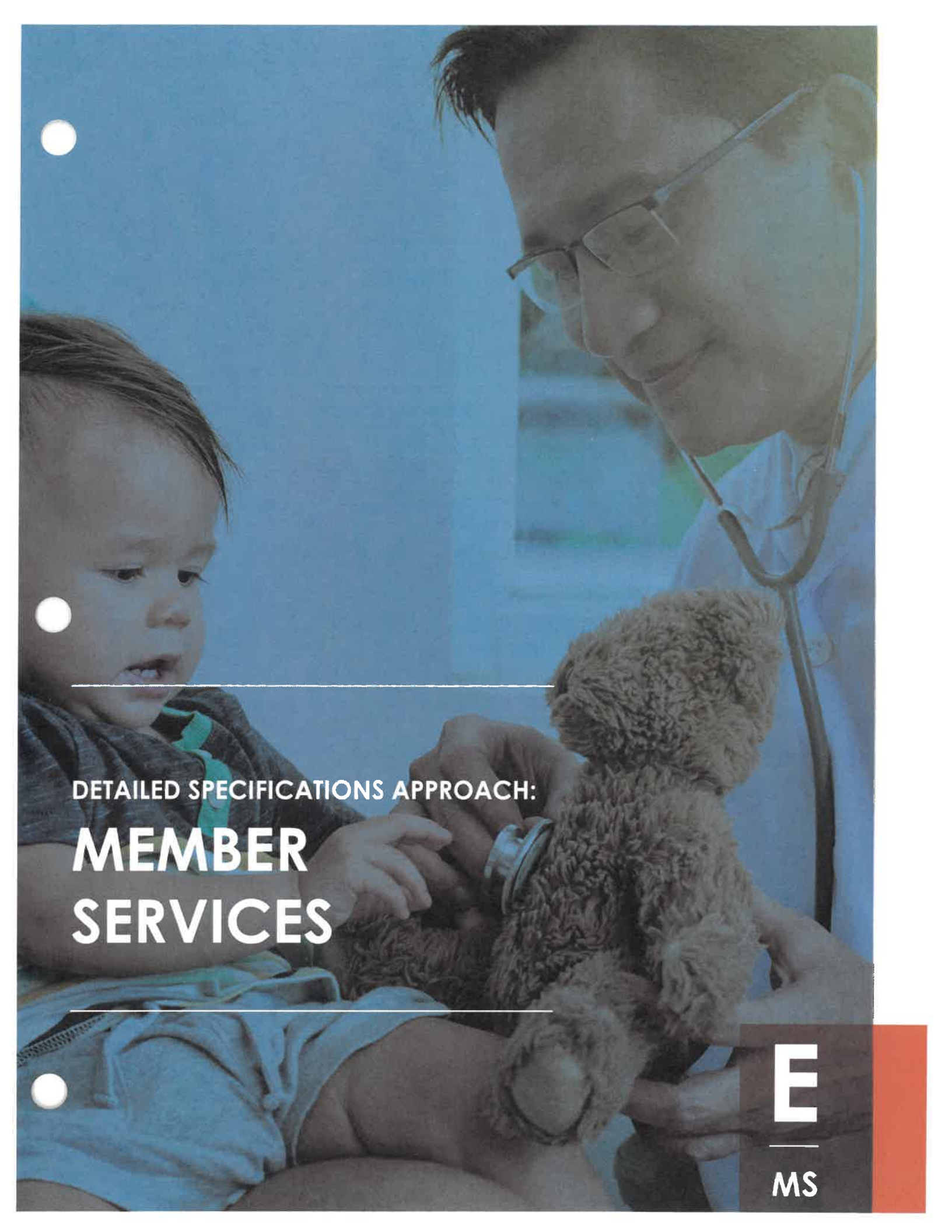
- CPS workers
- Judicial system/court representatives
- Educators
- Advocacy groups
- Foster care providers

CS014 The Vendor should coordinate with child placement agencies to ensure each agency has access to the most up-to-date records, as appropriate.

THP's COMET and HEART systems house all information related to member care and coordination of services. HEART is THP's system for utilization management, while COMET is used to document navigation and correspondence with providers and members. Frequently, THP obtains assessments, health records, immunization schedules, court documentation, guardianship papers and other information from outside entities. To navigate and coordinate services for THP members, a complete collection of the member's information is stored in a centralized location. THP's document repository in HEART is that centralized location, and it contains all medical and legal information related to the member. For child placement agencies to have timely information, THP's IT Department is developing a secure, limited access option for HEART. This would permit agencies to view applicable documentation. During care navigation, THP will obtain records from previous providers of members and upload that information into HEART.

In COMET, the landing page serves as the member's care summary. Similar to HEART, THP's IT Department will create a secure, limited access option for COMET so the child placement agency may access the system on demand. Included in the landing page are all active cases with the current care navigator listed. The status and level of care are also listed. Any review that has been completed is summarized on the landing page, with review documentation from providers and member correspondence noted. Reminders are listed as notes in the care plan for follow-up contact with the member, caregiver or provider. Assessments are available, as are gaps in care detail, and utilization history, which pulls from HEART when claims are processed.

When a child is removed from the home, the child placement agency will provide the assessment, court recommendations, guardianship papers, etc. to THP. This information will be housed in the document repository and will remain available, as permissible, in accordance with HIPAA and other state/federal regulation and for coordination of subsequent care that the member may require.

A photograph of a male doctor with glasses and a stethoscope around his neck, smiling as he examines a brown teddy bear. A young child is sitting next to the bear, looking at it. The scene is set in a clinical or hospital environment. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

MEMBER SERVICES

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Member Services

Within this section you will see how The Health Plan works with our members and their caregivers to ensure understanding of THP services which are offered, along with the member's rights and responsibilities. We demonstrate the internal processes which are in place to make certain members will receive any necessary services within the organization and assist with facilitating needed services with partners contracted through THP.

Our Member Services Department is located in our Charleston office. We also have a support team of Member Advocates, who provide outreach, which is located in our Wheeling Headquarters. Our supervising staff have over 25 years of Member Services experience. You will see that Members are given our contact information in various forms such as Welcome packets, member handbook, member newsletters and post cards so they have access to toll free phone numbers guaranteeing we are accessible to them. We routinely exceed industry call standards.

This section supports our dedication to our members and efficient processes already established for the most proficient implementation of new program to be offered such as the Foster Care initiative.

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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.

As soon as the THP is given the approval to proceed, it will execute an assertive plan to identify all Foster Care members for an immediate outreach and engagement. THP is committed to providing the most progressive service paradigm during this essential first step with members beginning with an initial process that will include an introduction, explanation and orientation to THP's member services. This orientation will allow members to ask questions and have a dialogue about THP's approach to services and the levels of services that will be provided based upon need. For example, each new member will receive a whole health wellness assessment includes elements of the individual health needs in the context of their individual characteristics and behavior, living environment and physical health. Given the circumstances of youth in foster care and especially those who may be vulnerable to entering foster care, THP realizes that the initial care plan must be fully aligned to incorporate physical health, behavioral health and socially necessary service needs from the onset of engagement.

During these initial interactions, THP will identify members with the greatest needs and construct a service plan that can be carried out immediately upon the implementation of the program. New members with identified special needs will be triaged to an assigned THP Navigator(s) to formulate a comprehensive service plan. This approach will allow THP to begin data gathering on the needs of new members that can be monitored throughout the members' relationship with THP.

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.

THP understands the power of social media and mobile friendly websites used by youth and young adults. THP will use these platforms as a resource for training, outreach and information that is easy to access. THP will also coordinate with the foster care provider case managers to provide this information as a resource during case management visits in the home of origin.

THP will provide direct culturally appropriate outreach/orientation to new enrollees, parents, and caregivers when a child enters the foster care system. . The outreach/orientation process will involve early contact to make sure the child/caretakers are aware of:

1. Key points of contact—THP Navigators, Foster Care case workers, CPS contacts, Guardian ad Litem, educational resources, etc.
2. How to obtain assistance
3. Role of various contacts—IE: THP role, Foster Provider Roles,
4. Materials that are available to them, what they will receive from us, etc. (ID cards, benefit brochures, educational documents, etc.)

Educational documents providing a wide array of information will be made available and distributed through multiple means, to include:

1. Follow-up documents will be mailed after completion of initial outreach/orientation calls (or if not able to reach in lieu of) to document information that was provided in the call.
2. General foster care materials will be developed with input from the various stakeholders to ensure consistent culturally competent materials are available to all parties as needed and are available for distribution through multiple avenues, including:
 - a. Direct mail upon request
 - b. Web resources
 - c. Distribution by case managers, case workers, CPS workers, educators and others who may be involved
3. Materials on a variety of topics and where appropriate based on professional evidence-based guidance.
4. Materials will incorporate resources currently available through DHHR, provider resources, community resources, foster program resources as well as materials that will be newly developed as needs when identified.
5. We will ensure that in addition to foster parents, children and caretakers, when applicable we also look to ensure the biological family is incorporated and programs are available to assist and train these individuals. In the past the biological family has not always been incorporated and it is important to try to ensure they are included even if they are separated from the child.

MS003	The Vendor should collaborate with community partners to help design materials that best meet the needs of the populations being served.
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THP will create a member services workgroup (to include youth, their families, foster care providers and other community partners) to assist with identifying the needs of the populations being served and assist in the design of materials to best meet the population's needs. THP can also access data from DHHR and the foster care providers that will support these needs.

In addition, the workgroup will collaborate with community resources through the Family Resource Network (FRN) and other groups to identify available resources and materials to address the needs of the populations being served. These resources will be made available through a variety of methods, as well as electronic and paper means. These resources will be captured regionally and modified into easy to use materials (handouts, website, etc.) that can be distributed by foster care provider case managers and THP Navigator(s) or through self-service on THPs website.

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MS004	The Vendor should leverage information technology (IT) solutions to improve access to information, including, but not limited to, the following:
MS005	Member health records (by the member, caregiver, and/or provider as appropriate)
MS006	Appeal processes
MS007	Other member rights and responsibilities

THP currently leverages multiple system resources and IT solutions to provide more efficient access to information. Our CORE systems are developed internally allowing the flexibility to enhance and collect data to meet the specific needs of the populations that we service. We have a robust structure which includes our internal mainframe system as well as web-based and mobile platform solutions.

THP will provide an innovative approach to centralization of the member health record using our electronic care navigation system known as COMET (The Health Plan Care Organization Management Evaluation Tool). Using the COMET platform, we have capabilities within the system to accept outside Medical Records, correspondence and other documentation which can be incorporated. THP will work with DHHR to incorporate information that is currently maintained in the states FACTS system and other DHHR systems. Through collaborative efforts with DHHR, providers, caregivers, parents, foster parents and other stakeholders, THP will be able to provide a centralized platform for all information pertaining to the foster child. Upon development of appropriate access protocols, this information can be made available to various stakeholders, including DHHR Case Workers. This will provide a unified and complete Medical Record for the Foster Child which can be centralized to provide access to care managers, case managers, providers and other appropriate individuals and entities.

THP uses its information system resources and IT solutions to ensure our members have resources and information readily available about all THP services. We use our information systems to maintain data on the number of grievances and appeals and makes their disposition available to our members upon request. In addition to written documentation provided with each denial letter and information in the member handbook, THP makes its member appeal process available to the member through the website and through the mobile application. The link appears on the main landing page for our Medicaid members under Member Resources so it can be easily located. THP will implement a similar process for the foster care population served. **A snapshot of our website's Member Overview is captured below:**



Member Overview

The Health Plan's practice guidelines and criteria for medical necessity are based on well-supported clinical evidence. These guidelines or criteria are reviewed and updated on a regular basis or when new scientific evidence is published. They are available to our members or potential members upon request. Based on these guidelines, The Health Plan makes decisions including:

- Utilization Management
- Enrollee Education
- Coverage Services
- Other Areas

In addition to the links to this information on our website, you can call our Customer Service Department at 1.888.613.8385 (TTY: 711) to request a printed copy or ask any questions or concerns. Our customer service representatives can also assist you with any of the following topics related to your coverage:

- Specialty care and other benefits, not provided by the PCP
- Mental health and non-emergency transportation are covered benefits available through Medicaid
- Benefits covered by The Health Plan
- How and where to access emergency care and post-stabilization services
- Providing benefit information in an alternative language or format due to special needs such as vision, read impairments, or language translation difficulties. Translation services are available at no cost for members.

Member Resources

Click on any of the links below to check out important information about your coverage through The Health Plan:

- [Medicaid Member Handbook](#)
- [ER Visit/Sick Child](#)
- [Well-Child Visits](#)
- [Medicaid Member Rights and Responsibilities](#)
- [Appeal Procedures](#)
- [Preventive Health Guidelines](#)
- [Supplemental Vision](#)
- [Newsletters](#)

Call our Customer Service Department at 1.888.613.8385 (TTY: 711) if you need a printed copy for any of these materials or if you have any questions.

Through our website, mobile applications and a range of technology solutions, THP will make available to Foster Care members information about their rights and responsibilities related to their healthcare in accordance with contract standards. Similar to our Medicaid member resources, THP will provide similar information links for the foster care population. This approach will also be used to ensure the rights and responsibilities for the Foster care population is available and can easily be located.

THP appreciates the variety of uses available through technology and will utilize these resources to ensure important information about foster care member rights and responsibilities is available.

MS008	The Vendor should distribute an Informational welcome packet to families impacted by the transition.
MS009	The Vendor should develop a community resource library, including, but not limited to, member handbooks, newsletters, and/or THP Navigator(s).

THP currently provides welcome packets to all newly enrolled members and will provide a similar welcome packet for the foster care population. Within the welcome packet, members receive a wide range of information, including how to obtain their member handbook electronically or paper copy, health risk assessment (HRA), preventative health guidelines and other related information. Enrollment ID cards are provided in a separate mailing.

THP will develop an informational welcome packet specifically for the Foster Care populations to be distributed upon enrollment into the plan consistent with our Medicaid membership process. In addition to standard welcome packet, the foster care welcome packet will provide additional detailed information regarding THP, services we will provide to the Foster

Child and his/her family and all of the players that will be involved in the members care. THP currently has a corporate website that houses pertinent information such as member handbook, newsletters, right and responsibilities and how to access services. For the Foster Care population, we will continue to expand our community resource library to include information pertinent to the population.

Member Overview

The Health Plan's practice guidelines and criteria for medical necessity are based on well-supported clinical evidence. These guidelines or criteria are reviewed and updated on a regular basis or when new scientific evidence is published. They are available to our members or potential members upon request. Based on these guidelines, The Health Plan makes decisions including:

- Utilization Management
- Enrollee Education
- Coverage Services
- Other Areas

In addition to the links to this information on our website, you can call our Customer Service Department at 1.888.613.8385 (TTY: 711) to request a printed copy or ask any questions or concerns. Our customer service representatives can also assist you with any of the following topics related to your coverage:

- Specialty care and other benefits, not provided by the PCP
- Mental health and non-emergency transportation are covered benefits available through Medicaid
- Benefits covered by The Health Plan
- How and where to access emergency care and post-stabilization services
- Providing benefit information in an alternative language or format due to special needs such as vision, read impairments, or language translation difficulties. Translation services are available at no cost for members.

Member Resources

Click on any of the links below to check out important information about your coverage through The Health Plan:

- [Medicaid Member Handbook](#)
- [ER Visit/Sick Child](#)
- [Well-Child Visits](#)
- [Medicaid Member Rights and Responsibilities](#)
- [Appeal Procedures](#)
- [Preventive Health Guidelines](#)
- [Superior Vision](#)
- [Newsletters](#)

Call our Customer Service Department at 1.888.613.8385 (TTY: 711) if you need a printed copy for any of these materials or if you have any questions.

MS010

The Vendor should facilitate connecting members to community resources and social services.

THP will work with the local and regional Family Resource Networks (FRNs) to ensure the resources are available to members. This information can then be shared via the THP website and handouts created by the Foster Care Member Services Workgroup.

Our outreach teams enable us to be engaged in each and every community with first-hand knowledge of resources available and resources needed. Located in various regions throughout the state, our Engagement staff are involved with the local FRNs and other resources and provide the organization with vast knowledge on services and supports available in each of the communities. Further, our team of Navigators have been working in the state for many years. They maintain a directory in COMET of resources in each community for use by our navigators and advocates who assist members with needed services and support.

THP will also act as a resource to various stakeholders to identify solutions that have been effectively implemented in other regions of the state and where possible provide assistance and support to develop those resources. Through our partnerships with provider entities, we are able to leverage support for various programs. For several years, THP has been a strategic

partner with two camps in WV meeting the needs of children with Chronic Conditions such as Asthma and Diabetes: Kamp Kno Koma and Camp Catch Your Breath.

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.

Similar to the materials developed for our Medicaid members, THP will develop materials specific to the needs of foster care, including but not limited to, members with special healthcare needs, in accordance with federal and state marketing regulations. THP complies with Section 504 of the Rehabilitation Act of 1973 and the relevant provisions of Section 1557 of the Affordable Care Act. THP complies with all federal and state laws relating to non-discrimination in accordance with the requirements for managed care organizations by the state of West Virginia Department of Health and Human Resources Bureau for Medical Services. Currently, THP has third-party vendors that can translate materials for members, free of charge, into a variety of languages, provide Braille materials, provide materials on audio CDs and provide large print when requested.

MS012 The Vendor should consult with persons with disabilities and advocacy groups while developing materials for members with social healthcare needs.

As indicated in the prior response, THP has third-party vendors that can translate materials for members, free of charge, into a variety of languages, provide Braille materials, provide materials on audio CDs and provide large print when requested. THP is also connected through its community involvement with various agencies and organizations that support individuals with disabilities. THP works with these entities and advocacy groups when developing materials for members with disabilities. One such example is The Seeing Hand Association who has assisted THP in the Wheeling area in ways to create materials to assist our hearing-impaired populations. We also consult with local specialists at colleges and universities.

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).

Managed care plans require members to utilize a designated practitioner network, therefore, THP ensures an adequate number and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet member needs. On an annual basis, we monitor practitioner availability against established standards, and initiate actions as needed to improve practitioner availability. Below, is a description of the monitoring methodology, results, analysis, and action conducted to assign members to a PCP.

On an annual basis, to determine whether the current provider network is meeting the cultural, ethnic and linguistic needs and preferences of our members, The Health Plan analyzes

statistical data regarding the needs and preferences of our members. For this effort, THP reviews the most recent Consumer Assessment of Healthcare Provider & Systems (CAHPS) survey.

THP also monitors the patient panel size of all PCPs. THP will not assign members to a physician with a panel size greater than 2,000 members. All of this ensures an adequate network for THP members.

THP, as an MCO, requires members to use a designated PCP. The THP preference is to obtain the PCP selection from the member. This is achieved during the enrollment process with the enrollment broker; however, some members do not have an established PCP and therefore are unable or unwilling to make a selection. In this case, THP will review member proximity and claims information to determine any previous activity that could identify a PCP. If there is information of a previously selected or assigned PCP, THP will default to that PCP, if appropriate otherwise, THP will make an automated assignment to an available PCP located near the member.

MS014 The Vendor should notify members in applicable populations of primary care provider (PCP) assignment.

Within 5 days of enrollment with THP, members receive their ID Cards listing their assigned Primary Care Physician. THP currently receives the PCP information from the enrollment broker within the enrollment file. If a member does not select a PCP, THP will assign a PCP based upon the member's location, claims history or prior PCP history where appropriate. If the member does not agree with the PCP that was assigned, the member can contact our customer service department and request to change. During the new member outreach call, the THP advocate informs the member of his/her PCP selection and advises the member on the process to change their PCP.

MS015 The Vendor should educate members in applicable populations of the right to change primary care providers (PCPs).

If the member does not agree with the PCP that was assigned, the member can contact our customer service department and request to change. New enrollees are informed in their welcome letter as well as through follow-up by Member Advocates during the welcome call of their option to change their assigned PCP at any time.

MS016 The Vendor should conduct follow-up communications to ensure members in applicable populations are aware of the primary care provider (PCP) assignment.

As with THP's Medicaid services, shortly following enrollment, THP Member Advocates will attempt to welcome, via telephone, new foster care enrollees to educate them about THP's policies and procedures. Data of all newly enrolled members will be abstracted from the monthly enrollment file for attempted outreach. Member Advocates will contact new

members via telephone to explain the contents of the welcome packet sent via mail upon enrollment. The welcome packet will contain preventive guidelines and the health risk assessment (HRA) as well as information on how to contact THP. Similar to THP Medicaid services, new foster care enrollees will receive a welcome call. Member Advocates will verify the PCP record and educate the new enrollee on the ability to change their PCP at any time. Additional education provided during the welcome call will include an explanation of THP member benefits, as well as carved out benefits. Other topics discussed during this contact will include:

- How to make appointments and utilize services
 - Importance of establishing w/PCP
 - Importance of obtaining a yearly physical
- Services available in the EPSDT program, where and how to obtain those services for members under age 21
- Non-emergency transportation assistance
- What to do in an emergency or urgent medical situation and how to utilize services in other circumstances
- How to file an appeal or grievance
- Members' rights and responsibilities
- Smoking and medical problems/concerns
- Advanced directives (copy to family/friend and in the provider's medical record)
- Oral interpretation services are available and written information is available in alternate formats if needed
- How to obtain a member handbook
 - Via web
 - Request from THP
- Family Planning service

An initial contact is made during the month of enrollment. Member Advocate assignments are generated from a database loaded into a welcome queue of appropriate members newly enrolled.

MS017	The Vendor should conduct outreach and transition planning efforts directed toward members with special healthcare needs.
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As with our Medicaid services, The Health Risk Assessment for new foster care enrollees will include screenings for functional and social risk factors. If a member has certain medical conditions, the appropriate electronic assessment is completed:

- If a member is found to be pregnant during the completion of the HRA, a prenatal assessment is completed.
- If a member has diabetes, asthma or children with special health care needs, an electronic notification is generated from the HRA and sent to disease management.

- If the PCP is changed or an OB/GYN is added, that information is changed in the operating system. If coordination of benefit (COB) information is obtained, THP staff will forward to the COB. .

All contacts and attempted contacts are documented in the THP system by completing a Welcome Completed or Welcome Attempted Note.

As information from the assessments and conversations with the member are evaluated, any member with current care needs is referred to THP Navigator(s) for assistance with care transition needs. This can include simple items such as questions regarding an upcoming appointment with a provider to complex issues such as a planned surgical procedure or a current admission to a hospital. THP Navigator(s) can assist the member to ensure they are getting their care needs met and assist them with any necessary transitions in care.

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:
MS019	Updates to the member handbook
MS020	Handbooks requested ad hoc by a member

THP Member handbooks are reviewed and updated on an ongoing basis. As with our Medicaid services, THP will make the Foster Care Member Handbook available to enrollees in hard-copy or electronic form. New enrollees will be advised that the information will be available on the internet as well as how they may request the document in paper form. Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. As with our Medicaid services, THP may provide periodic updates to the enrollee handbook as needed explaining changes to THP policies or the Foster Care Program. In addition, when there are program or service site changes, notification will be provided to the affected enrollees at least fourteen (14) calendar days before intended effective date of the change. THP will maintain documentation verifying that the member handbook is reviewed at least once a year. THP will notify enrollees that an updated member handbook is available at least annually after initial enrollment. We will publish and keep current the foster care program member handbook on the THP website and provide a member handbook to enrollees within five (5) business days upon request.

MS021	The Vendor should provide enabling services - including, but not limited to, assistance with complaints and grievances--to members with physical or developmental disabilities.
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THP provides enabling services to our members through our customer services and outreach team. As with our Medicaid services, THP will provide similar enabling services to foster care enrollees. If the needs become clinical, the member will be handed off to a clinician for handling. We believe our focus in this area leads to positive impacts on improved health outcomes, cost, access and member satisfaction.

Similar to our Medicaid services, our member service and outreach team will help identify specific needs of our foster care populations through their engagement with the member and often initiate an action to provide assistance needed by the member. Health education needs will be identified using data collected from their Health Risk Assessment and used to initiate health education and encouragement for the member.

We will provide language access and interpretation services for foster care members through a vended service, but the call will always be managed end to end by a THP member services team.

Our Foster Care Member Handbook will include detailed instructions for filing complaints and grievances but will also allow the member to call our customer services team and engage assistance in how to file a complaint, grievance, or appeal. THP's customer services team will complete any required documents for the member's signature and guide them through the process.

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.

THP's Contract Liaison is responsible for the oversight of all grievances including those related to services of all subcontractors. The Contract Liaison reviews the monthly reports pertaining to grievances and evaluates any grievances related to enabling services for members with disabilities. If based upon review there are issues, corrective actions are taken immediately to ensure the plan is taking appropriate steps to support the members including auxiliary aids and services upon request including, but not limited to, the provision of interpreter/translator services, toll-free numbers that have adequate TTY/TTD capabilities, and interpreter capability in accordance with contractual guidelines.

Each subcontractor is required to submit monthly reports outlining their appeals/grievances based upon the contractual guidelines provided. In addition, THP assists and requires subcontractors to render assistance at all stages of the grievance process, including auxiliary aids and services upon request including, but not limited to, the provision of interpreter/translator services, toll-free numbers that have adequate TTY/TTD capabilities, and interpreter capability in accordance with contractual guidelines.

MS023

The Vendor should provide methods for members to contact the member services department, including, but not limited to, the following:

MS024

An emergency hotline

MS025

A toll-free number

Consistent with our Medicaid services, THP will provide methods for foster care enrollees to contact the customer services department, including, but not limited to providing an

emergency hotline and toll-free number published in the member handbook, on the THP website member resource section and through the use of other technology solutions. Our call center staff will be operational at least eight (8) hours per day, Monday-Friday. At any time during the call the call needs to be escalated to management or another department, our staff has been trained on the appropriate way to transfer calls. All calls are documented into our customer service application to ensure accuracy and completeness of the call.

As with THP's Medicaid services, the foster care handbook will include a "contact us" section with instructions to call customer service toll-free anytime a member has questions about health plan benefits, services of a health problem.

THP's Foster Care Member Handbook's "contact us" section will include:

- Customer Services Department's hours of operation
- Address
- Toll-free Telephone Number
- TTY Contact Information for hearing impaired
- Website address for THP's Foster Care Program
- Instructions on ways to obtain additional services like:
 - Ask questions about services and benefits, eligibility, claims, prior authorization requests, or utilization management
 - Change your PCP or get help choosing a provider
 - File a complaint
 - Replace a lost member ID card
 - Get help with authorizations
 - To ask about any change that might affect their benefits
 - Changes in personal information
 - Request interpreter services or help for people with disabilities.

The member handbook will also provide instructions on what to do if you do not understand or speak English. For people with disabilities, it will provide instruction on ways THP can assist members to communicate effectively with their provider, including sign language interpreter services and a TTY phone number.

THP's Foster Care Member Handbook and all written materials, including provider directories, appeal and grievances notifications, and denial notifications will be provided in many formats, like large print, CD, audiotape for listening to plan benefits, or braille at no cost to the member, by simply contacting Customer Services toll-free and ask for another format.

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MS026 The Vendor should transfer calls between the member services department and subcontractors for review, if applicable.

THP's customer service representatives are trained to first try to handle a member's call without transferring the call. All member communication is documented in the member record. If a transfer is necessary, the member service representative will transfer the call. Based upon the contractual requirements with our subcontractors, our customer service staff will warm transfer any applicable call to the subcontractor's customer service department.

MS027 The Vendor should educate members about the ability to request out-of-network authorizations.

THP's member handbook includes information intended to educate members about out-of-network services. As with our Medicaid services, our Foster Care Member Handbook will include a section on "Out-of-Network Services" that provide instructions to members, to allow out-of-network services if we are unable to provide certain covered services. The cost will be no greater than it would be if the member received the service within the THP network and the service will be provided in an acceptable and timely manner.

In addition, during the new member welcome calls, Members Advocates will educate new enrollees on their ability to obtain an out-of-network referral and how to request this from their PCP.

MS028 The Vendor should educate member services representatives on the out-of-network referral process.

THP provides comprehensive training to Customer Service Representatives to prepare them for assisting members related to THP's out-of-network referral process.

Member Service Representatives are trained on THP's policy regarding the out-of-network process. For example, are trained to work with the members and their PCP to obtain out-of-network services when the needed service is not available within THP's network and the member wishes to continue to receive other services with THP.

During our new hire orientation with our customer service staff, they are educated and trained on the member handbook and requirements. Our customer service staff understands the guidelines around out-of-network services and if questioned from one of our members, they are able to respond appropriately.

Our customer service staff also direct our members to their member handbook which describes how they can access out-of-network services. In addition to customer service staff understanding the out-of-network process, our member engagement team is also trained on how to respond to these questions from our members during our new member orientation calls.

MS029	The Vendor should train member services representatives on topics including, but not limited to, the following:
MS030	Serving members with disabilities and chronic conditions
MS031	The culture of disability
MS032	Resources available to members

THP's Training Program is a comprehensive hands-on program administered in a class room technology-equipped setting. All customer service and claims analyst are required to complete a four-week program. Our customer service representatives have an additional two weeks in the class room related to customer service functions. Below is a brief overview of our training structure:

- Training begins with an overview of THP and any system applications shared by all employees.
- Training covers the various types of products we administer with an overview of the needs of the members we serve.
- Training includes modules for providing services to people with disabilities including hearing impaired, speech and visual disabilities, cognitive, intellectual or psychiatric and physical disabilities. Training also includes the variety of formats for materials & technologies used to serve members with disabilities or chronic conditions and vendor partnerships, that assist members with disabilities.
- Training on Cultural competence and cultural awareness.
- Training may also involve "shadowing" or observation of co-workers' performance.
- Trainees are required to complete classroom exercises and manual worksheets on all training material to assure they understand how the system applications work.
- Testing is completed on all subjects trained.
- A review of each trainee is sent to their Supervisor, Manager, and Director each week to keep managers informed of progress and needs.
- A weekly survey is distributed to the trainees to return anonymously to submit feedback regarding their trainer and the training content.

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.
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Nurses and member advocates are educated, during their Orientation. Set criteria t in our Case Management, Behavioral Health, and Disease Management Programs. Education is also provided on enrollment criteria for CSHCN, Birth to 3, and WIC. Scheduled In-services are

planned to facilitate engagement with other community resources (i.e. ACS, CCIL, WIC, Birth to 3, Encompass Rehab Programs, MedData/Disability Outreach).

On a biannual basis, employees will have the opportunity to further their education during lunch and learn sessions. Additional focused training is provided for the Medical Management, Provider Relations, Member, and Outreach staff that covers disease state prevalence and health disparities and barriers to access. They receive comprehensive as well as intensive training on a wide variety of subjects.

THP through its partnership with WVU Medicine and other providers is able to provide specialized education on specific topics related to the effective care and management of members with specialized healthcare needs. This assists our navigators, by giving them the ability to present any difficult Case Management challenges for intervention and ongoing collaboration

Staff is provided information, regularly, for educational Webinars and Continuing education, as it pertains to their patient populations.

THP staff are educated on The Children with Special Healthcare Needs (CSHCN) Program and the services available to members through this program including care coordination and access to specialty services through a system of community-based care coordinators and specialty clinics, thus enabling children and youth with special healthcare needs to receive a patient/family-centered medical home approach to comprehensive, coordinated services and supports

Information on THP staff training is tracked and logged. Required training is monitored to ensure staff received all required training along with updates.

MS034

The Vendor should use and report to the Department on customer service performance standards, including, but not limited to, the following:

Our customer service application provides the tools necessary to manage our call center representatives and statistical performance on an hour by hour basis if needed. All calls are recorded, and live calls are silent monitored for quality assurance and training purposes. All call center reporting can be scheduled and is also available upon demand. Reports are generated daily and monthly and reviewed by the responsible managers who address any issues meeting required performance standards.

MS035

Member-to-representative ratios

THP's average member to representative ratios are 7000:1. However because we expect the level of complexity to be higher on this membership, our member to representative ratios for the Foster Care Program will be 6000:1. This is reviewed with our monthly reporting to ensure staffing levels are consistent and appropriate and we are meeting required performance standards.

MS036

Call answering time, with a minimum of 83% of calls answered in 30 seconds

Reports are provided monthly on all answer time. This is reviewed with the customer service team in the event call standards are not obtained. We have consistently demonstrated the ability to meet this requirement. Our year to date average call answer time for 2019 is 85.49% for WV Medicaid member and provider calls.

MS037

Call abandonment rate not to exceed five percent (5%)

The Health Plan monitors all abandonment rates daily and reports this on a monthly basis. All of our call centers currently achieve a monthly abandonment rate of less than 5%. Our year to date average abandonment rate for 2019 is 1.32% for WV Medicaid member and provider calls.

MS038

Single contact resolution

We measure first call resolution through our customer service application. Our average percent of calls resolved on first contact for the 2019 year to date has been 84.3% for member and provider calls.

MS039

Turnaround time for member requests

THP strives for first call resolution. For those calls that require additional review, skill set, or level of care we have a 48-hour response time.

MS040

The Vendor should use warm transfer protocols for its member services and other applicable departments.

Our customer service representatives are trained to handle most calls without transferring them. We currently attempt to help the member if we can by engaging in a 3-way call. If that is not possible, then we will attempt a warm transfer when handing the member off to other departments.

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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:
MS042	Member contact, including, but not limited to, welcome calls, welcome letters, and/or home visits
MS043	Outreach to members who are difficult to contact, including, but not limited to, disabled members and members without telephones
MS044	Processing and issuing identification cards
MS045	Distributing member handbooks

Currently with our Medicaid membership, enrollment is received on a monthly basis from the fiscal agent. The applicable members are loaded into our system which creates their identification cards. In addition to their ID cards, members receive a separate mailing which includes their welcome packet, HRA, preventative guidelines and other pertinent documents. Welcome packets explain to members how to present their card to providers along with various THP departmental toll-free phone numbers, any prescription coverage contacts and State benefit coverage contacts. All newly enrolled members are loaded into our welcome call queue and our member advocates initiates their new member orientation calls. Advocates attempt to contact new enrollees typically within 30 days (max 90 as per WV contract) to complete their Health Risk Assessment, if it has not been returned by mail. Members who do not have a phone number listed in the enrollment file are sent postcards with the member advocates toll free phone number to contact to ensure the new member education is complete.

When an Advocate connects a member, their information is verified for accuracy in our system and the member verifies that the correct information is on their ID card and the PCP listed on their card is correct. Any information that is incorrect is corrected on the system and new ID cards are issued. Education is given to the member about the handbook location on our website or a hard copy is mailed, if requested. Members are given information on the appropriate use of the ER, how to obtain a referral, their relationship with their PCP, transportation for non-emergent care, how to see a specialist, what services are covered by using their THP ID card including the importance of keeping appointments and getting immunized. The advocate will log the call on the system and will include any information that the member may have provided regarding communication preferences, disabilities or special needs. This information is maintained in the computer system so that other staff can be aware of any special communication needs.

JHP will provide outreach to members who are difficult to contact including disabled members, and members without telephones. We mail all new members a new member welcome packet within 5 days of enrollment. Members also receive a letter included with their ID card with educational materials explaining how managed care works and describes services available to them. Upon request, THP can provide language interpretation, large print or other accommodations that may be reasonably necessary to assist disabled members.

MS046 The Vendor should distribute to members preferred drug list (POL) and formulary changes affecting members' care.

Pharmacy Services including formulary development and management, preauthorization, drug utilization review and specialty pharmacy management is one of the pillars of THP's core competencies. THP has the ability to distribute PDL formulary changes to member's showing on disruption reporting. This can be done in print or through general announcements on the secure member portal. THP is also able to post a copy of the PDL to the sponsor's public website. If requested, THP can mail the PDL to members.

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.

THP already has a strong relationship with WV Health Information Network (WVHIN) and would work with WVHIN on an implementation plan to incorporate electronic health record information into a centralized record system for foster children. THP through its COMET system will be able to provide a structure to house much of the required information within THP and could facilitate access to needed stakeholders based on appropriate security and privacy standards. While THP is currently in the early phases of implementation with WVHIN, we do believe that working with the state Health Exchange as a conduit for sharing information on the Foster Population would provide an efficient means of ensuring providers within the have access to needed health 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 Health Plan's secure multi-purpose website is designed to provide members, providers and brokers/clients with a platform that is customized to meet their needs. We tailor clients' MyPlan platform to meet the needs of the population making sure the content and resources are available and suited. The Health Plan's custom core systems are all developed and maintained in-house. Our team of programmers, web developers and network analysts continually enhance our systems to create an optimal end-user experience. The Health Plan earned a Security SSL grade of "A" in an annual external penetration test of all THP websites. This designation shows our commitment to the safety and security of each member's benefits and protected health information. We also strive to ensure our websites are Section 508 and West Virginia Medicaid compliant.

Our Medicaid Customer Service team works closely with our developers to identify resources that best meet the needs of our members. Materials are made available through both website and mobile applications allowing for each access to materials.

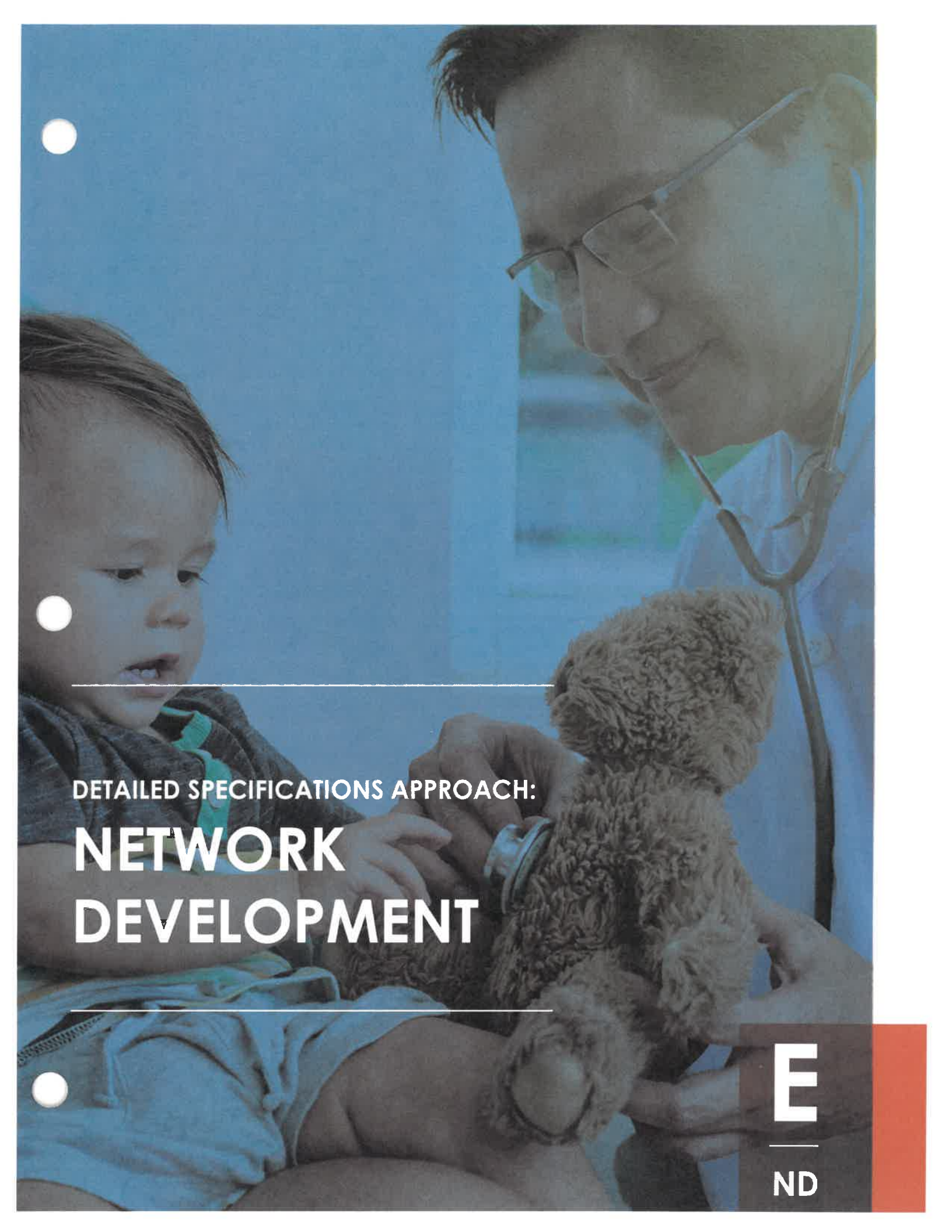
MS049	The Vendor should provide a secure member portal that allow members to log in and access benefit information, including, but not limited to, the following:
MS050	Medical records
MS051	Authorization status

The Health Plan offers a secure online portal for members where they can access their claims, benefit information, plan coverage, explanation of benefits, and CoreWellness. CoreWellness is our online wellness program where our members can take a health risk assessment and participate in wellness activities and obtain wellness information.

Members can also:

- Search explanation of benefits (EOB).
- View current enrollment status, coverage type, coverage start date and PCP information.
- Access their deductible amounts and copays.
- Access information on family members covered under the plan as permitted by HIPAA
- Find a provider or change a PCP
- Download their ID card.
- View other coverage information, such as vision or dental.
- View information on authorizations
- Complete health risk assessments and provide health status information which is incorporated into THP COMET systems for integration with other Medical record information

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A photograph of a male doctor with glasses and a stethoscope around his neck, smiling as he examines a child's brown teddy bear. The child is sitting and looking towards the bear. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

NETWORK DEVELOPMENT

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Network Development

Meeting the needs of Foster children takes a group of very dedicated folks with a variety of expertise to include, internally at THP and certainly externally beginning with BMS, the various agencies, and the providers who have cared for these children over the years. Being West Virginians, folks at The Health Plan understand the culture, the rural nature of the state and the geographical challenges it can present. They also know most of the providers who care for these children. The Health Plan is absolutely committed to doing everything possible to support all members. Networks plays an important role in making sure the right providers are available. This section will discuss The Health Plan's current network, how gaps are recognized and how deficiencies are addressed. Network's emphasis is on the continued monitoring, maintenance and development of a network that supports the needs of current Medicaid members and, with focused dedication, will make sure the providers are available to support the healthcare needs of children in Foster Care.

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.
ND002	The Vendor should establish a statewide provider network that is accessible to children and their caregiver(s).
ND003	The Vendor should establish a statewide provider network that incorporates evidence-based best practices and interventions.
ND004	The Vendor should establish a statewide provider network that provides for continuous communication with stakeholders.
ND005	The Vendor should establish a statewide provider network that has capacity in rural areas.
ND006	The Vendor should establish a statewide provider network that has capacity across specialty lines of physical health and behavioral health.

Based upon the data provided in the RFP, THP was able to complete a network analysis of our current provider network against the most recent Foster Care membership provided. This analysis can be found in Appendix 6.

THP maintains a Provider Network sufficient to provide timely access to the full range of Covered Services to Enrollees including physical, behavioral, and other specialty services and all other services required under this Contract. As such, THP has contracts with all West Virginia-based hospitals, skilled nursing facilities, behavioral health centers, and most practitioners. THP's Provider Network is comprised of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of this Contract. Moreover, as an existing West Virginia Medicaid managed care organization and Medicare Advantage plan, THP complies with all Bureau for Medical Services and Centers for Medicare and Medicaid Services network adequacy and comprehensiveness requirements, and it routinely reviews its network to identify potential gaps or shortage areas.

THP has extensive experience offering Medicaid coverage to West Virginians. The Medicaid population has a number of healthcare needs coupled with social service needs. Accordingly, THP has been able to develop networks sensitive to the needs of this population. With the rural nature of THP's programs in most communities, we have been able to secure contracts with nearly all of the specialty physicians within the communities to ensure adequate coverage for members. The tables below describe the THP Provider Network:

ALL THP WEST VIRGINIA PROVIDERS (6,319)

PROVIDER SPECIALTY	COUNT	PROVIDER SPECIALTY	COUNT
ADDICTIONOLOGY	7	OPTOMETRY	183
ADOLESCENT MEDICINE	4	ORAL SURGERY	17
ALLERGY	46	ORTHOPEDICS	291
AMBULANCE TRANSPORT	24	PALLIATIVE MEDICINE	14
AMBULATORY SURGERY CENTER	3	PED CARDIOTHORACIC SURGERY	1
ANESTHESIA PAIN MANAGEMENT	92	PEDIATRIC CARDIOLOGY	51
AUDIOLOGY	72	PEDIATRIC CRITICAL CARE	7
AUTISM TREATMENT PROVIDER	3	PEDIATRIC ENDOCRINOLOGY	10
CHILD PYSCHIATRY	6	PEDIATRIC GASTROENTEROLOGY	7
CHIROPRACTOR	138	PEDIATRIC GYNECOLOGY	1
COLON & RECTAL SURGERY	6	PEDIATRIC HEMATOLOGY/ONCOLOGY	11
COUNSELOR THERAPIST	599	PEDIATRIC INFECTIOUS DISEASE	4
CRITICAL CARE	13	PEDIATRIC NEPHROLOGY	4
DENTIST	6	PEDIATRIC NEUROLOGY	21
DERMATOLOGY	159	PEDIATRIC OPHTHALMOLOGY	2
DEVELOPMENTAL PEDIATRICS	1	PEDIATRIC PULMONARY	16
EAR NOSE AND THROAT	4	PEDIATRIC SURGERY	11
EAR NOSE AND THROAT	135	PEDIATRICS	4
ELECTROPHYSIOLOGY	2	PHYSIATRY	36
FAMILY PRACTICE	92	PHYSICAL THERAPY	174
GENERAL INTERNAL MEDICINE	58	PLASTIC/RECONSTRUCTIVE SURGERY	51
GENERAL PRACTICE	28	PODIATRY	116
GENETIC	10	PREVENTATIVE MEDICINE	1
GERIATRIC MEDICINE	2	PROSTHETIC/ORTHOTIC SERVICES	51
GYNECOLOGY/ONCOLOGY	18	PSYCHIATRY	385
HEALTH DEPARTMENT	56	PSYCHOLOGY	309
HEMATOLOGY	1	PULMONARY	167
INTERNAL MED/CARDIOLOGY	478	RADIOLOGIC ONCOLOGY	39
INTERNAL MED/ENDOCRINOLOGY	59	REGISTERED DIETITIAN	1
INTERNAL MED/GASTROENTEROLGY	121	REHABILITATION FACILITY	2
INTERNAL MED/INFECTIOUS DIS	41	REPRODUCTIVE ENDOCRINOLOGY	2
INTERNAL MED/NEPHROLOGY	148	RHEUMATOLOGY	39
INTERNAL MED/ONCOLOGY	140	RIGHT FROM THE START	14
INTERVENTIONAL CARDIOLOGY	24	RURAL HEALTH CLINIC	2
INTERVENTIONAL RADIOLOGY	12	SPEECH THERAPY/PATHOLOGY	18
MENTAL HEALTH FACILITY	129	SPORTS MEDICINE	17

PROVIDER SPECIALTY	COUNT	PROVIDER SPECIALTY	COUNT
NEONATOLOGY	38	SURGERY	304
NEUROLOGY	150	SURGICAL ONCOLOGY	4
NEUROPSYCH TESTING	4	THORACIC/CARDIOVASCULAR SURG	86
NEUROSURGERY	101	URGENT CARE	41
OBSTETRICS/GYNECOLOGY	415	UROLOGY	113
OPHTHALMOLOGY	187	VASCULAR SURGERY	60

PRIMARY CARE PROVIDERS BY COUNTY

COUNTY	FAMILY PRACTICE	GENERAL INTERNAL MEDICINE	GENERAL MEDICINE	GENERAL PRACTICE	PEDIATRICS	TOTAL
BARBOUR	26	0	0	0	0	26
BERKELEY	56	19	0	0	21	96
BOONE	33	13	0	1	5	52
BRAXTON	30	2	0	0	0	32
BROOKE	7	15	0	1	3	26
CABELL	207	56	0	5	52	320
CALHOUN	4	11	0	1	1	17
CLAY	28	0	0	0	0	28
DODDRIDGE	3	2	0	1	0	6
FAYETTE	54	7	0	0	5	66
GILMER	4	3	0	0	1	8
GRANT	10	8	0	0	3	21
GREENBRIER	86	8	0	0	9	103
HAMPSHIRE	20	3	0	0	1	24
HANCOCK	26	14	0	0	12	52
HARDY	31	1	0	2	2	36
HARRISON	101	10	0	5	20	136
JACKSON	60	8	0	7	3	78
JEFFERSON	38	12	0	0	10	60
KANAWHA	268	113	0	2	54	437
LEWIS	44	6	0	0	1	51
LINCOLN	85	9	0	0	5	99
LOGAN	89	10	0	2	7	108
MARION	49	21	0	2	28	100
MARSHALL	12	12	0	5	3	32
MASON	15	12	0	1	2	30
MCDOWELL	24	4	0	15	1	44
MERCER	74	8	0	1	5	88
MINERAL	14	13	0	1	1	29
MINGO	55	3	0	0	3	61
MONONGALIA	179	115	1	0	103	398
MONROE	12	0	0	0	0	12
MORGAN	11	6	0	0	1	18

COUNTY	FAMILY PRACTICE	GENERAL INTERNAL MEDICINE	GENERAL MEDICINE	GENERAL PRACTICE	PEDIATRICS	TOTAL
NICHOLAS	56	2	0	0	12	70
OHIO	48	10	0	5	22	85
PENDLETON	19	0	0	0	5	24
PLEASANTS	10	1	0	0	0	11
POCAHONTAS	22	1	0	0	0	23
PRESTON	58	8	0	0	5	71
PUTNAM	85	17	0	1	28	131
RALEIGH	54	32	0	3	16	105
RANDOLPH	52	6	0	1	4	63
RITCHIE	3	2	0	1	0	6
ROANE	35	2	0	0	1	38
SUMMERS	7	4	0	0	0	11
TAYLOR	23	1	0	1	1	26
TUCKER	13	1	0	0	0	14
TYLER	10	0	0	0	0	10
UPSHUR	51	8	0	0	5	64
WAYNE	34	2	0	0	1	37
WEBSTER	36	6	0	0	2	44
WETZEL	15	3	0	5	1	24
WIRT	13	0	0	1	2	16
WOOD	66	29	0	3	16	114
WYOMING	29	0	0	4	1	34
	2494	659	1	77	484	3715

THP will ensure Covered Services are reasonably accessible to Enrollees in terms of location and hours of operation. We will have available non-emergent after-hours physician or primary care services within its network when medically necessary. There will be sufficient personnel for the provision of Covered Services, including emergency medical care on a 24-hour-a-day, seven-days-a-week basis.

- THP will conduct on-going network analyses using geo mapping and other resources to ensure adequate access to care and services. We monitor provider changes monthly to isolate situations where providers have left the area, changed locations, eliminated or added services, etc.
 - With a significant staffing advantage in provider engagement representatives among the state's extant MCOs, THP is well-positioned to know when provider changes occur before other insurers.
- THP values its level of provider engagement and being provider-focused. The Provider Engagement Department facilitates the flow of information and timely addresses the concerns and needs of the Provider community. This is rare in an era of insurer

centralization and automation of provider engagement. THP is investing and growing its staff resources in this regard.

- THP's Provider-to-Representative ratio is low (14,000 / by number of Provider Representatives = 1,076 per representative).
 - THP has a designated Provider Engagement Representative for Behavioral Health.
 - THP's First-Line-of-Contact after Customer Service is often the Provider Engagement Representative, who can answer questions, handle problems, or provide various levels of training and education.
- As part of this RFP response, THP's Provider Engagement Representatives connected with federally-qualified health centers (FQHCs) and rural health centers to verify school-based health center sites, which will play a key role in serving foster care children.
 - The school-based health center sites are typically connected to FQHCs. The school-based center is an additional access point to primary and sometimes specialty care, such as dental. Moreover, this care is documented in a unified electronic medical record.
 - Ensuring that foster care children are seen by a Behavioral Health Provider or Medical Health Provider during the school day will better coordinate care, reduce missed appointments, and eliminate barriers to care such as transportation and other unmet social determinants of health. This also leads to fewer care transitions when coordinated with educational resources such as guidance counselors, teachers, law enforcement (e.g., school prevention resource officers), and/or school psychologists. Additionally, there is a possibility to link this care with the "Handle with Care" Program, which alerts school administrators of potentially traumatic issues and needed follow-up to care.
 - THP's Network team continually validates Provider Network status, location, etc. to ensure the provider list is current and appropriately reflects all provider locations and services. This is not done by many of THP's competitors, yet THP's Medicare LOB includes compliance requirements that mandate this process. Furthermore, THP has a specific written policy on ensuring network adequacy for THP members and utilizes complaints and appeals received, as well as results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

THP will conduct initial education and training to Network Providers at least thirty (30) calendar days prior to the start date of operations and within thirty (30) calendar days of a Provider joining THP's network. THP will, at a minimum, provide training to Network Providers on the use of evidence-based guidelines, THP's treatment guidelines, and the definition of Medical Necessity in THP's "21 Medical Necessity Rules." THP's "21 Medical Necessity Rules" are provided in the following table.

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21 MEDICAL NECESSITY RULES

A service is Medically Necessary if a physician or other treating health Provider, exercising prudent clinical judgment, would provide or order the service for an Enrollee for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms, and the provision of the service is in compliance with 1905(a) of the Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan. Medically Necessary services will be:

- 1 No more restrictive than those used in the Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in DHHR statutes and regulations, the State Plan, and other DHHR policy and procedures;
- 2 For Enrollees under age twenty-one (21) are services and benefits that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability;
- 3 Provided in accordance with generally accepted standards of medical practice;
- 4 Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition;
- 5 Not primarily for the convenience of the Enrollee or treating physician, or other treating healthcare Providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that Enrollees illness, injury, disease or physical or mental health condition;
- 6 THP will consider the individual circumstances specific to the Enrollee and will take into account available clinical evidence, as well as recommendations of the treating clinician and other clinical, educational, and social services professionals who treat or interact with the Enrollee;
- 7 THP will cover and pay for Emergency Services, regardless of whether the Provider that furnishes the services has a contract with THP. THP will be responsible for coverage and payment of Emergency Services and post stabilization care services;
- 8 THP will not deny payment for treatment obtained when THP's representative instructs the Enrollee to seek Emergency Services. In accordance with 42 C.F.R. § 438.114(b) THP will not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms;
- 9 THP will be responsible post-stabilization care services, in accordance with provisions set forth at 42 C.F.R. § 422.113(c). THP is financially responsible for post-stabilization services obtained within or outside THP's Provider Network that are pre-approved by a Provider

21 MEDICAL NECESSITY RULES

or other THP representative.

10 THP will be financially responsible for post-stabilization care services obtained within or outside THP's Provider Network that are not pre-approved by a Provider or other THP representative, but are administered to maintain the Enrollee's stabilized condition within one hour of a request to THP for pre-approval of further post-stabilization care services.

11 THP will be financially responsible for post-stabilization care services obtained within or outside the Provider Network that are not pre-approved by a Network Provider or other THP representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if:

11.1 THP does not respond to a request for pre-approval within one hour;

11.2 THP cannot be contacted; or

11.3 THP's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Network Provider is not available for consultation. In this situation, THP will give the treating physician the opportunity to consult with a Network Physician and the treating physician will continue with care of the Enrollee until a Network Physician is reached.

12 In accordance with 42 C.F.R. § 438.114(b), THP will not refuse to cover Emergency Services based on the emergency room Provider, hospital or Fiscal Agent not notifying the Enrollee's primary care Provider, THP, or DHCF of the Enrollee's screening and treatment within 10 calendar days of presentation for Emergency Services.

13 THP will pay for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. § 438.114(a) of the definition of Emergency Medical Condition. THP will not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an Emergency Medical Condition under the "prudent layperson" standard, was in fact non-emergency in nature. THP will not require prior authorization for Emergency Services. This applies to out-of-network, as well as to in-network services, which an Enrollee seeks in an emergency.

14 Enrollee who has an Emergency Medical Condition will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

15 The attending emergency physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on THP.

21 MEDICAL NECESSITY RULES

- | | |
|------|---|
| 16 | THP's financial responsibility for post-stabilization care services it has not pre-approved ends when: |
| 16.1 | A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care; |
| 16.2 | A Network Provider assumes responsibility for the Enrollee's care through transfer; |
| 16.3 | THP's representative and the treating physician reach an agreement concerning the Enrollee's care; or |
| 16.4 | The Enrollee is discharged. |
| 17 | THP is responsible for services ordered to be furnished to an Enrollee by a court of competent jurisdiction as described in this section. In the event that a Court orders a level or form of treatment that THP does not consider Medically Necessary, THP will develop and furnish an alternative treatment plan to the court with an and, if the court approves the plan, THP will assist the Enrollee to secure the treatment set forth in the plan. If the court rejects the alternative plan, THP will furnish the court-ordered services. THP will comply with the setting of care specified by the court (e.g., work, school, childcare, home, or other setting). |
| 18 | A service is Medically Necessary if it relates to the treatment that the Enrollee was receiving immediately prior to the Enrollee's enrollment with THP. |
| 19 | In the case of an Enrollee, regardless of age, who requires a health examination as a condition of new or continuing employment, the health examination will be considered Medically Necessary. |
| 20 | Services related to the screening, testing, diagnosis, counseling and treatment of HIV/AIDS are Medically Necessary. THP will participate in DHHR initiatives regarding HIV/AIDS. |
| 21 | A declared public health emergency, whether naturally occurring or human-made, will constitute a finding of Medical Necessity for purposes of this section, with respect to all Covered Services. |

THP's policies and procedures promote timely access to preventive treatment and rehabilitation services in accordance with evidence-based standards of care and include safeguards to ensure that the procedures are applied in an appropriate manner.

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.
ND008	The Vendor should measure and regularly verify network compliance standards.

Most West Virginia healthcare facilities, including all comprehensive behavioral health centers, and practitioners are already participating in THP's network, as it is an existing Medicaid managed care organization and active in commercial and Medicare Advantage lines of business. THP uses multiple avenues to identify additional contracting opportunities and monitors our provider networks to guarantee access to care for its members. THP completes all ratio tables, monitors all provider lists supplied by the State of West Virginia, and periodically audits this list against its current network. Furthermore, on a quarterly basis, THP downloads a non-participating provider list that identifies non-contracted providers who have submitted claims on behalf of members. THP's Network Development Department contacts all West Virginia-based non-participating providers who submit claims for members to discuss contracting opportunities. THP also maintains a public website that promotes and allows members to nominate providers for potential contracting.

Network inadequacies identified by the monitoring process are immediately addressed via direct mail, including participation materials and initial contact by telephone. The plan also has begun peer analysis of our network against other MCOs in the region, as well as, commercial carriers in the region to identify additional potential providers.

THP, through its monitoring processes, works with subcontractors including SKYGEN (dental subcontractor) and Superior (vision subcontractor) to identify any network inadequacies and assist the subcontractor in recruitment and retention of providers to service our members in all regions of the state. THP follow the same rigorous processes—detailed in the previous two paragraphs—to identify and address network adequacy problems for dental and vision providers as it does for medical providers.

Additional outreach that occurs when a network deficiency is noticed includes mobilizing the appropriate Provider Engagement Representative to educate that provider about THP in hopes of enrolling that provider.

Finally, THPs-WVU Medicine (WVUM) partnership will provide improved network adequacy and specialty access, particularly in the north central part of the state, as well as increase telehealth capabilities in psychiatry, psychology, neurology, nephrology, and other specialties.

THP has completed a network analysis based upon the information provided with this RFP. Our network analysis can be found in Appendix 3.

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ND009 The Vendor should take action if notified of inappropriate wait times before a member is seen by a provider.

THP contracts with the full array of providers necessary to deliver a level of care that meets or exceeds community norms for travel time, appointment scheduling, and waiting times, as specified in the Service Provider Agreement.

THP ensures that the hours of operation of providers are convenient, do not discriminate against enrollees, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS. Furthermore, THP ensures that waiting times at sites of care are kept to a minimum and that the waiting time standard for Medicaid enrollees is the same standard used for any commercial enrollees.

THP has standards for timeliness of access to care and enrollee services that take into account the urgency of the need for services and that meet or exceed such standards as may be established by WVBMS.

Current WVBMS standards for timeliness state that:

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within forty-eight (48) hours;
- Routine cases other than clinical preventive services, must be seen within twenty-one (21) calendar days (exceptions are permitted at specific times when PCP capacity is temporarily limited);
- EPSDT services must be scheduled in accordance to EPSDT guidelines and the EPSDT Periodicity Schedule;
- An initial prenatal care visit must be scheduled within fourteen (14) calendar days of the date on which the woman is found to be pregnant

To ensure Foster Children and evaluated in a timely manner and seen expeditiously during crisis situations, if awarded the contract, THP will work with DHHR to develop standards to the Foster Care population that take into account the critical need for prompt access to care.

THP regularly monitors its provider network's compliance with these standards and takes corrective action as necessary. THP Provider Engagement Representatives collaborate with the Quality Improvement Department to conduct annual provider accessibility surveys to ensure the Provider Network meets or exceeds set standards with regard to appointment wait times. These standards are for new or established patient appointments, as well as urgent or emergent appointment protocols providers have in place. Providers who do not meet standards receive education and are surveyed again to ensure compliance with these standards is achieved. These surveys also serve to update the provider directory to indicate providers who are taking new patients and what the expected wait time is on the day of an appointment. Additionally, the Provider Engagement Representatives follow-up if any deficiency/complaints are received from a member or regulatory agency/body.

- The aforementioned surveys are analyzed, and the results are submitted to the Quality Improvement Committee for recommendations. Noncompliant practitioners are required to submit a corrective action plan or root cause analysis of the findings. Practitioners

receive ongoing formal education on their contract requirements. These practitioners are reviewed at a later date to reassess their compliance. If the practitioner does not meet the established standards again, further remediation and courses of action may be taken as outlined in THP's notice of practitioner rights. The analysis of these results is also reviewed by THP's Continuous Quality Improvement Workgroup to promote collaboration of initiatives, development of practitioner education, etc.

- Standards are listed in the behavioral health and provider/physical health manuals, as well as presented in quarterly required WVBMS provider trainings.
- Ad hoc, random audits of wait times for behavioral and physical health providers occur annually. THP measures the wait times during the audit and during the site survey process conducted by Provider Engagement Representatives.
- Provider Engagement Representative role
 - Regularly do access studies consistent with Quality Improvement Department process to identify compliance issues
 - Educational lead in provider offices
 - Upon new enrollment, educate providers on expectations through in-person visits, phone calls, seminars, and distribution of provider manual on the provider portal
 - Upon identification of issue, arrange an on-site discussion
 - If issue is not corrected, possible referral to Quality Improvement Committee
- The Consumer Assessment of Healthcare Providers and Systems survey results provide an overall assessment of how well THP is meeting access and other patient experience requirements
- Regarding PCP 24-hour access and related scheduling standards
 - THP conducts annual appointment accessibility and availability and after-hours compliance audits of primary care practitioners. This audit is completed on a statistically valid sample of primary care practitioners that are categorized as general practitioners/family practitioners, internists, and pediatricians. The audit methodology includes after hours telephonic outreach to practitioners, practitioner surveys, and member complaint data related to primary care accessibility and availability. THP also completes an annual audit for availability and accessibility with specialty care practitioners and behavioral healthcare practitioners. This audit is performed using a statistically valid sample that also includes high-volume, high-impact practitioners, and practitioners with documented trends of noncompliance or member complaints.
 - THP has established measurable standards for the geographic distribution of each type of primary care practitioner, high-impact and high-volume practitioner, and behavioral healthcare practitioner. This is measured in geographic distribution in driving time and mileage from the member's residence. THP also has established measurable standards with the ratio of each type of practitioner to the number of members, as well as established standards for routine care, urgent care, and prenatal care and after-hours care. Annually THP analyzes our performance against these established standards and analyzes data from member complaints about appointment availability and

accessibility to determine if there are any gaps in network creating barrier to compliance.

ND010 The Vendor should continue to build upon the provider network and credential new providers across the State for applicable populations.

THP's approach to developing and managing the provider network begins with a thorough analysis and evaluation of BMS' network adequacy requirements. Since THP has been serving Medicaid members for many years as a managed care organization, it has a strong network of qualified providers in sufficient numbers and locations that is adequate and reasonable to meet medical and behavioral health needs. Additionally, THP meets the overall Provider Network Standards set forth by BMS for its general Medicaid membership.

THP's Network Department will continue to ensure the special needs of foster care children are met through this analysis. In the event the provider network is insufficient, THP will guarantee timely and adequate coverage of services through an out-of-network provider until a participating provider is available, as well as ensure coordination with respect to authorization and payment issues.

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 Health Plan will provide a monthly report to DHHR identifying any underserved areas of West Virginia where THP believes additional socially necessary services providers should be permitted to enroll to address a gap in care. Data used to evaluate underserved areas will include referral request volumes by community, availability complaints, provider travel time analysis and other available data. In addition to the specific reporting, THP will also incorporate information provided through meetings with various stakeholders.

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:

ND013 Time/distance

ND014 Appointment timeliness, by provider type

The Health Plan has, and will continue, to analyze the list of providers shared by BMS and remain proactive in recruitment to fill in any gaps. Most practitioners are already participating in THP's network. THP uses multiple avenues to identify additional contracting opportunities and monitoring of our provider networks to guarantee access to care for its members. THP completes all ratio tables, monitors all provider lists supplied by the state of West Virginia, and periodically audits this list against its current network. In addition, the Plan downloads quarterly a non-par provider list that identifies non-contracted providers who have submitted claims on

behalf of members. THP's Network Development Department contacts all West Virginia-based non-participating providers who submit claims for members in order to discuss contracting opportunities. THP also maintains a public website that promotes and allows members to nominate providers for potential contracting.

- Network inadequacies identified by the monitoring process are immediately addressed. The plan also audits the adequacy of its network against other MCOs in the region to identify any additional potential providers not yet contracted with THP.
- The Health Plan through its monitoring processes work with their subcontractors—such as SKYGEN (dental contractor) and Superior (vision contractor)—to identify any network inadequacies and assist the subcontract in recruitment and retention of providers to service our members in all regions of the state. THP uses multiple avenues to identify additional contracting opportunities and monitoring of our provider networks to guarantee access to care for our members. THP completes all ratio tables, monitors all provider lists supplied by the state of West Virginia, and periodically audits this list against our current network. In addition, the plan quarterly downloads a non-par provider list that identifies non-contract providers who have submitted claims on behalf of members. THP's Network Development Department contacts all West Virginia-based non-participating providers who submit claims for our members in order to discuss contracting opportunities. THP also maintains a public website that promotes and allows members to nominate providers for potential contracting.
- Network inadequacies identified by the monitoring process are immediately addressed via direct mail, including participation materials and initial contact by telephone. The plan also has begun peer analysis of our network against other MCOs in the region, as well as, commercial carriers in the region to identify additional potential providers.
- The Health Plan through its monitoring processes work with their subcontractors to identify any network inadequacies and assist the subcontract in recruitment and retention of providers to service our members in all regions of the state.
- Provider Engagement Representatives play a key role in recruitment and retention of providers. This team of 13 representatives work in the various communities to develop relationships with existing, potential and new providers. Determinations of network inadequacies are referred to the staff serving the region who have first-hand knowledge of the community and its providers. This team is able to respond to provider issues and promote participation in THP programs.
- THP's partnership with WVU Medicine (WVUM) will provide improved network adequacy and specialty access, by enabling THP to work with the largest integrated healthcare delivery system in the state on efforts aimed to address provider shortages within the state. As we identify needs and shortages, we will work with WVUM and other provider partners to identify strategies to bring services to the WV communities in need. This may be through recruitment of new providers, establishment of local community clinics or through telehealth capabilities such as those currently available for psychiatry, psychology, neurology, nephrology, and other specialties.

ND015 The Vendor should ensure member access to covered services in areas where the provider network standards do not require a specialist.

Typically, all regions require specialist access; however, in more rural areas that often requires travel to an adjacent community. In areas where there are no specialists or a shortage of specialist to recruit, THP will work with its existing provider base to identify available providers to recruit both within the region and outside of the region. If needed, THP will permit out-of-network referrals in regions where it is unable to secure contracts that would provide access to needed specialist services.

THPs partnership with WVU Medicine (WVUM) will provide improved network adequacy and specialty access, by enabling THP to work with the largest integrated healthcare delivery system in the state on efforts aimed to address provider shortages within the state. As we identify needs and shortages, we will work with WVUM and other provider partners to identify strategies to bring services to the WV communities in need. This may be through recruitment of new providers, establishment of local community specialty clinics or through telehealth capabilities such as those currently available for psychiatry, psychology, neurology, nephrology, and other specialties.

ND016 The Vendor should recruit specialty care providers and hospitals, for applicable populations.

THP has contracted with all West Virginia hospitals and many outside the state, including facilities in bordering counties and major referral hospitals for child-specific services.

While THP currently has a good network of specialists, Network Development continues to identify non-participating specialists to ensure the special needs of foster care children are met.

Besides hospitals and general specialists, Network Development also has a robust network of behavioral health/substance use disorder treatment agencies and clinically licensed behavioral health practitioners, including psychiatrists, psychologists, counselors/social workers, and nurse practitioners.

With the Foster Care award, THP will need to recruit additional providers for personal care services and for residential treatment facilities. THP will make efforts to contract with all currently enrolled providers. THP shall also evaluate children placed outside of West Virginia to determine needed services and available providers. Where possible, THP will attempt to contract with local providers or execute case agreements for needed services. THP shall work collaborative with DHHR and case workers to identify needed services outside of West Virginia. THP also has relationships through other business lines, to networks in other states. Where needed, THP shall work through those established relationships to identify opportunities to locate and contract with needed providers.

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).
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Once the CSEDW is approved by the Centers for Medicare and Medicaid Services, THP will work with the DHHR to educate medical and socially necessary services providers on the scope of benefits and limitations on these services. THP is committed to DHHR and the Family First Prevention Services Act's goal of helping children and their caregivers to receive needed special intensive supports they need to them remain safely in their homes and communities.

ND018	The Vendor should develop and implement a recruitment strategy for the following providers:
ND019	Federally Qualified Health Centers (FQHCs)
ND020	Rural Health Clinics (RHCs)

The Network Development Department's recruitment strategy begins with cultivating a good relationship with current providers and their respective membership organizations/associations. Most of West Virginia consists of rural areas, and local practitioners are the first to know when a new provider has located in their area. Other methods utilized to identify, and recruit providers/practitioners include:

- Regularly reviewing the list of providers who care for foster children
- Working with participating PCPs to determine current referral patterns, making sure the specialists to whom they refer are in-network
- Routinely monitoring the network/websites of competitors
- Collaborating with the West Virginia Board of Medicine and West Virginia Board of Osteopathic Medicine to determine who has been newly licensed in the state
- Member requests
- Quarterly reviews of reports showing out-of-network claim payments
- Developing and maintaining positive relationships with the West Virginia Primary Care Association, West Virginia Behavioral Healthcare Providers Association, and West Virginia Hospital Association

By utilizing the out-of-network claims report, THP can also identify providers who may be based outside of the state but who may practice occasionally at a West Virginia location.

The Health Plan has contracted with all West Virginia FQHCs and RHC's located in WV. Additionally, THP has a contract with several FQHCs/RHCs in bordering states, including Maryland, Virginia, Ohio and Pennsylvania.

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
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THP contracts with all West Virginia FQHCs and RHCs and will continue to do so; therefore, this question is not applicable.

ND022	The Vendor should develop and implement a recruitment strategy for the following publicly-supported providers:
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The Network Development Department's recruitment strategy begins with cultivating a good relationship with current providers and their respective membership organizations/associations. Most of West Virginia consists of rural areas, and local practitioners are the first to know when a new provider has located in their area. Other methods utilized to identify, and recruit providers/practitioners include:

- Regularly reviewing the list of providers who care for foster children
- Working with participating PCPs to determine current referral patterns, making sure the specialists to whom they refer are in-network
- Routinely monitoring the network/websites of competitors
- Collaborating with the West Virginia Board of Medicine and West Virginia Board of Osteopathic Medicine to determine who has been newly licensed in the state
- Member requests
- Quarterly reviews of reports showing out-of-network claim payments
- Developing and maintaining positive relationships with the West Virginia Primary Care Association, West Virginia Behavioral Healthcare Providers Association, and West Virginia Hospital Association

By utilizing the out-of-network claims report, THP can also identify providers who may be based outside of the state but who may practice occasionally at a West Virginia location.

ND023	Local Health Departments
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The state requires that local governmental departments administer certain public health programs, which are critical to the protection of the public's health and, therefore, must be available to Medicaid managed care members. For those services defined as public health services under state law, THP has chosen to contract with local health departments. If a THP member seeks such a service directly from a non-contracted local health department, THP pays for the service at the lesser of the health department's fee rate or the Medicaid fee rate.

THP provides the following core services to its Medicaid members and reimburses the local health departments as specified:

1. All sexually transmitted disease services including screening, diagnosis, and treatment;
2. Human immunodeficiency virus (HIV) services including screening and diagnostic studies;
3. Tuberculosis services including screening, diagnosis, and treatment; and
4. Childhood immunizations.

THP works with the local health departments to coordinate the provision of the above services and to avoid duplication of services.

Ninety percent of the state's local health departments are contracted with THP and THP reaches out regularly to attempt to contract with others.

ND024 Critical Access Hospitals

THP has contracts in place with all West Virginia Critical Access Hospitals. As new Critical Access Hospitals are identified, THP will attempt to obtain contracts for services.

ND025 Primary Care Centers

THP has contract with all federally qualified health centers/rural health centers (aka Community or Primary Care Centers). As new Primary Care Centers are identified, THP will attempt to obtain contracts for services.

ND026 School-Based Health Centers (SBHCs)

School-based health centers (SBHCs) provide general, primary healthcare services to school-aged children. THP recognizes these centers as increasingly important providers of primary healthcare, especially in rural communities that face shortages of primary care providers. THP contracts with or has developed cooperative agreements with SBHCs. As the SBHC's are typically run by federally qualified health centers/Primary Care Centers, THP has a robust network of SBHCs and will continue to recruit and contract for SBHC services.

ND027 Right from the Start (RFTS) Providers

Right from the Start (RFTS) is a program aimed at improving early access to prenatal care, lowering infant mortality, and improving pregnancy outcomes. THP contracts with RFTS providers; THP has most RFTS providers in network. THP does not place prior authorization requirements on RFTS services. The Network Development Department periodically conducts a thorough analysis and evaluation of those providers, as identified by WVBMS, and works to fill any gaps.

ND028 Bureau for Public Health (BPH) Laboratories

For certain cases (e.g., metabolic testing for newborns, rabies, etc.), Public Health Laboratories are required to perform tests for THP members for public health purposes. In addition, all laboratories contracted by THP that have positive findings of certain reportable diseases under the Reportable Disease Rule must submit an isolate, serum specimen, or other designated material to the Office of Laboratory Services (OLS) for confirmation or other testing needed for epidemiological surveillance. These services are usually funded by state or federal funds; however, whenever a service is not funded by other state or federal funds, THP reimburses OLS for its services.

ND029 Children with Special Healthcare Needs (CSHCN) Program

Providers who work with CSHCN members generally include:

- Cardiology
- Cystic Fibrosis
- Orthopedics
- Neurologists
- Myelodysplasia
- Urology
- ENT
- Plastic Surgeons

THP generally has an adequate network of contracted specialists in the aforementioned areas. In the event the provider network is insufficient according to WVBMS established standards, THP will ensure timely and adequate coverage of these services through an out-of-network provider until a participating provider is available and will ensure coordination with respect to authorization and payment issues. THP Navigators work directly with CSHCN on member needs. As provider network needs are identified, the Navigator will work with THP network staff to identify potential contracting opportunities.

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.

THP contracts with publicly supported providers and will continue to do so; therefore, this question is not applicable.

ND031 The Vendor should develop and implement recruitment strategies for new or modified provider types.

For any new or modified provider types, THP's Network Development Department will work to contract with them as soon as possible. In the event the provider network is insufficient, THP will

ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is available.

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:

THP defines the standard provider types that may provide primary care services as those whose specialties are family practice, general medicine, internal medicine, OB/GYN, and pediatrics. When deemed appropriate, a specialist may be permitted to serve as a primary care provider (PCP).

When the member's medical condition warrants, any specialist is granted unobstructed access by either a standing referral or specialist coordination of healthcare services. To ease administrative burden for the most common specialty provider types, THP allows nephrologists, endocrinologists, and certain pediatric subspecialists to be designated secondary care providers. This permits a member to select the provider without any additional approval process and for the provider to deliver primary care services in addition to specialty care services.

In medically justified cases, THP may allow a specialist to act as a PCP. In every case, though, specialists acting as a PCP must be able to offer all necessary primary care services in addition to specialty services.

Nurse Practitioners and Physician Assistants who practice in a PCP specialty are also permitted to act as a PCP.

ND033 The circumstances and process under which a member may select a specialist as his/her primary care provider (PCP)

THP facilitates ongoing specialist care and coordination for the benefit of appropriate members. This applies when the PCP, in consultation with a specialist provider, identifies the need for specialty care over an extended period of time for a chronic condition that is life-threatening, degenerative, and/or disabling.

ND034 Any managed care organization (MCO) approvals required

The PCP, or THP Navigator(s), is responsible for initiating the specialist provider coordination referral. Medical providers submit a treatment plan for review by THP's Medical Department. Behavioral health providers submit a plan of care for review to THP's Behavioral Health Services Department. Upon approval of the specialist provider coordination referral, the specialist is authorized to provide and refer for healthcare services in the manner of a PCP, provided that the care is relevant to the expertise of the specialist.

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

No restrictions apply for specialists who have capabilities to provide preventive healthcare services and agree to manage the member across the care continuum. However, the specialist must agree to serve in the PCP capacity. Any physician with a subspecialty such as pediatric pulmonology, pediatric nephrology, etc. can be listed as the member's PCP, provided the physician agrees to deliver all preventive services for the member. In this case, the specialist receives a letter to determine if he/she is willing to be listed as the PCP and will provide all preventive services for the member with unique needs.

The assignment of a specialist as a PCP is determined based upon clinical review by THP medical staff, case navigators, care managers, and a Medical Director, which focuses on the relevance of the specialty to the member's needs and the ability and willingness of the specialist to provide primary care services to the member. This process must be reviewed annually. For the specialist to continue to coordinate care, the PCP is required to request an extension of the specialist provider coordination referral every year and to provide updated reports and treatment plans to support medical appropriateness. This does not apply for behavioral health services.

All PCPs are expected to abide by the following restrictions as recommended by the American Medical Association:

- Providers should not treat themselves or their immediate family members, or members of their household.

The following degrees of relationship are included within the definition of immediate relative:

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

Emergencies: In the case of medical emergencies, a THP provider can provide care for a family member until a qualified provider is available.

Orders (written or verbal): THP providers shall not write orders or dictate verbal orders for themselves or a member of their immediate family.

Prescriptions: THP providers shall not write prescriptions for themselves or members of their immediate family.

PCP Assignment: THP providers shall not be permitted to act as a PCP for themselves or members of their immediate family.

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:
ND037	Availability of compounds
ND038	Availability of specialty drug pharmacies

The credentialing process for independent pharmacies in HEAT Zone areas includes obtaining a list of current wholesalers and wholesaler invoices that show purchases of adequate inventory to service Express Scripts' members.

Express Scripts has administered and managed Medicaid and income-based health programs since 1995. Recognizing the unique needs of our Medicaid clients, our industry-leading Medicaid service model drives superior results for our clients and supports Express Scripts' ability to develop exceptional retail network solutions. At Express Scripts, we work tirelessly to:

- Understand each Medicaid plan and its unique state requirements
- Develop innovative, Medicaid-specific pharmacy network offerings to meet your beneficiaries' needs
- Drive improved patient health outcomes through our thoughtful network solutions
- Continuously monitor and respond quickly to meet new state, Centers for Medicare & Medicaid Services (CMS), and Any Willing Provider (AWP) regulations

We are committed to providing Foster Children the best network solutions for you and your Medicaid beneficiaries. Our Client Solutions Consultants will take the time to discuss your business needs, analyzing your members' drug and pharmacy utilization trends, familiarizing ourselves with your preferences, and strategizing on how to achieve your short-term and long-term savings goals. We will discuss your range of options and guide you to the network solution that optimizes pharmacy access, choice, and price for you and your Medicaid beneficiaries.

Pharmacies that participate in Express Scripts' networks must meet our rigorous credentialing and re-credentialing requirements and agree to our standard contract and pricing terms. In addition, network pharmacies are required to:

- Display drug utilization review (DUR) messages and custom client messages
- Provide prescription consultation services for members
- Support formulary compliance and stock all drugs included on the formulary
- Support coordination of benefits (COB) and electronic prescribing (e-Prescribing)
- Comply with state and federal laws, regulations, licenses, and permits
- Comply with the Health Insurance Portability and Accountability Act (HIPAA)
- Not discriminate in the performance of services
- Dispense generic substitutes when permitted by state law and according to clients' benefit designs

Whichever network Foster Children chooses, you and your members will benefit from:

- Flexibility in choice
- Convenient locations including access to compounding pharmacies

- Stringent credentialing and re-credentialing
- Comprehensive network management that includes auditing and Fraud, Waste, and Abuse programs to ensure accuracy and prevent fraud
- Access to The Health Plan's own specialty pharmacy network backbone by specialty pharmacies domiciled within the state of West Virginia.
 - This allows local providers to understand the unique needs of West Virginians to provide better access to local specialty drugs.
 - This unique specialty network keeps healthcare dollars within the state of West Virginia not being sent to the pockets of specialty pharmacies in other states.

ND039	The Vendor should make additional outreach efforts to the following types of pharmacies:
ND040	High volume
ND041	Rural
ND042	Public health entities administering the Vaccines for Children (VFC) program

Express Scripts, THP's pharmacy benefit manager, understands the importance of having access to retail pharmacies in rural communities. Therefore, Express Scripts works diligently to include rural independent pharmacies and pharmacy services administration organizations (PSAOs) at competitive market reimbursement rates in these areas. Express Scripts' proposed financial offer and pricing guarantees include Express Scripts' previously negotiated rural rates. Should the foster care population require rural pharmacies, Express will take the lead in negotiating these rural rates.

THP and Express Scripts can utilize fax blasts to notify the pharmacy community of large-scale changes. These notifications can also be customized to target specific subsets of pharmacies, including high volume or those in rural settings, as requested. Similar notifications were utilized during previous Medicaid pharmacy benefit transitions to THP.

Public health entities administering the Vaccines for Children program are generally local health departments, federally qualified health centers, and rural health centers, as well as pediatricians and internal medicine providers. Ninety percent of local West Virginia Health Departments are participating with THP. Most pediatricians, internal medicine, and other providers who may administer the vaccines are also participating. In the event the provider network is insufficient, THP will ensure timely and adequate coverage of these services through an out-of-network provider until a participating provider is available.

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ND043 The Vendor should ensure that pharmacy services are available to members in a timely manner, including, but not limited to, nights and weekends.

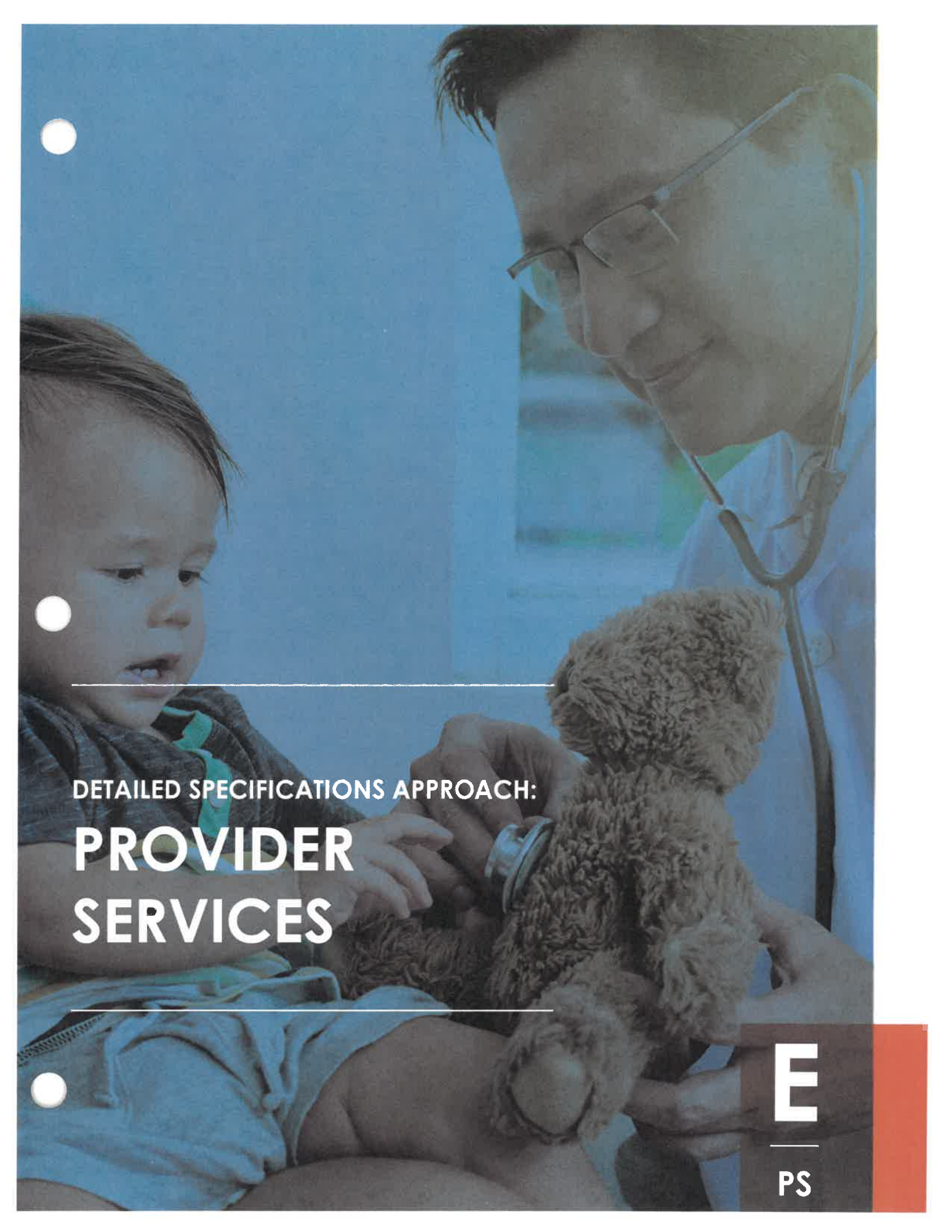
THP operates its pharmacy call center from its Wheeling, West Virginia, headquarters. The call center is open 24 hours a day, 365 days per year. This service enables THP pharmacy technicians and pharmacists to respond to member, provider, and pharmacy inquiries immediately.

ND044 The Vendor should establish and implement a provider recredentialing cycle for physical health and behavioral health providers.

Recredentialing is completed at least every 36 months. The process is as follows.

- Each practitioner's recredentialing cycle will be within a 36-month period following the original effective approval date and within 36 months thereafter.
- The Credentialing Representative receives automated reports of practitioners due for reappointment six months prior to the recredentialing due date.
 - If THP is unable to access or obtain an application due to an expired attestation or missing documents, the practitioner will be notified via e-mail and/or telephone to update the application.
 - If the practitioner fails to respond within 30 days, the Credentialing Representative will follow-up with another e-mail and/or telephone call.
 - Any practitioner who fails to respond to the request will be sent a letter stating they will be removed from the provider directory and placed in an inactive status.
- If a practitioner exceeds the 36 months and wishes to continue as a participating provider, an initial application will need to be completed and the practitioner will need to be credentialed as an initial applicant.

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A photograph of a male doctor with glasses and a stethoscope, smiling as he examines a brown teddy bear. A young child is visible on the left, looking towards the bear. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

PROVIDER SERVICES

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PS

Provider Services

This Provider Services section of THP's proposal addresses:

- training for current and new providers;
- mandated reporters training;
- PCP and BH provider continuity of care;
- establishment of a quality rating measure accessible to members; the distribution of the provider manual to providers;
- claim payment as defined by the SPA;
- implementation of guidelines for payment of claims that occur out-of-network;
- implementation of a review process for emergency service payments;
- education of PCP's on their responsibility of coordinating care;
- education of specialty providers on the importance of encouraging patients to obtain PCP's;
- education of providers for coordination medical, BH and SNS;
- education of PCP's on the importance of dental screenings;
- education of providers on the ability to request out-of-network authorizations;
- education of all providers on the complex needs of foster care members; access of a secure website with information for targeted providers; and
- portal accessibility for providers, case workers and other stakeholders.

This section is answered with easily identifiable responses to each specification. It will be clear to the reader that THP is fully equipped to educate providers on the necessary information for their care of foster care members. THP's successful implementation of their provider engagement department has provided them with the tools and staff necessary to properly educate providers and get information out to providers in an efficient and timely manner.

THP understands that continuity of care between all providers involved with a member is an essential part of properly caring for the foster care population. Collaboration between our complex case navigators, our providers and our provider engagement team will occur as often as needed to ensure we are meeting all necessary standards to provide seamless continuity of care. THP providers will be knowledgeable on the provider manual as well as full access to our portal to manage members through our secure platform.

In addition, this section will give a look into the functions of the provider engagement team in collaboration with all other departments of THP to become a liaison for all providers to ensure they are up to date with any and all guidelines, policies and procedures of THP. THP commits to holding our providers to the highest standards and ensuring the members of our network are properly served. THP is fully equipped to provide support to our network physicians to provide the best care possible to the members of West Virginia and beyond.

PS001 The Vendor should provide initial (during implementation) and ongoing training for existing providers.

THP provides initial and ongoing training for existing providers. THP employs a Provider Training and Education Director. The director is responsible for developing presentations, scheduling webinars, coordinating the updating of the Provider Manual, maintaining current training materials on THP's provider website and coordinating the quarterly provider newsletter.

THP also employs thirteen (13) provider engagement representatives to provide education and training throughout the state of WV and the contiguous states of Ohio, Maryland, Pennsylvania, Virginia and Kentucky. These representatives attend seminars, workshops, professional organization meetings (i.e., Palmetto GBA, WV Medical Group Management Association, WV Office Managers Association of Healthcare Providers and Practice Management Institute) and conferences to present educational updates and provide targeted onsite education for provider offices.

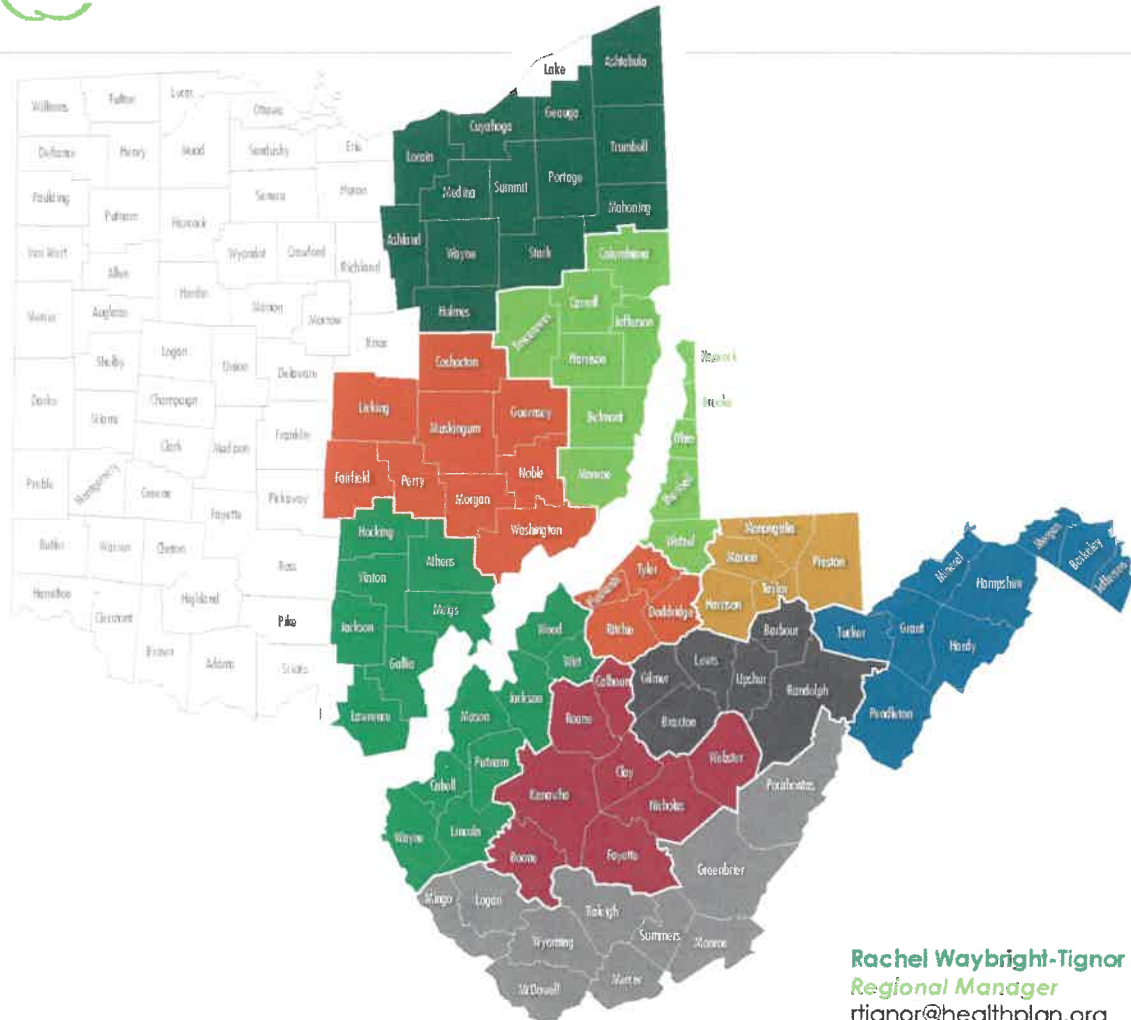
THP takes advantage of BMS' bi-annual required workshops as a means to provide updates and ongoing training to providers. THP's Provider Manual is readily available for download on THP's public website and contains guidelines to assist providers in navigating through THP's system.

We have supplied a copy of our Provider Engagement Territory map on the following page.

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Provider Engagement Regional Representative Map



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PS002 The Vendor should provide initial and ongoing training targeted to new providers.

THP provides initial and ongoing training targeted to new providers. THP has a Provider Engagement Department that employs thirteen (13) provider engagement representatives to provide education and training throughout the state of WV and the contiguous states of Ohio, Maryland, Pennsylvania, Virginia and Kentucky.

Provider engagement representatives are required to conduct on-site surveys on all PCPs, Ob-gyns, behavioral health and high volume/high impact providers as defined by THP policy and in accordance with West Virginia Medicaid Program (BMS) guidelines. The representatives provide targeted education to providers in areas such as: billing and coding, HEDIS® measures, preauthorization requirements, etc. Along with THP's Director of Strategic Initiatives, provider engagement staff attend value-based reimbursement meetings with strategic provider partners such as WVU Medicine. Provider engagement representatives also attend meetings with other large health systems: Mon Health System, Cabell Huntington Hospitals, Charleston Area Medical Center and Thomas Healthcare System.

Provider engagement representatives are also available to provide one-on-one provider training or provider group trainings upon request of the provider and when issues with provider performance of requirements have been noted. Provider visits and training are logged and tracked.

PS003 The Vendor should provide training on mandated reporters to support applicable State Code, as defined by the Department.

West Virginia Code §49-2-803 establishes suspected child abuse and neglect mandated reporters. Relevant to this RFP response are mandated reporters in the medical, dental, and behavioral health fields; social workers; child care/foster care workers; and circuit court judges. The WV State Task Force on the Prevention of Sexual Abuse of Children and other advocacy groups recommended that the legislature "simplify and clarify" state code regarding suspected abuse and neglect, which it did during the 2018 legislative session. The law now unambiguously calls for mandated reporters to notify WVDHHR by using the WV Child Abuse and Neglect Hotline within 24-hours and to notify the West Virginia State Police or relevant law enforcement during that same time period if there is serious suspected physical abuse or sexual abuse/assault.

THP views these revisions to state code positively for foster care children, and all children, and it will require training of its relevant medical, dental, and behavioral health staff and other covered professionals on mandated reporting requirements. Furthermore, KVC Health Systems, a key partner of THP, has experience with mandated reporting requirements and will assist THP in developing training materials for use with network providers, staff and other stakeholders. Likewise, stakeholder programs such as the "Making a Difference" train the trainer program at TEAM for West Virginia Children will be incorporated. For THP-contracted providers, training will be provided via a webinar, through in-person seminars and by one-on-one in office

education. For those not attending a THP sponsored training program, the providers will be required to attest to successful completion a webinar or state provided mandated reporter training.

THP will collaborate with the "Making a Difference" train the trainer program, TEAM for West Virginia Children, and other relevant child advocacy organizations in West Virginia to increase knowledge and awareness about legal requirements regarding child abuse and neglect.

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.

Care coordination, including primary and behavioral healthcare integration, is the cornerstone of many healthcare redesign efforts. It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.

Physicians are informed of patient's diagnostic results and treatment history; THP navigators can transmit patient information to primary and specialty care providers in real time; community resources are fully engaged with primary care providers in supporting care for the THP members.

THP will house the complete patient record (medical and behavioral) for each foster care member. This information will be made available through COMET to the providers who are involved in the provision of care. COMET is the online comprehensive medical record. This will include a complete record of all services and medications provided as well as medical record information incorporated through the case management process. Treatment plans for both primary and behavioral health will be made available on COMET to ensure clear sightlines by each provider into the care being provided.

The nurse care/complex case navigator maintains collaboration and communication with the member, family, practitioners and other healthcare practitioners/providers to facilitate review of the care plan and to initiate changes.

The THP navigator maintains regular communication with the member and family to gather information on the current status of the member and determine impact, if any, to the care plan. The care navigator maintains current communication with the primary and behavioral healthcare providers to discuss issues and make adjustments to the care plan as appropriate. The THP navigator communicates with primary and behavioral providers in the transition of care needs. Care plans are based on evidence-based guidelines and any deviations from the standard of care are addressed. The THP navigator performs an assessment of the member's progress toward obtaining goals of the care plan as needed. Barriers to the member meeting goals or maintaining care plan adherence are documented in COMET.

THP navigators facilitate authorizations to resources and follow-up to ensure members have taken approved visits and received appropriate care. Development of scheduled follow-up is documented in COMET with corresponding creation of reminders. Care plans including self-management are shared with all members' caregivers and progression toward short term and long-term goals is documented.

The Health Plan provides guidance to their PCP's and behavioral health providers within the provider manual on coordinating medical and behavioral health services in section 9 titled "Behavioral Health". The sub- section titled "Continuity and Coordination of Care" found on page 201 states the following:

"The Health Plan Behavioral Health Services Department advocates continuity and collaboration of care between behavioral health and physical health practitioners/providers. Continuity and coordination is an important aspect in the delivery of quality healthcare as behavioral and medical conditions interact to affect an individual's overall health. Information is expected to be exchanged between behavioral and physical healthcare providers whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner/provider to communicate with the PCP and the PCP to communicate with the behavioral health practitioner/provider. Any information that is shared between practitioners/providers should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, the Behavioral Health Services Department is available to provide this service.

All federal and state confidentiality laws should be followed. The Health Plan expects that this information be shared accordingly and recognizes the right to keep progress notes private. The Health Plan also understands that there are special situations where information cannot be shared. A continuity of care consultation sheet is available on The Health Plan's website for use in facilitating this communication at www.healthplan.org."

The Health Plan hosts a series of forms to make transitions from PCP to Behavioral Health provider a seamless process to ensure continuity of care. All forms are conveniently available online to THP's providers and can be submitted by fax, email or electronically. The forms available to THP providers to ensure coordination and continuity of care are listed below:

- Authorization to Disclose Health Information to PCP
- Admission Review Form
- BHU Fax Cover Sheet
- Concurrent Authorization for ABA/Behavioral Services Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Crisis Encounters Report Form
- Initial Authorization for ABA/Behavioral Services Form
- Psychological Testing Preauthorization Request Form

- Treatment Continuation Request Form
- Substance Abuse Admission Review Form
- Substance Abuse Continuity or Discharge Review Information Form
- Intensive Outpatient or Partial Hospitalization Programming
- Pre-authorization of Drug Screening (labs)
- Request for ACT Programming – Medicaid Lines of Business only
- Request for CFT Programming – Medicaid Lines of Business only
- Request for ECT/TMS
- Pre-authorization for Telehealth Services

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 Health Plan incorporates analytical software that provides an efficiency and effectiveness score for the provider network based on groups and individual physicians, based on patterns of care and related cost, utilization and adherence to quality measures. This information is available to be shared with members to allow an understanding of peer-to-peer comparisons of providers. Scoring entails assignment of 1.00 as the peer norm with higher and lower scores indicating deviation from utilization. THP is currently evaluating a process to make this information available to its members.

Additionally, members are directed to the "Find a Provider" on the THP website when they are seeking a primary care or specialist to provide care. The member may then select the type of provider and location of the provider they are seeking. Each listed provider is described in detail, including Board Certifications. The listed board certifications are updated upon notification by the practitioner and verified by The Health Plan directly through Board Certified Docs (an official American Board of Medical Specialties display agent) or the pertinent board prior to adding to the directory. This information is validated every 36 months and quarterly upon expiration. If applicable, this information specifies the American Board of Medical Specialties board through which the practitioner has obtained certification and the expiration date of the certification.

PS006 The Vendor should distribute provider manuals according to set timeframes and methods of delivery.

THP's Provider Manual is updated bi-annually (December and June) per THP's Provider Manual Policy (MK-09) and is published upon medical director approval.

The Manual has one section devoted just to Medicaid providers. Also contained in the Manual are the following sections: Physician Availability, Member Benefits, Medical Management Program, Quality Improvement, Behavioral Health, Billing, Coordination of Benefits, Payment Voucher, Credentialing and Fraud, Waste and Abuse.

The Provider Manual is available to providers on THP's public website: www.healthplan.org or, upon request, may be distributed in paper form or on compact disk (CD) by contacting THP's Provider Relations Department.

PS007 The Vendor should accept and pay claims on time for physical and behavioral health services, as defined by the Service Provider Agreement (SPA).

THP ensures that provider claims are accepted into our system upon receipt and paid in the required timeframe of 30 calendar days. We provide a complete description of the payment method or payment amounts applicable to a provider with the payment voucher. Our provider contract and provider manual will explain to providers how to submit a clean claim including a complete listing of all required information, such as claims coding and processing guidelines for the applicable provider type. THP will pay both in-network and out-of-network providers within thirty (30) calendar days of clean claims receipt. We currently meet all requirements for timeliness of payment for all claim types, including behavioral health services. In the rare event that a claim is paid in greater than thirty (30) days, THP pays interest on the claim at the rate establish in the Service Provider Agreement. This interest payment is included in the same check as the claim payment and does not require any action on the part of the provider.

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).

Out-of-Network claims for physical and behavioral services are reviewed by the claims staff and further evaluated by clinical staff as needed. Claims staff first evaluate to determine if the claim was authorized for the out-of-network provider and if so payment is made. If the service is determined to be emergent, included crisis stabilization services for up to 72 hours, payment is made to the out of network provider. Other claims or authorization requests are forwarded for clinical review.

The clinical review is handled by the THP navigator and includes consideration of the member's medical needs and determination if their needs can be met with an in-network provider. Out-of-network care is approved when services or providers required to meet a member's medical needs are not available within The Health Plan's network or cannot be safely provided in network due to complexity of care or physical location of this fragile population. Additionally, in the instance of Foster Children placed at an out of area placement, services will be approved in the local community if a contracted provider is not accessible.

The THP navigator obtains the information necessary such as the status of the illness, direct treatment plans, medication, and treatment protocol. This will allow the THP navigator to determine the active course of treatment. If the navigator determines that the active course

of treatment is one in which discontinuing the services would cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes the service will be authorized, and arrangements made for a single case agreement.

If it is determined that the member can be safely transitioned to an in-network provider a mutually agreed upon plan of care for transition will be implemented with the past provider, member/family, and THP contracted provider.

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:
PS010	Which types of claims are automatically paid
PS011	Which types of claims are automatically pended
PS012	Evaluation of pended claims for payment, upholding the "prudent layperson" standard

We currently have a review process in place for all emergency room claims incorporating both claims review staff functions and clinical evaluation functions. This process includes a request and review of the medical records relating to the emergency services when the information provided with the claim does not clearly meet guidelines for payment. Claims that cannot be approved at the Claims Analyst level are reviewed by clinical staff based on the prudent layperson definition of emergency. Initial clinical review is completed by a registered nurse and if an adverse determination is needed a final review is completed by a THP Medical Director.

THP does not auto adjudicate emergency services claims but rather reviews all claims evaluating the treatment documents and presenting factors along with the emergency claim. Based on the diagnosis and presenting symptoms, the claims is reviewed by claims staff and further reviewed by the clinical team if a necessity determination is indicated. THP evaluate all claims for payment in accordance with "prudent layperson" standards

In most cases, ER claims are not pended but rather reviewed upon receipt. In some cases, medical records or other documentation may be requested to support the level of care being billed by the provider. Upon receipt of requested documentation, THP claims analysts will review to determine if the level of service being billed is supported by the ACEP (American College of Emergency Physicians) ED Facility Level Coding Guidelines. If the level billed meets the guidelines, the analyst will pay the claim. If the analyst is not able to approve payment as billed, he or she will send the documentation to a registered nurse and or Medical Director for further review. The RN/Medical Director will either approve the level billed or instruct the analyst to reduce the reimbursement amount to a lower level code. These reviews are all based on correct coding.

PS013 The Vendor should educate primary care providers (PCPs) on their responsibility to coordinate a member's overall health, for applicable populations.

The Health Plan takes great care to educate their providers, specifically PCPs on the importance of coordinating care for members. THP considers the PCP as the "connector of services," especially between physical/medical and behavioral health. THP understands that coordination of care is directly related to patient safety and better outcomes; therefore, it is continually highlighted by provider engagement representatives during outreach to providers. Section 8 (Quality Improvement) of THP's provider manual has a sub-section dedicated to continuity and coordination of care, which THP provider engagement representatives use as a reference when educating providers.

In the provider manual, THP strongly suggests the following to its providers, for proper continuity and coordination of care:

- "Specialists and/or PCP mail or fax updates as needed and include the information in the patient's medical record;
- Phone consultation or conference calls when multiple doctors are involved in the member's care;
- Concise documentation in the medical record to show that PCP/specialist consultation has occurred; and
- For behavioral health members, behavioral health providers are encouraged to discuss with their patients the importance of sharing their behavioral healthcare issues with their PCP. A release form is available by calling Behavioral Health Services at 1.877.221.9295 or on THP's website."

Additionally, The THP provider website provides forms for information sharing purposes to assist provider with coordination of care. THP quality review staff, periodically review practices to evaluate coordination of care effectiveness.

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.

When a THP member is determined to be a complex needs patient through our case management Health Risk Assessment, the THP navigator then takes the patient through our processes listed in our policy manual. The following are excerpts from Policy CL-601 – Case Needs Assessment, CL-24 – Communication of Information for Provision of Healthcare Services, CL-25 – Continuity and Care Coordination:

CL-24 lists the steps that THP navigators go through in order to ensure they tee up everything necessary for member care:

1. "All available information is reviewed to evaluate the member for care/complex case navigation. Information is reviewed via The Health Plan system including past claims, census, service pre-authorizations and any related clinical information already received

from practitioners or facilities. If limited information is available in The Health Plan system, the review should be accepted, the "Under Review" flag is placed, and the navigator process is to proceed to member contact for assessment to determine appropriateness.

2. Documentation of the review includes the referral type, information gathered, reviewer remarks, decision, decision rationale and date reviewed.
3. Once the member is found to be appropriate for program consideration, system flags are entered, and a case is created. The case will be active and following until member engages."

CL-24 reviews the process our THP navigators follow in order to ensure transparency of shared information between providers caring for the member.

1. "The nurse navigator facilitates the sharing of information regarding the member's care between the requesting practitioner/provider and the practitioner/provider furnishing the service.
2. The referral notification directs the receiving practitioner/provider to provide the referring practitioner/provider with needed correspondence and diagnostic evaluations.
3. The nurse navigator cannot review the request for services until all appropriate clinical information is received or allowed extension is exhausted.
4. Copies of referral notification are sent to the member, primary care practitioner or referring practitioner/provider and practitioner/provider furnishing the service."

CL-25 speaks on continuity and coordination of care between providers and THP. This policy specifically speaks to the importance of a primary care provider being assigned to each complex need member and their role in ensuring coordination of care between all providers.

1. "The primary care practitioner (PCP) bears primary responsibility for coordinating the member's overall healthcare in a manner consistent with the member's own goals and preferences. Most referrals to specialty practitioners or other practitioners/providers must originate with the PCP. Treatment plans should specify an adequate number of direct access visits to specialty practitioners to accommodate implementation of the treatment plan. Members are afforded direct access to behavioral health practitioners/providers. All referral notifications will include a reminder to all parties to share clinical information in a timely fashion. (Refer also to CL-24).
2. Practitioners/providers must document member input in all treatment plans submitted for authorization; Medical Department/Behavioral Health Services nurse navigators will review treatment plans for such documentation before approving requested services.
3. THP navigators, when required, will educate members regarding their rights and responsibility to provide input to practitioners/providers as to their care preferences, and document such education appropriately.
4. THP navigators, will, where appropriate, advise members and practitioners/providers of available training in self-care, health promotion, etc. This advice should include information about non-covered community resources as well as The Health Plan coverage for such

services as dietary consults, smoking cessation programs, certified diabetic education, home health nurse educators, wound or ostomy care teaching, home infusion services, etc. and are documented.

5. THP navigators will periodically review treatment plans with their members to ascertain progress and compliance. These reviews will be shared with the primary care practitioner, and updated plans requested where appropriate. This process and outcomes are documented."

The Health Plan employs a provider engagement department made up of 13 representatives spanning across the state. This team will be sure to communicate the above listed policies with the specialists in our network. Between the nurse navigators and the PE team at THP all specialists working with THP members will know the importance of encouraging THP members to seek primary care services.

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.
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The Health Plan provides guidance to their PCP's within the provider manual on coordinating medical and behavioral health services in section 9 titled "Behavioral Health". The sub-section titled "Continuity and Coordination of Care" found on page 201 states the following:

"The Health Plan Behavioral Health Services Department advocates continuity and collaboration of care between behavioral health and physical health practitioners/providers. Continuity and coordination is an important aspect in the delivery of quality healthcare as behavioral and medical conditions interact to affect an individual's overall health. Information is expected to be exchanged between behavioral and physical healthcare providers whenever clinically appropriate.

It is the responsibility of the behavioral health practitioner/provider to communicate with the PCP and the PCP to communicate with the behavioral health practitioner/provider. Any information that is shared between practitioners/providers should be maintained in the member's medical record. If assistance is required to facilitate this exchange of information to ensure care coordination, the Behavioral Health Services Department is available to provide this service.

All federal and state confidentiality laws should be followed. The Health Plan expects that this information be shared accordingly and recognizes the right to keep progress notes private. The Health Plan also understands that there are special situations where information cannot be shared. A continuity of care consultation sheet is available on The Health Plan's website for use in facilitating this communication at www.healthplan.org."

The Health Plan hosts a series of forms to make transitions from PCP to Behavioral Health provider a seamless process to ensure continuity of care. All forms are conveniently available

online to THP's providers and can be submitted by fax, email or electronically. The forms available to THP providers to ensure coordination and continuity of care are listed below:

- Authorization to Disclose Health Information to PCP
- Admission Review Form
- BHU Fax Cover Sheet
- Concurrent Authorization for ABA/Behavioral Services Form
- Concurrent or Discharge Review Information Form
- Continuity of Care Consultation Form
- Crisis Encounters Report Form
- Initial Authorization for ABA/Behavioral Services Form
- Psychological Testing Preauthorization Request Form
- Treatment Continuation Request Form
- Substance Abuse Admission Review Form
- Substance Abuse Continuity or Discharge Review Information Form
- Intensive Outpatient or Partial Hospitalization Programming
- Pre-authorization of Drug Screening (labs)
- Request for ACT Programming – Medicaid Lines of Business only
- Request for CFT Programming – Medicaid Lines of Business only
- Request for ECT/TMS
- Pre-authorization for Telehealth Services

The Health Plan employs a provider engagement team made up of 13 representatives. The purpose of this team is to continually update providers on new initiatives, quality information and to be a provider liaison for issue resolution. This team works hand in hand with the providers to improve and educate on their efforts to provide a smooth coordination and continuity of care for all THP members. As THP coordinates SNS, similar activities and policies will be implemented to ensure information sharing with SNS providers.

PS016 The Vendor should educate primary care providers (PCPs) about the importance of dental screenings to ensure appropriate authorizations 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 Health Plan offers their providers information on EPSDT in our provider manual. We ensure our providers are fully aware of section 1905(a) in the Social Security Act and the entitlement of Medicaid eligible infants, children and adolescents of these services.

We cover dental services in the manual as well as screenings that are a necessity for those eligible for EPSDT such as dental services (furnished by direct referral to a dentist for children beginning six months after the first tooth erupts or by 12 months of age.

The Health Plan currently has a BMS Performance Improvement Project (PIP) regarding "Annual Dental Visits for 2 to 3 Year Old's" that provides a systematic approach to quality improvement. The PIP measures performance using objective quality indicators, implement interventions to achieve quality improvements, and evaluate effectiveness of interventions. Through qualitative and quantitative analysis, We have identified opportunities for improvement. The following interventions are designed to increase dental awareness and education for members and providers:

- Increasing education to our providers on best practices of referring children to dental services,
- Ensuring providers are educating parent/guardian on the importance of dental visits for children,
- Providing practitioners' offices with a one-page LogistiCare data sheet to assist members with transportation for appointments,
- Exploring opportunities to facilitate dental care such as mobile resources.

The Health Plan will use their Provider Engagement department, made up of 13 representatives across the state of West Virginia to ensure providers are properly educated on best dental practices for children 6 months and up.

The Health Plan mails post cards on the birthday month of children ages 2 and 3 years of age to remind them of the importance of scheduling a dental exam. In addition, THP makes all new members aware of their dental benefits during their welcome call to THP.

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.

Participating PCPs and pediatricians are required to do EPSDT exams according to the EPSDT periodicity schedule.

The Health Plan monitors this compliance by sending a reminder notice to the PCP and the member of the screening due date. The PCP is asked to return the notice to The Health Plan noting whether or not the member kept or missed the appointment and if any authorizations were made. This information is entered into the HEART System tracking tool that automatically updates the file for the next screening due date based on the periodicity schedule. This EPSDT tool tracks well child exams from birth up to age 21. Additionally, THP monitors the claims system for EPSDT encounters that it may not have been notified of formally. If the provider documents a referral on the reminder notice, it is documented in the EPSDT program.

During the exam, if a suspected problem is detected, the child should be evaluated in order to obtain a definite diagnosis that will then determine the treatment plan. Follow-up diagnostic and treatment services, which are medically necessary and covered benefits, are covered by The Health Plan.

Members should be referred for other services as needed such as vision, hearing, or dental. The MCO covers children's dental services effective 1/1/2014.

When a member doesn't keep the appointment, a Member Advocate will contact the parent/guardian to stress the importance of these exams. If necessary, the Member Advocate can make the appointment for the parent/guardian. Transportation assistance is also discussed if needed. There is no deductible, per-visit charge, or co-pay for childhood immunizations.

PS018 The Vendor should educate providers about the ability to request out-of-network referrals.

The Health Plan educates their providers of policies regarding out-of-network authorizations through the provider manual, specifically the product matrix. The provider engagement team at THP ensures each provider is aware of the location of the provider manual and they also give a paper copy of the product matrix portion to each new provider welcomed to the network. The product matrix can be found beginning on page 17 in the provider manual. The product matrix breaks up care by line of business and gives specific instructions for PCP's on their best method for authorizations to specialty care in and out-of-network.

Out-of-network care is also listed in the provider manual under section 7 of the manual in the prior authorization requirements. This list is updated on a regular basis and also given to providers directly from the provider engagement team.

PS019 The Vendor should support e-Prescribing functions.

THP's contracted PBM Express Scripts currently supports the following electronic prescribing functionality:

- Rx prescribing
- Submit Rx to retail
- Drug interaction/safety edits
- Formulary view
- Submit Rx to mail
- Prior Authorization criteria
- Prior Authorization clinical criteria submission
- Drug price
- Benefit design view
- Step Therapy notifier
- Member drug history view
- Formulary alternative selection tool
- Physician direct messaging

We're currently piloting:

- Medication adherence
- Quantity limit notifier

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:
PS021	Opportunities for standing authorizations
PS022	Opportunities for specialists to serve as primary care providers (PCPs)
PS023	Availability of disease management

THP provides multiple avenues for provider education. Prior to implementation of Foster Care, THP will provide live educational webinars to providers on various days at various times to accommodate provider schedules. Time will be allocated to allow for provider questions and answers during each live webinar. Topics covered will include general information on the needs of the Foster Care population, medical management (including information on standing referrals, specialists as PCPs and disease management), behavioral health, socially necessary services, billing and claims guidelines, authorizations and referrals, EPSDT and Family Planning services, credentialing and contact information. The presentation including a list of frequently asked questions, will be posted to THP's website as a resource for providers THP's provider engagement team will be contacting, and providing onsite education to identified large volume providers and other providers unable to participate in the on line training. The provider engagement team ensures providers are aware of the availability and location of THP's Provider Manual which incorporates information provided during training. Articles related to healthcare of the foster care population will be provided in THP's provider and member newsletters to reinforce various aspects of training.

It is The Health Plan's policy to facilitate ongoing specialist care for the benefit of appropriate members. This goal is accomplished by the use of standing referrals. This would apply when the primary care physician (PCP), in consultation with a specialist, identifies the need for continuing specialty care, over a short period of time, for resolution of a condition that is not life-threatening, degenerative, or disabling. Educational information regarding standing referrals is available in THP's provider manual, section 7, page 140 located at

https://www.healthplan.org/application/files/9915/6382/4388/Full_Provider_Manual_-_07.22.19_Version.pdf

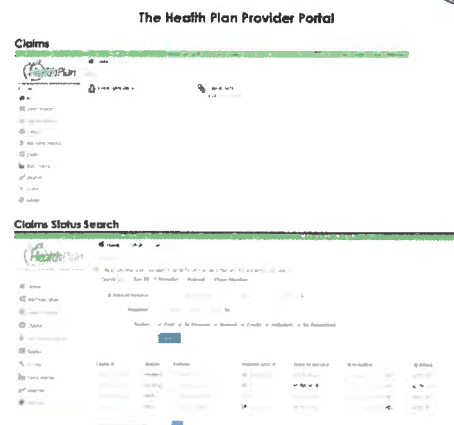
PS024 The Vendor should provide a publicly accessible, secure website with information targeted to providers.

THP's public website www.healthplan.org offers many general resources for both members and providers. Providers may access the Provider Manual, Medicaid Behavioral Health Manual, quality measures, educational materials, and access links to: fee schedules, prior authorization forms and refer members to case management.

Providers may access THP's provider secure website via the public website in two locations on THP's public website. A "Secure Login" button is prominently displayed at the top of THP's home page and providers may access the same location by clicking the "For Providers" button and clicking the "Access Your Provider Account" login button on the right of the screen. After logging into the provider secure site providers may submit electronic preauthorizations, access claims information, search for member information and download payment vouchers and provider performance reports and PCPs and OB/GYNs may download member.

The Health Plan's public facing website (<https://www.healthplan.org>) offers providers the following informational items.

- Overview
 - Contact us
 - Join our network
 - Meet the provider engagement team
- Education
 - Communication and newsletters
 - Compliance and fraud, waste, and abuse
- Patient Care Programs
 - Advance directives
 - Behavioral health
 - Consumer driven services
 - Dual Eligible Special Needs Plan (D-SNP)
 - Medical management
 - Pharmacy
 - Quality measures
 - WV Medicaid
- Resources
 - Helpful links
 - Physician case management referral
 - Policies and fee schedules
 - Prior authorization
 - Provider manual
 - Quick reference



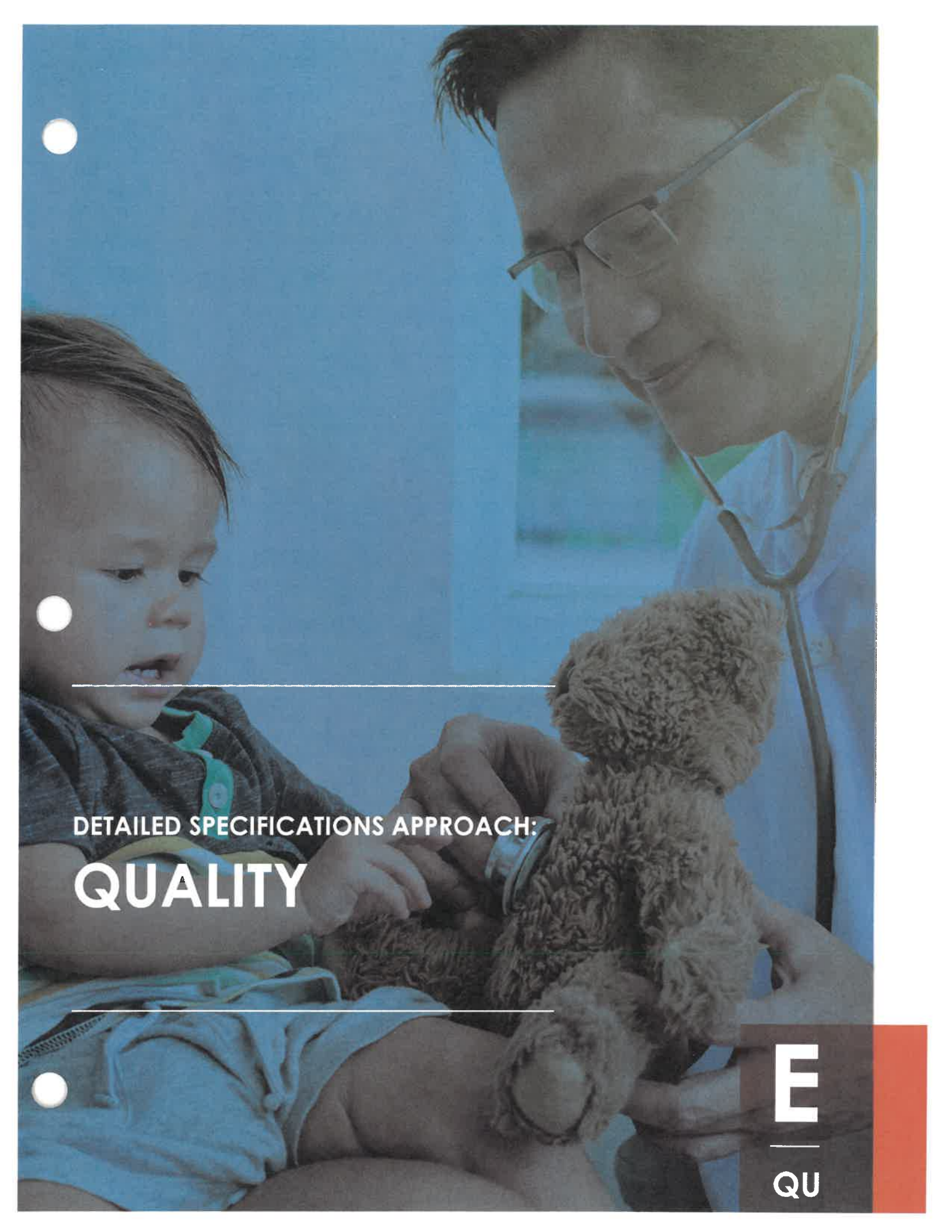
PS025	The Vendor should provide a secure portal-accessible by providers, Department caseworkers, and other stakeholders as permitted by the Department -- that allows these stakeholders to log in and access information as permitted by the Department, including, but not limited to, the following:
PS026	Medical records
PS027	Authorization status
PS028	Confirmation of services previously provided to avoid duplication

The Health Plan offers a secure online portal for providers, allowing access to information about their practice and our members. Providers can search member eligibility data for any member of The Health Plan, but can only see claims, remittance advice, and pre-certification/pre-authorization information for their practice and providers within their practice. Functions available on the website are:

- Member eligibility inquiry by name, member ID, or government ID such as HICN or MBI
- Claims submission
- Claims status inquiry by claim number, patient name, provider, and tax ID
- Remittance advice inquiry by provider within a group, tax ID, and check number
- Pre-certification/prior authorization submission including ability to submit supporting medical documentation
- Pre-certification/prior authorization inquiry by number, provider, and member
- Primary care physician member rosters by provider within a group or tax ID

The portal can be customized to allow access for Department caseworkers and other approved stakeholders as well. Screenshot samples of our provider portal are attached.



A photograph of a male doctor with glasses and a stethoscope, smiling as he examines a child's brown teddy bear. The child is sitting and looking towards the bear. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

QUALITY

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Quality

The Quality Improvement Department at The Health Plan is comprised of data analytic staff and registered nurses. This staffing structure promotes clinically driven, technology enhanced and a member focused Quality program integrity.

THP is committed to advancing the quality of care delivered by our providers and received by our members using best practices available. Our goal is to improve the quality of care and service outcomes across all healthcare settings including behavioral health and substance abuse management to those we serve. Our Quality Improvement objectives and goals are used to drive strategic performance improvement.

The Health Plan utilizes a multidisciplinary approach to monitor, analyze and evaluate the effectiveness, efficiency, safety and overall quality of care and services which incorporates promoting the enhancement of physical health of adults and children through prevention and wellness initiatives.

The Quality Improvement process links all knowledge, structure, and processes within THP for use in the assessment and improvement of quality of care and service. This process is coordinated through the Quality Improvement Department and is supported by the Continuous Quality Improvement Workgroup and the Clinical Quality Improvement Committee.

The framework of the Quality Improvement process comes from the Quality Management Program which defines the range of clinical care and service issues relevant to our members. The program monitors performance seeks opportunities for improvement across all healthcare services provided and addresses meaningful clinical issues that reflect the health needs within our member populations.

The Quality Management organization structure consists of the following:

- Board of Directors
- Executive Management Team
- Medical Directors (EMT)
- Quality Improvement Committee (QIC)
- Continuous Quality Improvement Workgroup (CQI)
- Credentials Committee
- Medical Director Oversight Committee (MDOC)
- Physician Advisory Committee (PAC)
- Pharmacy & Therapeutic Committee (P&T)
- Transplant and New Technology Assessment Committee (T&T)
- Star Ratings Workgroup
- Government Programs and Operations Workgroups

QU001 The Vendor should reward physical and behavioral health providers that adhere to the quality or performance standards of the Department.

Population Health is an approach to healthcare that consists of interrelated processes that improve healthcare quality and optimize healthcare spending.

Our goal is to provide a 360-degree view of all populations in the form of a comprehensive, up-to-date health information that can provide insight for **predictive** and **prescriptive analytics**

Five (5) Goals:

1. Keeping the well, well
2. Reducing health risks
3. Providing quick access to care for acute illness so that health does not deteriorate
4. Managing chronic illness to prevent complications
5. Getting those with complex or catastrophic illnesses to centers of excellence or compassionate care settings

Our Population Health Stratification Software

- Applies analytical intelligence to claims data
- Builds episodes of care based on medical or behavioral health conditions – includes a severity of illness indicator
- Applies evidence-based guidelines related to quality and utilization
- Develops a Predictive Score and a Care Need Index for each individual
- Creates Practice Pattern Variation Reports based on patterns of care
- Actionable reporting to drive early interventions and improvement

THP will conduct two CAHPS surveys per year for Adults and Children. THP will include any additional questions requested by DHHR and the external quality review organization in the surveys.

To assess Provider/Practitioner satisfaction, THP will conduct a Provider/Practitioner satisfaction survey annually and conduct an Enrollee access and availability survey at least annually to assess compliance with the Contract standards for access to Covered Services and appointment times. We will:

1. Identify disparities in medical health and behavioral health services and outcomes between subpopulations/groups (i.e., race/ethnicity and language);
2. Identify social determinants of health; and
3. Identify the causes for health disparities.

THP will develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions and include this plan and timeline in THP's QAPI program and CQI plan submissions to DHHR. This plan of action will include a performance measurement and evaluation component. We will submit reports to DHHR quarterly

Provider Performance Requirements

THP will measure the performance of Providers quarterly utilizing a Provider profiling and report card system. THP's system will consist of, but not be limited to Provider profiling activities for PCPs, Behavioral Health Providers and other high Provider utilizer types. As part of our quality activities, we will describe the methodology we use to identify which and how many Providers to profile and identify measures to use for profiling such Providers. THP's Provider profiling activities will include, but are not limited to:

- Developing Provider-specific reports that include a multi-dimensional assessment of a Provider's performance using clinical, administrative, and member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
- Establishing Provider, group, or regional benchmarks for areas profiled, where applicable, including WVDHHR Medicaid-specific benchmarks, if any;
- Providing feedback to Providers, at least quarterly, regarding the results of their performance and the overall performance of the Provider Network and THP will submit copies of this feedback to WVDHHR, upon request;
- Designing and implementing Quality Improvement Programs (QIPs) for Providers who receive a relatively high denial rate for pre-service, concurrent, or post-service authorization requests, including referral of these Providers to the Network management staff for education and technical assistance; and
- Using the results of our Provider profiling activities to identify areas of improvement for Providers, and/or groups of Providers, THP will:
 - Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established THP standards or improvement goals and take appropriate action when THP determines the Provider's performance is out of compliance;
 - Recommend actions to correct identified deficiencies and monitor corrective action by Providers.
 - Develop and implement incentives, which may include financial and non-financial incentives, such as APMs, to motivate Providers to improve performance on profiled measures;
 - Conduct on-site visits to Network Providers for quality improvement purposes; and
 - At least annually, identify and establish improvement goals, with periodic measurement and report on the Provider Network's progress, or lack of progress, toward meeting such improvement goals.

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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.

THP has developed and published numerous practice guidelines for providers that are evidence-based. A minimum of two non-preventive acute or chronic condition guidelines and at least two behavioral healthcare guidelines are always in place and monitored. Currently, THP has practice guidelines that impact areas of Quality Improvement, Disease Management and Behavioral Health. The guidelines are as follows:

- Standards for Access to Care and Services
- Patient Medical Records
- Preventive Health
- Management for Asthma
- Management for COPD
- Management for CHF
- Management for Diabetes
- Perinatal Care Preventive Health
- Revascularization in Stable Ischemic Heart Disease
- Adults with ST Elevation and Non-ST Elevation Myocardial Infarction
- Management of ADHD
- Management of Depression
- Treatment of Substance Abuse

These guidelines are designed to measure quality across THP and ensure content is consistent for each condition managed, as well as guarantee appropriate practitioner oversight of chronic disease or care management programs.

These guidelines are updated at least every two years and made available via THP's website, the provider portal, and in the provider manual, with notifications to providers when changes occur. Practicing providers, via THP's Physician Advisory Committee, offer input/insight into development of the guidelines. The Physician Advisory Committee reviews guidance from federal sources (e.g., Centers for Disease Control and Prevention and Substance Abuse and Mental Health Services Administration), professional medical societies (e.g., American Academy of Pediatrics and American Board of Internal Medicine), and well-regarded health advocacy groups (e.g., American Diabetes Association and American Heart Association) when it approves THP's practice guidelines.

We monitor compliance with these guidelines and offer routine education, as well as targeted education, for providers exhibiting unacceptable performance. The full process of educating providers demonstrating unacceptable performance is detailed in the QU003 response. As part of provider monitoring, THP utilizes Practice Pattern Variation Summary Reports and Practice Pattern Variation Full Reports to objectively quantify provider efficiency and effectiveness compared to network peers. Appropriate aspects of SNS will be integrated into

existing reporting and monitoring methodologies once SNS is transitioned to the managed care model.

- As the SNS ASO, THP will work collaboratively with the Bureau for Children and Families to remedy any SNS provider deficits, close care gaps, or, as a last resort, recruit new providers to the service area to provide appropriate coverage. KVC Health Systems, a key strategic partner for our foster care implementation, has 23 years of experience in providing SNS. KVC will facilitate the involvement of current West Virginia foster care providers and community stakeholders in the implementation of THPs foster care program by establishing an advisory group including foster care service providers, West Virginia Department of Health and Human Resources representatives, foster care families, health care providers, and other stakeholders. Through this advisory committee/group, KVC and THP will:
 - Discuss mechanisms to review, approve, and pay SNS;
 - Develop and review evidence-based criteria for SNS;
 - Review the authorization request process and other best practices to minimize administrative burden for needed services; and
 - Establish a monitoring system for SNS providers, evaluation criteria for effective delivery of SNS, and a reporting structure for SNS.

THP clinical staff actively participate in Project Extension for Community Healthcare Outcomes (ECHO) through the West Virginia Clinical and Translational Science Institute, a best practice for improving primary care providers' exposure to specialists. The ECHO model eliminates barriers between specialty and primary care, as it links specialist teams at an academic "hub" (in this case, West Virginia University and WVU Medicine) with primary care providers in local communities, especially rural areas and federally qualified health-centers.

THP encourages Project ECHO participation so primary care providers can expand their knowledge of specialties (e.g., psychiatry, endocrine, and chronic lung disease) to better serve members in their patient-centered medical home. This allows primary care providers to better manage care in an ambulatory/primary care setting rather than a hospital or institution. Leveraging the grand rounds fashion of ECHO further permits THP to target provider needs, trainings, etc. on specific chronic diseases, particularly those relevant to the foster care population and increase its own capacity for care coordination and care navigation. THP will include information about relevant ECHO clinics via its website and in its provider newsletter—highlighting the importance of participation to meet the unique needs of foster care children and their families/care givers.

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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.

Depending on the level of severity, identified provider performance deficiencies will be addressed through:

- **Empowering Providers** to know where they stand on a peer level by offering customized reporting via CAVE Consulting Group, Inc. on benchmarks. A summary report is made available via THP's provider portal, and a provider may request an in-depth practice variation report. The reports are shared as an educational tool to help the provider understand where he/she may not be delivering care in the most efficient or effective manner relative to peers.
- **Outreach** by a Provider Engagement Representative to review THP policies, procedures, and best practices. Additional on-site training or education may be completed to ensure the provider understands internal THP policy and procedures and contractual requirements.
- **Quality Improvement Committee and Clinical Committee** interventions, including the following:
 1. Peer to Peer consultation with a THP medical director or a Specialist Provider. Specialist review is conducted blindly (a Specialist Reviewer will not be selected to review another physician within his/her own practice or department). THP also has vendor relationships for Specialist review when a potential conflict might arise, as well as access to its own Physician Advisory Committee of THP's participating Providers.
 2. Corrective action processes and/or limitation on access until a situation is resolved
 - a. Limit providers ability to see members and/or perform certain procedures
 - b. Place provider under a focus review via medical record review or reviews generated by claims data at scheduled intervals
 - c. Require practitioner to enter into a preceptor relationship
 - d. Require practitioner to complete continuing medical education regarding the treatment, procedure or service in question
 - e. Non-renewal of contracts
 - f. Referral to THP's Special Investigations Unit
 - g. Referral to West Virginia Medicaid Fraud Control Unit

Deficiencies identified in the realm of socially necessary services (SNS) would be reviewed with WVDHHR. THP will provide regular reports on any identified issues with SNS providers and will review with WVDHHR. At the request of WVDHHR, THP will assist in the development and monitoring of Quality Improvement projects directed toward SNS.

Instances of suspected or confirmed waste, fraud, or abuse will be shared with the West Virginia Medicaid Fraud Control Unit as soon as practical.

Although THP's typical process for unacceptable performance is detailed above, in cases of suspected waste, fraud, or abuse may require skipping or concurrent steps, such as limitations on access or assignment of new patients coupled with Provider Engagement Representative education or direct referral to THP's Special Investigations Unit. THP will submit a monthly report to the West Virginia Department of Health and Human Resources on any identified SNS deficiencies.

QU004 The Vendor should adopt strategies to simplify administrative procedures.

THP currently engages in several processes to simplify administrative procedures and reduce burden for Providers and to better serve members. For example, THP provides coding standards to practitioners and key coding staff to reduce chart review issues; expedites utilization management requests of Medicaid members typically within 48-hours rather than the contractual maximum of seven calendar days; and offers members and Providers the ability to speak to a West Virginia- or Ohio-based representative quickly when calling customer service lines. Complying with West Virginia HB 2351 concerning prior authorization, THP also allows submission of electronic claims, authorizations, and utilization management/prior authorization requests via its Provider portal. Additionally, as mentioned in the QU011 response, THP will align quality measures among its value-based agreements to limit Provider reporting burdens and reduce unnecessary effort to meet multiple, varied quality measures.

THP leverages its Provider portal as a key source for up-to-date membership rosters and analytics reports (such as CAVE reports and practice pattern variation summaries) and Provider manuals, newsletters, and announcements. If Providers have questions or need assistance finding information or materials, customer service representatives are available. For more complicated matters, especially claims issues, Providers may reach out to the designated Provider Engagement Representative/Manager assigned to cover their county in West Virginia. THP also has a Provider Engagement Representative dedicated specifically to working with Behavioral Health Providers, which will be crucial in serving the foster care population. THP considers face-to-face Provider engagement as important to its success, particularly important to the transition of foster care to managed care, and it has invested heavily in this area in recent years.

Our 13-person, all West Virginia-based Provider Engagement Team is on the frontlines with Providers daily. By virtue of this, THP is able to respond to administrative problems quickly and anticipate future ones. The Provider Engagement Team works collaboratively with Providers to triage administrative problems and streamline processes whenever possible.

Finally, THP makes its clinical staff, including medical directors, nurses, pharmacists, navigators, etc., available for peer to peer consultations and grand rounds with Providers. This allows Providers to glean additional information and perspectives to better manage the care of THP members. THP's capacity in this regard will be strengthened through collaboration with WVU Medicine and KVC. The collaboration will provide access to specialty clinicians and expertise in socially necessary services for input specific grand rounds cases. This expertise is important

since WVU Medicine has the greatest specialist coverage in child and adolescent psychiatry and psychology, major areas of need for the foster care population and children with serious emotional disorder and KVC has proven experience in delivery of socially necessary services.

Proactive Strategies to Simplify Administrative Procedures

To encourage Providers to join and remain in our network, THP recognizes that there is a need to communicate regulations, policies, and procedures clearly and be transparent. By streamlining and clarifying administrative procedures, fees, costs, and potential penalties, THP can improve its relationships with Providers, and strengthen collaboration with our Provider network and WVDHHR.

Greater transparency and simpler procedures will contribute to Providers' success because they will be better informed about requirements, understand their responsibilities better, and spend less time complying with regulations, policies, and procedures. This also reduces the likelihood that Providers will be subjected to penalties, denial of payments, or other disciplinary actions.

1. Departments examining potential areas/matters for administrative Simplification
 - a. Examination of the matter will largely be conducted by THP's Provider Engagement Team.
 - b. Working groups composed of experts will be put in place to contribute to examinations of technical matters.
2. Concrete steps to be taken
 - a. Establish working group(s) that include THP staff, Providers, and WVDHHR staff, as appropriate.
 - b. Conduct interviews with high-volume and key strategic foster care providers.
 - c. Start examination of regulations and administrative procedures to be simplified and determine concrete measures that can be simplified sooner wherever possible.
 - d. As for other regulations and administrative procedures to be simplified over the medium term, determine concrete measures for simplification and incorporate them into a "Management and Reform Plan," to keep track of the status of execution.

QU005	The Vendor should administer a Quality Assurance and Performance Improvement (QAPI) Program.
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THP's experience with Medicaid, Medicare Advantage and commercial insurance demonstrate it has the knowledge and technical capacity needed to achieve improvements in the quality of health care and service on an ongoing basis. THP currently operates a Quality Assurance and Performance Improvement (QAPI) program, which is reviewed and/or revised annually and submitted for DHHR's approval. THP will emulate its DHHR-approved and well-established QAPI program for this RFP, subject to modification by DHHR or its designee's

directions. This response, therefore, showcases the robust QAPI program THP already implements as an existing Medicaid MCO in West Virginia.

THP maintains a well-defined QAPI structure that includes a planned, systematic approach to improving clinical and non-clinical processes and outcomes. At a minimum, THP ensures that the QAPI program structure:

- Is organization-wide, with clear lines of accountability within the organization
- Includes a set of functions, roles and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians and non-clinicians
- Includes annual objectives and/or goals for planned projects or activities, including clinical and non-clinical programs or initiatives and measurement activities
- Evaluates the effectiveness of clinical and non-clinical initiatives

THP submits a QAPI Program Annual Summary in a format and timeframe specified by DHHR or its designee. The written summary describes how THP:

- Analyzes the processes and outcomes of care using currently accepted standards from recognized medical authorities
- Analyzes data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to members
- Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of emergency services
- Uses measures to analyze the delivery of services and quality of care, over- and under-utilization of services, disease management strategies and outcomes of care

THP keeps network providers informed about the QAPI program and related activities and includes in provider contracts a requirement securing cooperation with quality initiatives.

THP integrates behavioral health into its QAPI program and includes a systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of behavioral health services provided members. THP collects data, as well as monitors and evaluates for improvements, of the physical health outcomes resulting from behavioral health integration into the member's overall care.

The QAPI program is consistent with the following requirements, but not limited to:

- At least annually collect and submit performance measurement data
- Use performance measures including, but not limited to, HEDIS®, CAHPS®, Provider surveys, satisfaction surveys, CMS-specified Core Measures, EPSDT, Clinical and Non-Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events, as part of its QAPI program
- Use mechanisms to detect both under-utilization and over-utilization of services
- Contract will use mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by DHHR

- Ensure that all its agreements (or provision of an agreement) with providers contain a requirement to allow DHHR, or its designee, reasonable access to records or files for quality improvement activities
- Integrate the following program descriptions/strategies into the QAPI:
 - Case management and care coordination
 - Utilization management
 - Provider network management
- Use the results of these performance measures and any other performance measures specified by DHHR to assess the effectiveness of its QAPI program. The QAPI program includes iterative processes for assessing and monitoring quality performance, including but not limited to:
 - Barrier analysis
 - Identifying opportunities for improvement
 - Implementing targeted and system interventions
 - Regularly monitoring for effectiveness utilizing continuous quality improvement strategies

To maintain an organizational structure, lines of authority and accountability for quality improvement functions within the QAPI, THP conducts performance improvement projects (PIPs). These PIPs are designed to achieve, through ongoing measurements and interventions, sustained improvements in clinical care and nonclinical areas that are expected to have a favorable effect on health outcomes and member satisfaction. When DHHR specifies required performance measures and/or PIPs, THP will report such performance measures to DHHR and conduct such PIPs. THP reports the status and the results of PIPs at least annually to DHHR.

THP adheres to the following practices as part of its QAPI program, and includes the following elements in PIPs:

- Objective quality indicators to measure performance
- Performance goals and identifying benchmarks
- Planning and initiation of activities for increasing or sustaining improvement
- Implementation of system interventions to achieve improvement in the access to, availability of and quality of care
- Systems in place to evaluate the effectiveness of each intervention based on the performance measures
- On a quarterly basis, THP submits performance improvement data and an analysis of that data to DHHR and/or the external quality review organization (EQRO) in the timeframe and format specified by DHHR or its contracted EQRO, as applicable

THP conducts an annual evaluation of its QAPI program which, at a minimum, includes:

- Analysis of improvements in the access and quality of health care and services for members as a result of quality assessment and improvement activities and targeted interventions carried out by THP
- Consideration of trends in service delivery and health outcomes over time and includes

- monitoring of progress on performance goals and objectives
- Information on the effectiveness of THP's QAPI program is provided annually to network providers, upon request to member and annually to DHHR through compliance review or upon request

THP will incorporate measures and projects into the QAPI that are relevant to the foster care population based on an analysis of data and reporting relevant to the population.

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

Accountable members ensure better HEDIS and EPSDT compliance, which results in a healthier West Virginia, especially for the foster child and youth population. Through the collaborative efforts of its employees, providers, government officials and community-based organizations, THP intends to accomplish its goals of delivering high-quality health care using national HEDIS and NCQA benchmarks as standards of performance and monitoring.

We will maintain a utilization log that tracks over- and under-utilization, along with the appropriateness of services, in accordance with the requirements of the program. THP monitors for under-utilization through review of:

- HEDIS performance measures for the individual and group physicians
- Measurements established for various programs related to the effectiveness of care
- Claims analysis
- Compliance with reporting requirements as specified in physician contracts

THP will directly contract with a NCQA certified HEDIS® auditor and CAHPS® vendor – Professional Services Network.

We will submit all performance measures required by DHHR in accordance with the DHHR specifications and timelines. For the purposes of public reporting, all NCQA HEDIS® performance measure data will be submitted to NCQA Quality Compass. CAHPS® survey results will be submitted to NCQA Quality Compass and to the National CAHPS Benchmarking Database. THP will have systems in place for analyzing its performance measures and will report to DHHR any quality improvement activities.

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.

As stated in the QU005 response, THP's QAPI program includes a plethora on non-HEDIS programs and policies that will serve West Virginia's youth and families well. For instance, THP, through its QAPI program, uses performance measures including, but not limited to, CAHPS®, provider surveys, satisfaction surveys, CMS-specified Core Measures, EPSDT, Clinical and Non-

Clinical Initiatives, Practice Guidelines, Focused Studies, Adverse Events and all EQRO activities. Additionally, THP

- Uses mechanisms to detect both underutilization and overutilization of services
- Contract mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by DHHR;
- Ensure that all of its agreements (or provision of an agreement) with providers contain a requirement to allow DHHR, or its designee, reasonable access to records or files for quality improve activities;

THP also maintains a Continuous Quality Improvement (CQI) Workgroup, along with the Quality Improvement Committee (QIC), that is comprised of external providers for purposes of reviewing the QAPI program, its results and activities, and recommending changes on an ongoing basis. The CQI will be comprised of THP staff representing each department to promote collaborative initiatives and to further develop ways to improve care for foster children and families beyond HEDIS® measures.

QU008	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:
QU009	Healthcare Effectiveness Data and Information Set (HEDIS) scores
QU010	Measures that go beyond traditional Healthcare Effectiveness Data and Information Set (HEDIS) scores

THP will report audited HEDIS® measures to DHHR annually by June 15th. Once our NCQA HEDIS Compliance Audit are completed, the audited results will be submitted to DHHR upon submission to NCQA. We understand DHHR will provide guidance regarding which measures must be reported, according to the current version of HEDIS. Additionally, THP will conduct CAHPS surveys annual as required by DHHR.

THP understands that DHHR will establish a quality withhold program that may include non-HEDIS and even non-medical measures of performance. These measures, however, should align with the legislative goals stated in West Virginia Code Chapter 49, specifically article 2, section 126 et seq.; requirements of the U.S. Department of Justice and provisions of the Family First Prevention Services Act. THP pledges to work with DHHR in developing the measures for the quality withhold; yet it urges DHHR to convene or consult subject matter experts on this topic, as well. For this RFP response, THP suggests DHHR to consider a subset of the following measures as potential areas of performance or topics for subject matter expert discussion:

- Improved CAFAS results over time and changes
- Improved CANS results over time and changes
- Reduction of transitions while in foster care and percentage of foster care reentries
- Improved reunification rates/safe returns to the home
- Reduction in the number of emergency events while in foster care
- Improved timeliness of mandated assessments

- Permanency goal achievement such as reunification or placement in kinship care or adoption
- Reduction in out-of-state foster child placements when an in-state placement is available

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.

THP deploys a number of Alternative Payment Models (APMs) for the various Provider types throughout its service area, including care coordination payments with shared savings for meeting quality measures and total cost of care models. By analyzing multiple years of financial data, as well as three years of clinical-based analytic data, THP creates APMs that meet the "quadruple aim of healthcare:"

1. Improving the quality of care,
2. Achieving lower costs,
3. Promoting better health outcomes, and
4. Reducing Provider burnout.

THP adheres to an APM risk readiness approach developed by the Healthcare Payment Learning & Action Network. Since 2016 the West Virginia Department of Health and Human Resources and the Centers for Medicare and Medicaid Services' preferred approach to tracking/building APMs has been guided by this framework. This is further evidenced in West Virginia's State Innovation Model (SIM) grant plan.

THP's Director of Provider Strategic Initiatives, who is also listed as the Community Engagement Director in the RFP staffing plan, leads THP's APM initiatives and assisted the state in developing its approach to APMs during the SIM grant. Originating from the SIM grant, THP's Director was instrumental in establishing/operating a non-profit, the West Virginia Partnership for Health Innovation, an organization committed to moving the state toward value-based healthcare.

We seek to meet Providers where they are on the APM framework risk continuum. To date, THP's APMs are either category 2A through C or 3A. These APMs include payment bonuses or upside risk only. No payments are taken back or withheld from the Provider(s). THP collaborates with Providers to develop APMs that are the best fit for their needs, as well as the needs of our members. We do not have panel size requirements or restrictions on our APMs and have maximum flexibility to design APMs.

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CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION - BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

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Examples of THP's Current APMs:

Shared Savings and Total Cost of Care

Shared Savings

In THP's shared savings arrangements, providers receive contracted fee-for-service reimbursement, a per member per month care coordination fee, and increased access to claims and population health and risk stratification data (e.g., Cave reports, HEDIS care gap reports, and customized data analytics, by request of the provider). In turn, providers are expected to build out care coordination infrastructure and manage the needs of the assigned membership. A signed agreement establishes shared savings payments between THP and the provider contingent on the latter meeting/improving certain quality measures (better quality), as well as medical loss ratio thresholds (lower costs). Monthly meetings between THP and provider representatives occur to discuss operational issues with the APM, and a quarterly meeting takes place to review financial and quality reporting.

Quality measures in these shared savings arrangements to date are generally HEDIS-based. The following quality measures related to the foster care population have been included.

- Adolescent Well Care Visit
- Immunizations for Adolescents-Combo 2
- Weight and Assessment Counseling for Nutrition and Physical Activity for Children and Adolescents-BMI Percentile
- Follow-Up After Hospitalization for Mental Illness-7 Days (which, if met, would count for 30-day follow-up, too)

The other HEDIS measures listed below may be included as quality measures in subsequent THP APMs.

- Childhood Immunization Status-Combo 3
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

THP intends to utilize these measures, as well as discuss with the Bureau for Children and Families/Bureau for Medical Services and other stakeholders additional HEDIS or non-HEDIS measures that should be prioritized. Wherever possible, though, THP will seek to ease provider/administrative burden by aligning measures between its APMs—that is, it will make its foster care measures a subset of measures in wider Medicaid population APMs.

Total Cost of Care

THP is formalizing a total cost of care model with a major comprehensive behavioral health center that serves Southwestern West Virginia. This pilot includes a 25-patient panel determined mutually by THP and the comprehensive behavioral health center. A care coordination payment will be provided to the center on a quarterly basis for the 25 patients. The total cost of care for the member in the rolling 12-months before the intervention will be used as a baseline for costs, then compared 12-months after the model commences. The center will earn a portion of the shared savings if it reduces costs and meets one or more quality measures:

- Measure 1: Reduces the CAVE proprietary Care Need Index by 10% or more;

- Measure 2: Reduces emergency department visit total by 10% or greater; and
- Measure 3: Eighty-eight percent (88%) or more assigned members have a claim originating in a primary care setting for any reason during the performance year.

The quality baseline is the previous rolling 12-months from the start of the model, which will be compared 12-months after the model commences. For attaining one measure, the center will receive 30% of any savings; 40% of any savings for attaining two measures; and 50% of any savings for attaining all three measures. This model encourages physical and behavioral/mental health integration, and it meets members where they most frequently access care (e.g., the comprehensive behavioral health center). The pilot currently only includes adults 18 years of age or older. If the pilot shows promise, it will be modified and expanded to include foster care children/adolescents.

Finally, all of THP's APMs and related agreements prohibit incentivizing member under-utilization. THP members are entitled to receive all medically necessary services, and THP monitors utilization to ensure its provider partners are compliant. THP encourages its provider partners to freely express concerns about potential underutilization so issues can be addressed collaboratively and assure members receive the care he/she needs.

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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:
QU013	Cost savings
QU014	Reductions in inappropriate utilization of services, including, but not limited to, inappropriate admissions and readmissions

Shared Savings

In THP's shared savings arrangements, Providers receive contracted fee-for-service reimbursement, a per member per month care coordination fee, and increased access to claims and population health and risk stratification data (e.g., CAVE reports, HEDIS care gap reports, and customized data analytics, by request of the Provider). In turn, Providers are expected to build out care coordination infrastructure and manage the needs of the assigned membership. A signed agreement establishes shared savings payments between THP and the Provider contingent on the latter meeting/improving certain quality measures (better quality), as well as medical loss ratio thresholds (lower costs). Monthly meetings between THP and Provider representatives occur to discuss operational issues with the APM, and a quarterly meeting takes place to review financial and quality reporting.

Quality measures in these shared savings arrangements to date are generally HEDIS-based. The following quality measures related to the foster care population have been included.

- Adolescent Well Care Visit
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The other HEDIS measures listed below may be included as quality measures in subsequent THP APMs.

- Childhood Immunization Status-Combo 3
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

THP intends to utilize these measures, as well as discuss with the Bureau for Children and Families/Bureau for Medical Services and other stakeholders additional HEDIS or non-HEDIS measures that should be prioritized. Wherever possible, though, THP will seek to ease Provider/administrative burden by aligning measures between its APMs—that is, it will make its foster care measures a subset of measures in wider Medicaid population APMs.

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The total cost of care for the member in the rolling 12-months before the intervention will be used as a baseline for costs, then compared 12-months after the model commences. The center will earn a portion of the shared savings if it reduces costs and meets one or more quality measures:

- Measure 1: Reduces the CAVE proprietary Care Need Index by 10% or more;
- Measure 2: Reduces emergency department visit total by 10% or greater; and
- Measure 3: Eighty-eight percent (88%) or more assigned members have a claim originating in a primary care setting for any reason during the performance year.

The quality baseline is the previous rolling 12-months from the start of the model, which will be compared 12-months after the model commences. For attaining one measure, the center will receive 30% of any savings; 40% of any savings for attaining two measures; and 50% of any savings for attaining all three measures. This model encourages physical and behavioral/mental health integration, and it meets members where they most frequently access care (e.g., the comprehensive behavioral health center). The pilot currently only includes adults 18 years of age or older. If the pilot shows promise, it will be modified and expanded to include foster care children/adolescents.

Finally, all of THP's APMs and related agreements prohibit incentivizing member underutilization. THP members are entitled to receive all medically necessary services, and THP monitors utilization to ensure its Provider partners are compliant. THP encourages its Provider partners to freely express concerns about potential underutilization so issues can be addressed collaboratively and assure members receive the care he/she needs.

Reductions in Inappropriate Utilization of Services

All quality of care and/or service-related concerns or potential problems identified by any department, that occurs in any inpatient or outpatient setting, are to be reported to the Quality Improvement Department in a timely manner. The Quality Improvement Department is responsible for ensuring resolution and follow-up. Possible sources of information include, but are not limited to:

- Medical Management Department – Concurrent review of all hospitalized members is performed by the Medical Management Department to establish appropriateness of admission and length of stay. During this review, any potential variance identified in the quality of care or service given to hospitalized members is reviewed further and if indicated, forwarded to the Quality Improvement Department for investigation. Included in this review is the identification of Hospital Acquired Conditions, Healthcare Associated Conditions, and Never Events, as defined by CMS. Collectively, these are referred to as "variances." Possible quality of care issues might also arise during retrospective utilization review. Utilization reviews may be inpatient or outpatient reviews. These cases are sent to the Quality Improvement Department for review and resolution.
- Operations Department – During review of claims, any possible quality variance noted is forwarded to the Quality Improvement Department for investigation.

- Behavioral Health Department – During the process of managing patient's behavioral healthcare, a case manager may forward a potential quality of care or service variance to the Quality Improvement Department for investigation.

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.

Responses to specifications *QU011* and *CM006-CM010* detail THP's implementation of alternative-payment models and a patient-centered medical home approach based on measurable outcomes, typically HEDIS-based quality measures.

- Other recognized measures include the care need index, a risk stratification algorithm created by THP's vendor CAVE Consulting Group, Inc., and utilization measures such as reduction of emergency department visits per 1,000.
- Managing care of members by making providers and health systems accountable for meeting or exceeding well-established quality measures (i.e., HEDIS) and for reducing a major source of unnecessary healthcare spending (i.e., non-emergent use of the emergency department) leads to better health outcomes, reduced costs, and increased member understanding of appropriate healthcare utilization.
- Likewise, attainment of the aforementioned quality measures is tied to shared savings payments that incentivize providers to prioritize primary care—unless emergent or there is no other source of care for the member—as the appropriate, first setting for care.

As THP designs a medical home for foster care children, it will reinforce accessibility and coordination, both American Academy of Pediatrics manual guidelines, by offering bonus payments to providers who: 1. See a foster care member within 24-hours of requesting an appointment and 2. Offer primary care or specialist visits after normal business hours (e.g., after 5 p.m. on weekdays and on anytime on the weekends or holidays). Over time, by making such bonus payments, THP will form a high-performing primary care network for foster care members. THP can then leverage that network for better care of the foster care child, potentially the child's foster family, and, where appropriate, the biological family. This approach supports West Virginia Department of Health and Human Resources' desire to select one managed care organization to specialize in children and youth, as well as serve the needs of the immediate family, if Medicaid eligible. Moreover, it is a family-centric approach to healthcare in accordance with the Family First Prevention Services Act's legislative intent, particularly for the delivery of mental health services and substance use treatment and the coordination of socially necessary services.

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 contract oversight, according to the Service Provider Agreement (SPA).

THP supports the Bureau for Medical Services' embrace of alternative-payment models (APMs) as a way to improve quality, reduce costs, improve population health, and alleviate provider/administrative burden. THP has advanced APMs in its existing Medicaid lines of business, as described in the response to QU011.

THP intends to expand APMs through its key strategic partner, WVU Medicine, and major comprehensive behavioral health centers including Prester Center for Mental Health Services, Southern Highlands Community Mental Health Center, and Westbrook Health Services, federally qualified health centers, and other types of integrated health care delivery systems. Letters of intent (included in addendum 3) demonstrate the commitment of providers to work with THP to develop and implement APMs that appropriately reward quality and increase access to care, among other collaborative efforts to better serve the foster care population.

Section 3.7.10 of the Draft Foster Care Model Purchase of Service Provider Agreement mandates the reporting process that THP should follow for APMs developed. APPENDIX H of the aforementioned service provider agreement includes a template for report submission. THP will comply with this process and complete the APPENDIX H template for reporting to the Bureau for Medical Services or its designee no later than August 15, 2020, as required by the service provider agreement.

THP recognizes that APMs cannot be implemented in a monolithic fashion with providers, especially with a vulnerable and medically needy population such as foster care children. Therefore, THP will engage the Bureau for Medical Services, Bureau for Children and Families, and other relevant stakeholders for a pre-implementation meeting to discuss potential strengths/challenges regarding APMs for foster children, arrange and hold a mid-point implementation meeting in April 2020 to review lessons learned and challenges, and arrange and hold an after-action meeting in September 2020 to evaluate the first six months of APM implementation. This pre, mid-point, and after-action meeting cycle will ensure THP, providers, and state partners are aligned on how to best proceed in terms of evolving APMs—whether toward models that include downside risk, capitations, bundled payments, or, in isolated circumstances, scaling back to fee-for-service reimbursement with targeted bonus payments.

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QU017	The Vendor should monitor quality Improvement strategies with measurements including, but not limited to, the following:
QU018	Access to care
QU019	Demand for services
QU020	Quality of care
QU021	Health outcomes
QU022	Member satisfaction
QU023	The Vendor should analyze utilization data to monitor quality improvement strategies.
QU024	The Vendor should collect and analyze quality measures at a set frequency.

THP Annual Quality Improvement Work Plan ensures the delineation, integration, and coordination of all quality improvement activities. The action plan provides a framework for the Quality Improvement Program and serves as the basis for the annual program evaluation process.

THP develops an annual QIP Work Plan that includes specific initiatives and measurable objectives. This work plan is modified throughout the year as necessary to address current conditions and emerging issues. Initiatives include, but are not limited to:

- Studies & analysis to identify opportunities for improvement in the area of care and service;
- Health promotion/education related to the management of ambulatory care sensitive conditions resulting in increased member self-management and decreased disease-related complications /co-morbidity;
- Appointment availability analyses to determine provider compliance with required access and availability standards;
- Data analyses and review of industry standard benchmarks and/or target performance levels to identify emerging opportunities for improvement of health outcomes and member satisfaction;
- Review of the coordination of care for children with special healthcare needs to ensure adequate access and service delivery; and
- Ad hoc studies based on trends in members' health data, service and satisfaction.

Procedure:

A multidisciplinary team, lead by the Quality department with representation from all of the various departments works collaboratively to develop the annual work plan. This work plan will be evaluated on a continuous basis throughout the year for revisions and to ensure attainment of the goals set.

The workplan is developed around quality dimensions that include Quality of Clinical Care, Safety of Clinical Care, Quality of Service, and Members' Experience.

- Identify Potential areas of program focus:

- quality of Clinical Care,
- safety of Clinical Care,
- quality of Service and Members' Experience
- high risk/high volume/high cost activities
- member complaints/member and practitioner satisfaction
- processes of care
- development and review of standards and practice guidelines
- outcomes management
- interrater reliability
- updating criteria
- Evaluate the status of the current work plan
 - goal achievement
 - problems identified which still require resolution
 - projects not completed
- Formulate the quarterly plan to include the following elements:
 - mandatory surveys/studies
 - problem-focused studies
 - standards/guidelines to review/develop

The annual work plan is reviewed and approved by THP's Executive Management Team.

THP's annual program evaluation serves as a mechanism to determine the extent to which the Quality Improvement Program is achieving identified goals. The annual review provides a detailed analysis of progress toward the various components in the work plan identifying successful project as well as areas with barriers. Each year the evaluation serves as the catalysts for the work plan for the coming year.

Procedure:

- Yearly planned QI activities and objectives for improving: Quality of Clinical Care, Safety of Clinical Care, Quality of Service, Members' Experience, and Health and Wellness.
- Time frames identify when each activity should be accomplished.
- Staff members responsible for each activity.
- Analysis of data identifies if progress towards goal is realized or met.
- Barrier analysis identifies potential impediments to reaching goal.
- Action Plans define how the objectives will be achieved.

The Quality Improvement Department is responsible for the oversight of the yearly work plan. This work plan is evaluated by each respective organizational department on a continuous basis throughout the year for Revisions and to ensure attainment of set goals. The following process may be utilized to develop a work plan:

a. Identify areas of program focus:

1. High risk/high volume/high cost activities that impact patient care preventive services
2. Medical record documentation

3. Accessibility and availability
4. Member complaints/member satisfaction
5. Processes of care
6. Compliance review of standards and practice guidelines
7. Needs for various disease conditions
8. Safety

b. Health and Wellness

1. Evaluate the status of the current work plan:
2. Goal achievement
3. Problems identified which still require resolution
4. Projects not completed

The yearly work plan is to be reviewed by CQI and QIC Committees and approved by the Executive Management Team, as delegated by the Board of Directors.

HEDIS scores are reportedly annually with review of trends being performed monthly. This provides an opportunity to develop targeted improvement plans if scores are deviating from expected.

Using HEDIS certified software, THP runs reports on a monthly basis and ties them to physicians and Provider Engagement reaches out to the provider to close the gaps in care. The trends are also reviewed for geographic variance to assure there is not an issue with access to care. For instance, if members in a rural area are found to be below the averages in adherence to mammography, community resources may provide an opportunity for providing the service.

THP has both a clinical data analytics team and a HEDIS team within the Population Health Unit that reviews trends in quality of care and looks for areas to improve, incorporating THP Medical Directors, pharmacy and clinical staff, outreach and provider engagement as part of the round table discussions to drive improvements. Additionally, with the use of value-based agreements, THP has strong provider partners within the network to assist in driving improvements in quality of care. The data on compliance rates is distributed routinely to these providers to help drive improvement.

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 Health Plan has defined standards in place for access to care and availability to care. These standards ensure that The Health Plan meets the needs of our members by assessing member-to-Provider ratios, as well as demographic distribution of Primary Care, Behavioral Healthcare and Specialists. Practitioner and Provider availability and accessibility is monitored annually against defined standards.

The guidelines monitor the practitioner compliance for:

- Emergency Services: Availability 24 hours a day, 7 days a week
- Urgent Care: Within 48 hours

- Non-Urgent/Sick Care: Within 48 hours
- Routine, Non-Urgent/Preventive Care: Within 21 days of request
- EPSDT standards

Practitioners and Providers who do not meet the standards with a score of 90% are required to submit a corrective action plan to improve services to our members. Where accessibility does not meet the defined standards, The Health Plan Provider Network Department is notified for collaborative strategy initiation.

PCP's who are identified as outliers regarding compliance to the variety of data sources outlined above, can result in a multitude of corrective actions plans that can be formal or informal based on the severity of noncompliance.

The Health Plan completes an annual qualitative and quantitative analysis regarding access to care. The analyses include identified barriers and opportunities for improvement. Information on review of access to care is incorporated into the work plan and annual report prepared by THP and ultimately shared with DHHR. As the Foster Care is moved into managed care, THP will evaluate additional access standards based on relevance to the needs of the populations. Potential access standards for this population may include elements such as provider access for trauma services and access for complete assessment and EPSDT screening within 72 hours.

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:
QU027	Focus groups

The Health Plan implements Focus Groups to improve the quality and value of services that we deliver to the members and community we serve. Focus Groups are the result of data analyses showing potential gaps in care, barriers and opportunities for improvement. This may be a collaborative approach from several departments at The Health Plan or may be isolated to a specific department. Focus groups align with quality, safety, member satisfaction, improved health outcomes, cost reduction, member and community education, provider education and The Health Plan employee education.

The goal of the focus group is to impact the overall effectiveness of the care and services The Health Plan provides. The Health Plan's Continuous Quality Improvement Workgroup (CQI) serves as an internal advisory team that is responsible for the multidisciplinary oversight of The Health Plan quality improvement activities. Representation from each department enables a multidisciplinary approach to form clinical, non-clinical and operational areas to promote problem identification and problem solving. The goal of the workgroup is to implement appropriate quality initiatives and focus groups when indicated. Focus groups provide a targeted approach to develop initiatives for improved quality of care and service outcomes across all healthcare settings, improved compliance and cost reduction strategies.

The quality team at THP will work directly with the advisory group established for the Foster Care population to obtain input into quality concerns and barriers to care that are identified through our analysis. We will also seek input from that same body on areas of concern and report back to the Department input we have received from the advisory group and actions we have taken as a result.

QU028 Surveys

The Health Plan uses a variety of survey data sources to identify barriers to care for individuals with special healthcare needs. Member satisfaction surveys and Behavioral Health member satisfaction surveys as well as Disease Management and Case Management member satisfaction surveys are analyzed to produce quantitative and qualitative results. Surveys are also completed by The Health Plan to assess how well our members understand our marketing materials.

Detailed Health Risk Assessment (HRA) surveys are also part of The Health Plan's data sources. Health Risk Assessment surveys assess the member's physical, medical, psychological, functional and cognitive needs. The HRA serves as a risk stratification tool for interdisciplinary teams at The Health Plan. These teams work to establish a plan of care to include identified problems with individualized member specific goals.

QU029 "Secret shopper calls"

Upon receipt of complaints or survey results pertaining to access issues, THP will use "secret Shopper Calls" to evaluate practitioner compliance with access requirements. Calls are made to practices after normal business hours or on weekends. THP afterhours accessibility guidelines are used to determine compliance. This is based on the type of after hour access the practitioner has in place for their office location: answering service, answering machine or no response. If an answering service is used, the service must offer to page the practitioner on call with the practitioner calling back, or the service must offer to transfer the call directly to the practitioner. Answering machines must clearly provide a message instructing the member to call 911 or go to the nearest emergency room if the member feels the issue is too urgent to wait for a return call. Practitioners who do not meet the guidelines are required to submit a formal corrective action. The Health Plan resurveys those practitioners at random times for compliance. THP Quality Improvement Committee, comprised of participating practitioners, reviews any issues of continued non-compliance and recommends appropriate remediation steps.

QU030 Aggregate utilization monitoring

THP identifies members with special healthcare needs and creates a flagging system to allow break out trending of specific special and high needs enrollees. This creates distinct population buckets for comparative analysis of adherence to quality measures and utilization of services.

Additionally, by reviewing the monthly enrollment file received from BMS, members with special health care needs are identified. In addition to the enrollment file, a monthly comment file is also submitted to the MCOs. This file identifies members with special health care needs. The report is reviewed and submitted to our case management nurses for prompt follow-up and management. Our clinical staff evaluate the unique healthcare needs of the member and coordinates on going care and transition needs.

All new Medicaid members are contacted and welcomed to THP via phone by our outreach representatives. Our teams discuss the member's benefits and determine if there is a need for the member to be enrolled into either case management or disease management programs.

THP analytical software has the capability to create disease specific reports, as well as, allow data mining, that will assist in identifying enrollees with special needs and chronic conditions. Data files are updated monthly, and reports are generated based on medical conditions such as diabetes, congestive heart failure, asthma, seizure disorders, major depression, etc., and incorporated into the clinical services workflow, assigning the enrollees to a care or disease management nurse. A care need index and care summary are produced, identifying the conditions and utilization patterns of the enrollee, ER utilization, severity of illness, comorbidities, and gaps-in-care related to quality measures. The nurse uses this summary to develop a care plan and assist the member in achieving goals related to the medical condition(s). Upon enrollment in care and disease management programs, flags are created internally to track ongoing intervention and outcomes related to the medical conditions.

Members with special health care needs, often have unique and complex health care needs. Depending upon the clinical indications, the healthcare navigators at The Health Plan work directly with those members to develop an effective care plan to maximize health outcomes. Staff work directly with these patients and their clinicians to develop individualized treatment plans consistent with the care needs of the member.

THP analytical software has the capability to create disease specific reports, as well as, allow data mining, that will assist in identifying enrollees with special needs and chronic conditions. Data files are updated monthly, and reports are generated based on medical conditions such as diabetes, congestive heart failure, asthma, seizure disorders, major depression, etc., and incorporated into the clinical services workflow, assigning the enrollees to a care or disease management nurse. A care need index and care summary are produced, identifying the conditions and utilization patterns of the enrollee, ER utilization, severity of illness, comorbidities, and gaps-in-care related to quality measures. The nurse uses this summary to develop a care plan and assist the member in achieving goals related to the medical condition(s). Upon

enrollment in care and disease management programs, flags are created internally to track ongoing intervention and outcomes related to the medical conditions.

QU031 The Vendor should develop, update, and disseminate Clinical Guidelines to participating providers.

THP adopts Clinical Guidelines to measure quality across the organization and ensure content is consistent for each condition managed as well as ensuring appropriate practitioner oversight of programs. Evidence-based clinical guidelines are valuable to the organization for analyzing performance, taking action for quality improvement and demonstrating improvement in performance. Clinical guideline development focuses on areas THP has determined to be high risk, high volume, and/or problem prone areas. This ensures that the topics selected are worthwhile, population based, and deserving of resource commitment.

THP's Disease Management Department is responsible for the revisions of the following guidelines:

- Management of Congestive Heart Failure (CHF);
- Management of Chronic Obstructive Pulmonary Disease (COPD);
- Management of Diabetes Mellitus;
- Perinatal Guidelines; and
- Coronary Artery Disease.

THP's Behavioral Health Unit is responsible for the revisions to:

- Management of Depression;
- Diagnosis, Evaluation and Treatment of ADHD; and
- Substance Abuse.

THP's Quality Improvement Department is responsible for revisions to the following guidelines:

- Standards for Access to Care and Services
- Patient Medical Records
- Preventive Health Services

These clinical practices were determined by THP to be high risk, high volume, and/or problem prone areas. At least two non-preventive acute or chronic condition guidelines and two behavioral health guidelines are maintained at all times.

THP's Practice Guidelines are developed consistent with clinically appropriate guidelines and ensure the involvement of THP's medical directors, Quality Improvement (QI) Committee and practitioners.

THP's Practice Guidelines are researched, adopted, and distributed to appropriate participating practitioners to ensure the most current clinical practices are in place for the treatment of THP's members. Updates to THP's Practice Guidelines are made every 2 years or more frequently as changes are warranted.

THP accesses national web-based resources periodically to review any updates and identify the most current national recommendations to existing THP Practice Guidelines. The literature

review assists in collecting information from existing guidelines and in the establishment of thresholds and acceptable standards of care. The draft form of THP's Practice Guidelines is forwarded to in-plan physicians, based on specialty, for review and input, if needed. After receipt of specialist input, or review of nationally recognized resources, the draft guidelines are reviewed by THP's Physician Advisory Committee (PAC). If the PAC approves, the guidelines are forwarded to THP's Executive Management Team (EMT) with a memo that indicates the update or revision and/or any changes from the previous guideline. EMT will indicate approval or recommend changes. THP member benefit coverage materials and member educational materials are reviewed to ensure that guidelines are consistent with those materials. The final Practice Guideline is approved by the Medical Directors Oversight Committee (MDOC).

Compliance with the guidelines is monitored on a schedule to meet National Committee for Quality Assurance (NCQA) standards. THP's QI Department is responsible for maintaining the schedule for guideline review/revision. Each guideline is reviewed no less often than biannually by the PAC to ensure that the information contained within the guideline remains consistent with medical advancements in technology and standards of care. Guidelines may be retired when any of the following occur:

- a. They are no longer relevant to THP's population.
- b. Provider compliance with the guideline(s) remain consistently high.
- c. By recommendation of the QI Committee.

THP's Practice Guidelines are made available to providers after final approval. This is accomplished by placing the guidelines on THP's website located at www.healthplan.org under the *For Providers* tab and notifying providers of the availability of the updated guidelines via THP's *Provider Focus* quarterly provider newsletter, provider training seminars (including BMS' bi-annual provider workshops) and on-site visits by THP's provider engagement representatives during provider on-site reviews. As new providers become participants with THP, they are educated on the availability of the guidelines on the website.

QU032	The Vendor should follow a process to address quality issues, including, but not limited to, the following:
QU033	What steps will be taken
QU034	Who is responsible for addressing issues
QU035	Timeframes for resolution

The Health Plan monitors all quality issues through the Quality Improvement Department's workflow. Member complaints that are categorized as quality issues are reviewed in depth with a review of all pertinent documentation including claims encounters, medical records, and written responses from providers/practitioners. All complaints are tracked and trended with quarterly and annual quantitative and qualitative analysis.

The Quality Improvement Department also investigates adverse events or potential Quality of Care concerns using the same workflow addressed above. More detailed investigations may take place based on the severity of the potential Quality of Care concern that is identified.

The Registered Nurse Clinical Quality Improvement Coordinators reviews each event and completes a case summary. The case summary includes a root cause analysis and any additional information that was requested of the provider/practitioner. Each completed case summary is presented to the Quality Improvement Department and Medical Directors for any further recommendations.

The Quality Improvement Department is responsible for addressing the issue, but it can be done collaboratively when specific cases warrant the assistance of our Medical Directors, Provider Engagement Team, Compliance Department, etc.

Each Quality of Care issue reviewed is to have a completed case summary including a follow up information requested of the practitioner/provider and any corrective action plan if required within 90 days. The Health Plan tracks and trends the turnaround time for the resolution of each case reviewed.

The Health Plan also reviews all potential Quality of Care concerns. The Quality Improvement Department reviews and monitors all adverse events identified.

- Quality of care concerns are reviewed by Clinical Quality Improvement Registered Nurses who complete a case summary on each identified event.
 - This review consists of medical record review; letter inquiries to the practitioner or provider involved and may even require a formal corrective action.
 - Case Summaries are reviewed by a team consisting of the Clinical Quality Improvement Registered Nurses, Medical Directors and other internal staff when needed.
 - Case summaries are then categorized and tracked for true Quality of Care concerns and substandard care.
 - If warranted, the case summary can be sent to a peer review specialist to review and provide expert opinion.
- Case summaries can also be taken to The Health Plan's Quality Improvement Committee (QIC).
 - This committee consists of employees of The Health Plan in Clinical Quality Improvement and Medical Directors along with external practitioners representing a variety of specialties at THP who review the case summary and make recommendations for further formal intervention.
 - Recommendations may include a focus review, formal corrective action, additional education, restricted privileges or termination of contract depending on the severity of the Quality of Care concern.

Member complaints categorized for possible Quality of Care related to care, services, access and availability are reviewed. Complaints are analyzed as aggregate results as well for trends and opportunities for improvement. These complaints are analyzed by practitioner for trending as well as by complaint volume related to membership quarterly with a yearly analysis completed. Defined benchmarks are outlined. Any area that does not meet the benchmark

results in an opportunity for improvement. Prevalence by practitioner or practitioner type results in an opportunity for improvement as well as a corrective action from the practitioner when warranted.

QU036 The Vendor should initiate data-driven clinical initiatives that yield improvements in clinical care for applicable populations.

THP has a structured Population Health strategy that is data-driven and based on the experience of each of the various populations it manages. Understanding the current health status of population then building programs around the needs of that population and evaluating for improvement is ongoing.

As part of overall Population Health initiatives at THP, and with the use of analytical software that creates bundled episodes of care, data was analyzed looking for trends in avoidable care and high utilization patterns. An example of this is the trends that have been identified in cost and utilization of treating low back pain and cervical spine pain. For several years this trended upward along with increased opioid usage and the evolution of chronic pain that is unresolved and debilitating. Identifying this trend and reviewing the data with THP clinical team and executive management prompted THP to do a complete evaluation of potential programs that are available to assist in managing this population. This program is now implemented and includes a process for review of medical appropriateness of services, including supporting conservative management at the onset of back pain and incorporating cognitive behavioral therapy. Data around these conditions and related clinical care programs are currently being analyzed to demonstrate improved outcomes, member satisfaction, and reduction in cost associated with chronic back and neck pain.

QU037 The Vendor should establish and collect member satisfaction measures following the implementation date.

Member satisfaction surveys and Behavioral Health member satisfaction surveys as well as Disease Management and Case Management member satisfaction surveys are ongoing at The Health Plan. Each survey is analyzed to produce quantitative and qualitative results.

CAHPS surveys include Child and Adult Member Satisfaction surveys. The Health Plan uses the metrics for getting needed care, getting care quickly, how well doctors communicate, customer service, shared decision making, health promotion and education, coordination of care, ease of filling out forms, claims processing, as well as ratings of their healthcare, providers, specialists and Plan.

As the new Foster Care population is transitioned to managed care, THP will carefully evaluate survey results and assess the various satisfaction members incorporating additional measures as relevant to the population.

QU038	The Vendor should profile the quality of care delivered by network providers, including, but not limited to, the following:
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QU039	Primary care providers (PCPs)
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Primary Care Providers are profiled for quality of care indicators with the data sources previously mentioned (member complaints and appeals, survey results). PCP quality of service is also analyzed through practitioner availability and accessibility survey results.

Applicable HEDIS measures are also used to examine the quality of care provided to our members from their PCP's. Practitioner performance is evaluated using the HEDIS specifications and methodology.

THP has a provider analytics program that uses software to establish peer-to-peer evaluation of care provided to its members. The report provides a scorecard that includes an analysis that is based on cost, utilization of services, adherence to quality measures and referral patterns.

The clinical predictive analytics platform that is claims based and houses clinical intelligence is used to provide predictive modeling and risk stratification for our member population. The software builds medical condition episodes of care and incorporates quality measures to identify gaps in care. This trends efficiency and effectiveness of care and tie to the member level and practitioner level and provides comparative data to evaluate the overall effectiveness of the provider compared to his/her peers.

QU040	High-volume specialists
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High volume specialists are profiled for quality of care indicators with the data sources previously mentioned (member complaints and appeals, survey results). Specialist quality of service is also analyzed through specialist availability and accessibility survey results.

High volume specialists are identified through encounter data and include at a minimum OB/GYN practitioners and behavioral health practitioners. The Health Plan uses this same approach to identify High Impact Specialists as well.

A clinical predictive analytics platform that is claims based and houses clinical intelligence is used to provide predictive modeling and risk stratification for our member population. The software builds medical condition episodes of care and incorporates quality measures to identify gaps in care. This trends efficiency and effectiveness of care and tie to the member level and practitioner level and provides comparative data to evaluate the overall effectiveness of the provider compared to his/her peers.

QU041 Hospitals

The Quality Improvement Department profiles the quality of care delivered by our hospitals in-network. Data from member complaints, appeals and quality of care concerns from member facility stays are trended and analyzed. Outlying facilities are requested to submit formal corrective action plans when warranted. Hospitals are trended based on their performance of member outcomes related to admissions and discharges.

As previously stated, THP has a provider analytics program that uses software to establish specialty specific peer to peer evaluation of care provided to its members. The report provides a scorecard that includes an analysis that is based on cost, utilization of services, adherence to quality measures and referral patterns.

QU042 Other acute care providers

Similar mechanisms are used for other acute providers. THPs analytics program allow for stratification of data for all providers type; enabling targeted analysis based on the reporting analysis.

QU043 The Vendor should monitor and reinforce primary care Provider (PCP) compliance with program requirements for applicable populations.

THP has made Provider engagement an essential component of our business strategy. THP utilizes an internal committee that continuously develops new approaches to improve Provider relationships. Emphasis is placed on improving the quality of the THP Providers. The engagement team includes the following:

- Three Provider Relations Representatives are supported by internal operations staff
- A team of 13 Provider Engagement Representatives to assist with education and outreach that are field based.

Our team of Provider Engagement Representatives serve as a consistent point of contact for Providers and community resources. The goal of these Provider contact points is to improve Provider insights through a monitoring system designed to track:

- engagement activities;
- physician demographics;
- credentialing status;
- required regulatory trainings;
- site visits; and
- compliance actions.

The engagement team uses each Provider contact as an opportunity to reinforce Primary Care Provider (PCP) compliance with program compliance and requirements. THP is the only MCO in WV that has made the investment in Provider engagement.

The Health Plan monitors compliance using a variety of data sources such as surveys, medical record audits, encounter data, member complaints, clinical practice guideline adherence, adherence to access to care and availability to care standards, clinical program engagement, continuity and coordination of care indicators, prescribing patterns, utilization patterns.

The Health Plan has defined standards in place for access to care and availability to care. These standards ensure that The Health Plan meets the needs of our members by assessing member-to-Provider ratios, as well as demographic distribution of Primary Care, Behavioral Healthcare and Specialists. Practitioner and Provider availability and accessibility is monitored annually against defined standards.

The guidelines monitor the practitioner compliance for:

- Emergency Services: Availability 24 hours a day, 7 days a week
- Urgent Care: Within 48 hours
- Non-Urgent/Sick Care: Within 48 hours
- Routine, Non-Urgent/Preventive Care: Within 21 days of request
- EPSDT standards

Practitioners and Providers who do not meet the standards with a score of 90% are required to submit a corrective action plan to improve services to our members. Where accessibility does not meet the defined standards, The Health Plan Provider Network Department is notified for collaborative strategy initiation.

PCP's who are identified as outliers regarding compliance to the variety of data sources outlined above, can result in a multitude of corrective actions plans that can be formal or informal based on the severity of noncompliance.

QU044	The Vendor should use data to identify access barriers for members with special needs, including, but not limited to, the following data:
QU045	Complaints and grievances

All complaints and grievances are monitored ongoing with an annual analysis that is both quantitative and qualitative. The analysis captures the categories of grievances and complaints as well as the provider/practitioner involvement. The complaints and grievances are trended for access barriers that may be attributed to type of provider/practitioner, demographic region, and particular practitioner/provider. When the analysis reveals a potential barrier to the member's access to care, the Clinical Quality Improvement Coordinator collaborates with other departments including Provider Engagement, Network & Credentialing, Clinical Services, and other departments when applicable to address the barrier that works towards opportunities for improvement and optimal member outcomes.

QU046 Primary care provider (PCP) change requests

When members choose to change PCP's, The Health Plan Quality Improvement Department is notified. Once this occurs, a letter is generated to the member from the Quality Improvement Department informing them that we have been notified for their PCP change. The intent of the letter is to ask the member if they are willing to provide feedback on their reason for changing PCP's. The letter contains a free text area where the member is free to write in their response for changing PCP's. The member is provided with a self-addressed stamped envelope to return their response to the Quality Improvement Department. Returned responses are reviewed by the Quality Improvement Department. The responses are tracked and trended. If responses indicated a potential quality of care concern or member complaint with their PCP, the Quality Improvement processes and workflows in place for complaints and quality of care concerns are followed.

QU047 Out-of-network authorizations

Examining multiple sources of data about access and availability of care provides insight into the adequacy of the provider network's ability to meet member care needs. This analysis considers data on member experience with access to care as well as review of data on out-of-network utilization and gaps identified through monitoring network availability and access to determine opportunities to improve network adequacy.

The Health Plan measures out-of-network utilization using data on the number of requests for prior authorization of out-of-network services. All out-of-network requests, regardless of provider or facility type are evaluated. Examples of the services provided out-of-network include DME requests, ambulance transfers, genetic testing, and specialized eating disorder clinics.

Barriers identified area addressed based on the population served, the type of service authorization request, and whether or not the services are available from an in-network provider. The Health Plan has a network of tertiary facilities which is used when an in-plan provider needs to send the member out of the area for extended or more in-depth services.

QU048 Emergency room (ER) usage

The Health Plan is digitally integrated with West Virginia and bordering facilities via the PreManage and WVHIN systems, which are systems designed to allow sharing of electronic health record information in a real-time environment. Additionally, The Health Plan has full access to West Virginia University Hospital Facilities through their medical record system Epic. These connectivity solutions provide immediate clinical reporting of member use of the Emergency Room allowing for real-time action and intervention with members including concurrent or post ER follow-up calls to coordinate required behavioral health and medical follow-up care and to address alternatives to use of the ER.

Additionally, The Health Plan analyzes claims data to identify members with ER overutilization and condition specific risks. Reports are pushed to care navigation staff and Outreach staff for specific targeted intervention and redirection to primary or specialty care when appropriate.

The Health Plan also incorporates data on ER usage in value-based arrangements with providers. The goal of the value-based arrangements related to ER use specifies interventions to increase primary care efficacy and further reduce ER utilization. Interventions with current VBA facilities include sharing of clinical analytic reports on individual members and monthly clinical huddle discussions with population health teams from both the provider and the health plan resulting in a collaborative approach to solutions for inappropriate ER utilization.

QU049	The Vendor should use reports/data from subcontractor(s), as applicable, to ensure appropriate subcontractor oversight and the following member-related outcomes:
QU050	Access to care
QU051	Member satisfaction
QU052	Continuity of care

THP requires our subcontractors to maintain the same service level agreements THP currently has in place with BMS related to Access to Care; Member Satisfaction; and Continuity of Care. Our subcontractors are required to submit monthly reports and those reports are reviewed and analyzed through our Medicaid Oversight Committee. During the review if there are any outliers identified during the review, THP will address those with the subcontractor.

QU053	The Vendor should run data at a set frequency to identify which members in applicable populations have not received primary care services.
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THP has the ability to track and trend primary care services using various reporting methods including HEDIS software, claims, and eligibility data.

The responsibility of identifying adherence to timely primary care services will fall within the Population Health Unit using various data sources, including HEDIS software and internally built dashboard reporting. These reports can be run at set intervals, mostly monthly as part of overall population health improvement strategies and are reported to primary care physicians so they may engage the member. Additionally, care navigators within Clinical Services are aware of these gaps in care through THP electronic health record and the nurse navigator can encourage those visits during telephonic engagement with the member and primary care physician.

QU054 The Vendor should contact members within a set timeframe after identifying which members in applicable populations have not received primary care services.

In accordance with federal and DHHR regulations and RFP requirements, THP will ensure that all eligible individuals and their families understand THP's Program. We have policies, procedures and guidelines that incorporate age-appropriate definitions for medical necessity and the medical necessity criteria as well as initial visit with the member's designated PCP.

All members will receive services based on the DHHR's periodicity schedules, American Academy of Pediatrics and the Advisory Committee on Immunization Practice (ACIP) recommendations. Outreach is conducted in an effort to assess member compliance and facilitate access to screening services. THP has policies and procedures in place to ensure that our services comply with appropriate rules and regulations. We provide annual notification letters to remind members of due dates (pre-due service notices) and five outreach attempts to notify and assist members with compliance. We use claims, encounter, pharmacy and laboratory data and periodicity schedules as references to monitor and track member compliance.

THP will ensure that its members receive age-appropriate services in accordance with DHHR policy, regulations and all federal laws in accordance with the requirements as outlined in the DHHR Contract. All periodic screening services will be provided whenever an eligible Enrollee, or the Enrollee's parent or caretaker on his/her behalf, requests the services, unless THP has documentation from the enrollee's medical record that the most recent age-appropriate screenings, according to the periodicity schedule have already been provided to the Enrollee.

Further, THP currently has a process in place to monitor when members complete their wellness visits with their PCP's. This process is outlined in the attached policy Q175. The outreach department receives call queues that are populated using claims experience. Once a queue is populated, the outreach department is made aware that a member has not seen their PCP and then begins to make phone calls to the member to encourage the member to visit their PCP for their annual wellness visit. Should the member be unable to be reached via phone, postcards are sent to the address THP has on file requesting the member to reach out to THP.

This process can easily be duplicated for the foster care population. THP will use their claim information to determine which members have not received primary care services. That data will be transferred to the outreach department to reach out to the guardian in place and to ensure the child receives necessary services.

Call queues are populated using claims experience for Wellness outreach to contact members who have not had a visit to their PCP within the past year. These calls are attempted on an annual basis. If the member does not have a phone, post cards are sent requesting they call us for further information.

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.

In addition to the above, the THP provider engagement team will work to make providers aware of their current foster care roster and to educate the providers on monitoring the care of these members and encouraging them to have an initial visit as soon as possible and to bring the members in on a regular basis for follow up exams and routine checkups.

Once the outreach representative identifies that a member has not received their Primary Care services, they will pass the information on to Provider Engagement who will then contact the provider directly.

QU056 The Vendor should analyze and synthesize reports on data about members in applicable populations who have not received primary care services.

THP has the ability to track and trend primary care services using various reporting methods including HEDIS software, claims, and eligibility data. The responsibility of identifying adherence to timely primary care services will fall within the Population Health Unit using various data sources, including HEDIS software and internally built dashboard reporting.

Once the members/populations not receiving primary care services are identified, further analysis regarding access to care, geographic variations and primary care assignment will be conducted. Network, clinical services and social services will be engaged in reviewing patterns where there may be a concern for lacking services, travel constraints, and primary care education requirements. An improvement plan will be developed to ensure timely access to primary care providers and development of a care plan that supports the member.

QU057 The Vendor should establish and implement ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.

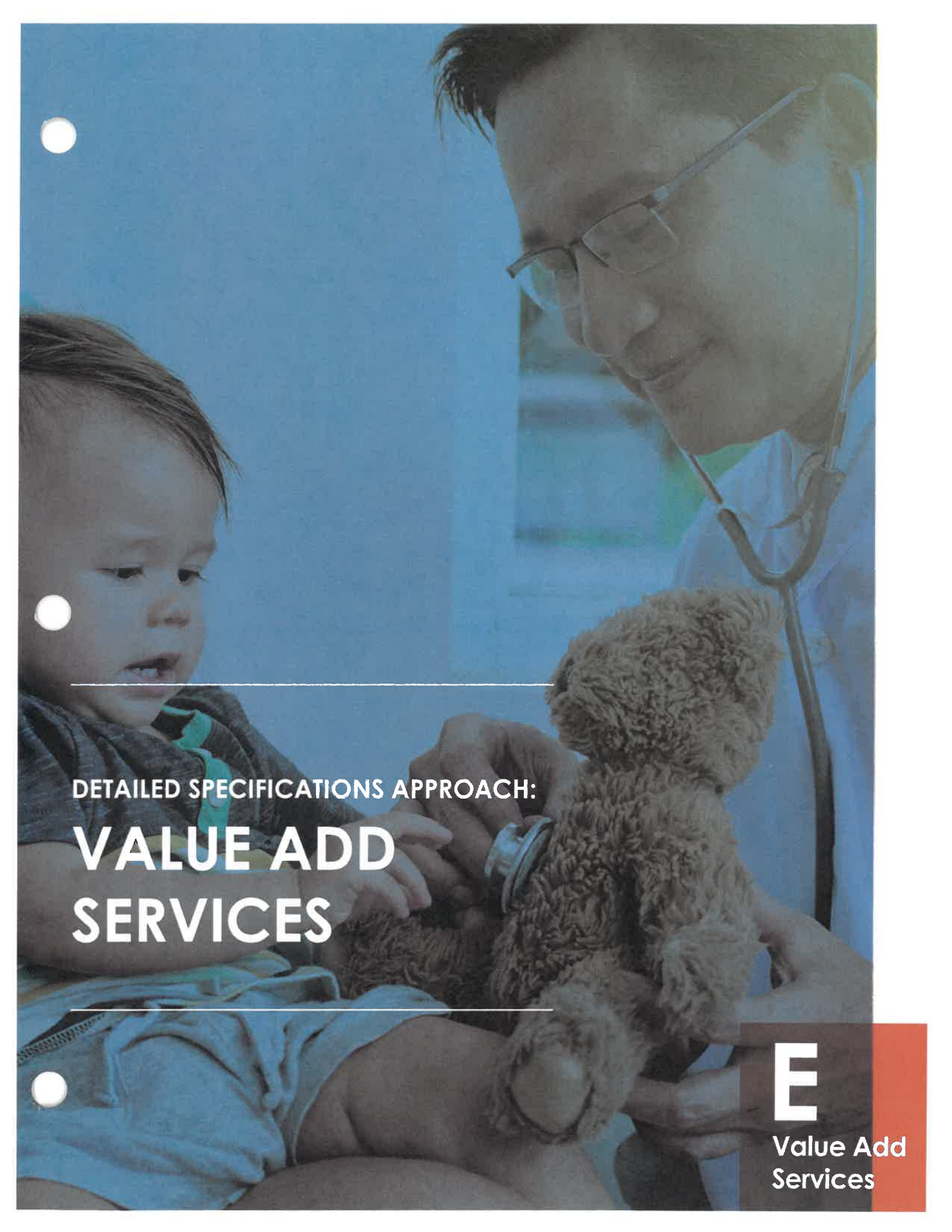
The Health Plan utilizes its Quality Management Program Description and Quality Management Work plan to establish and implement ongoing quality monitoring to ensure quality for our members and compliance with program requirements. The Program Description includes an overview of what each department does to improve member outcomes with specific reportable indicators and measurable outcomes. The work plan includes these indicators along with initiatives implemented as a result of data analysis showing a need to improve member outcomes. The work plan is a collaborative document that The Health Plan uses to house the reportable indicators and other data sources that are used to drive initiatives and measurable outcomes. The work plan is updated and analyzed at least quarterly to assess the progress of our initiatives. Barriers are addressed as well as opportunities for improvement. The work plan updates are shared at the Continuous Quality Improvement Workgroup to promote collaboration across all areas of the company to

strategize opportunities for improvement based on data analysis and identified barriers. Annually, all areas of the document are analyzed to promote changes or recommendations for the New Year.

QU058 The Vendor should periodically enhance ongoing quality monitoring activities to ensure quality for members and compliance with program requirements.

The data from the work plan is analyzed and reviewed at least quarterly, with ongoing enhancements made based on the analysis. Initiatives and other program offerings are evaluated quarterly for their effectiveness based on multiple data sources. Program changes are made based on the analysis, engagement, barriers and overall opportunities for improvement.

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A photograph of a male doctor with glasses and a stethoscope around his neck, leaning over a young child. The child is holding a brown teddy bear, and the doctor is using a stethoscope to examine it. The scene is set in a clinical or hospital environment. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH:

VALUE ADD SERVICES

E

Value Add
Services

Value-Added Services

The Health Plan will propose to provide the following value added services:

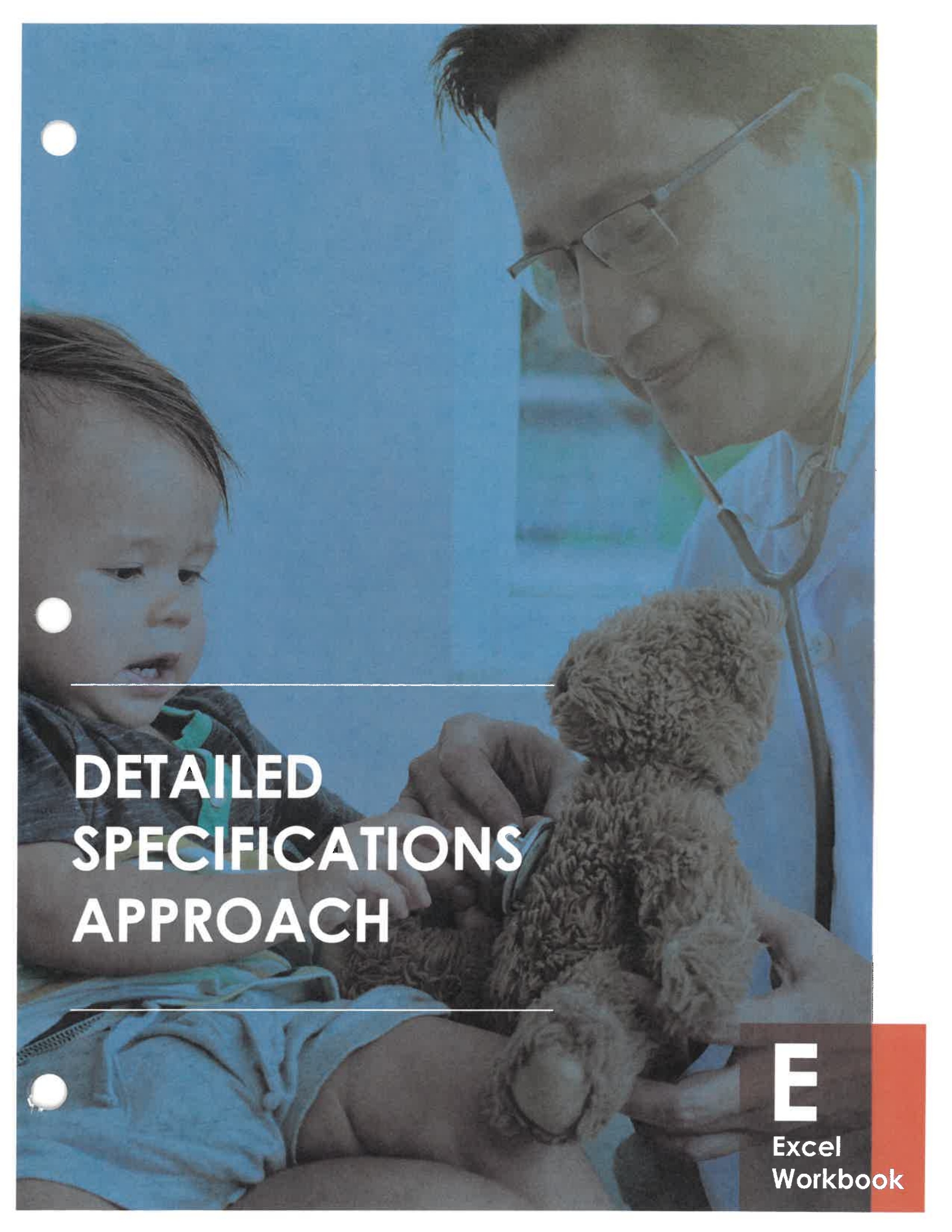
- 24-Hour Health Line, Call nurse at 1-800-624-6961
 - Extra Help with Asthma
 - One-on-one education with asthma nurse educator
 - Scholarships to Camp Catch Your Breath
 - Asthma pack with peak flow meter, spacer, and backpack
- Extra Help for Diabetes
 - Diabetes education by case managers
 - One-on-one education by diabetes educators on glucometer and insulin pump use and general diabetes education
 - Scholarships to Camp Kno Koma for children ages 7-1
- Extra Phone Help
 - Free cell phone with free minutes for text and voice, unlimited calls to Member Services, and free wellness and appointment reminder text
- Extra Help for Pregnant Women
 - Text4Baby messages to keep mom and baby healthy
 - Care Coordination through baby's first year for mothers with:
 - High risk pregnancies
 - Substance use disorder during pregnancy
 - NICU babies or babies with complex conditions
- Health and Wellness
 - Quit smoking packets for all members ages 12 and older, with workbook, relaxation exercises CD, and quit smoking survival kit
 - Access to our Core Wellness online tool that helps members learn ways to get and stay healthy
 - Care managers to help members manage medications, disease and improve overall health
 - Health risk assessments
 - Specialized care managers:
 - Neonatal Abstinence Syndrome (NAS)
 - NICU
 - High Risk OB
 - Hepatitis
 - Behavioral Health
 - Regional face-to-face case management with high risk members
 - One-on-one help to quit smoking with Certified Coordinator
- Camp Scholarships:
 - In addition to the Asthma and Diabetes camps for children/youth with chronic conditions, THP will offer a \$100 scholarship to Foster Care Youth to be applied to fees associated with camps.

- Camp must be located in WV
- Camp must be geared toward health, wellness or educational goals
- Limited to one scholarship per member per year
- Application must be submitted 30 days prior to camp and payment will be made directly to camp

THP will work with the State and the various stakeholders to develop an additional value add through development of a camp experience for Foster Children.

- THP will work with various stakeholders to develop a Foster Care Camp for foster children in WV. The camp will be designed to provide a fun and safe environment for youth within the foster system to experience "normal camp FUN" in an environment that provides supportive programming to increase self-confidence and social skills.
- Benefits of Camp:
 - Will benefit youth by providing a FUN experience with other youth in similar situations to grow and learn.
 - Will benefit foster families and care givers by providing a respite opportunity

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A photograph of a male doctor with glasses and a stethoscope, smiling as he examines a brown teddy bear. A young child is visible on the left, looking at the bear. The image has a blue tint and three white circular punch holes on the left side.

DETAILED SPECIFICATIONS APPROACH

E

Excel
Workbook

Excel Workbook

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	BA	BA-2
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	BA	BA-2
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	BA	BA-3
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	BA	BA-3
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	BA	BA-3
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	BA	BA-3

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-6
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). <i>Note: Link to additional information:</i> 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	Tab E - BA	BA-7
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	Tab E - BA	BA-8

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-8
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)	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	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-8

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		program, for applicable populations.	(EPSDT) program. 2) The Vendor should explain how it will emphasize EPSDT services to children receiving primary care from a specialist.					
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	Tab E - BA	BA-8
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	Tab E - BA	BA-9
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	Tab E - BA	BA-9
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	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-10

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
			guidelines.					
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	Tab E - BA	BA-10
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	Tab E - BA	BA-10
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	Tab E - BA	BA-12
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	Tab E - BA	BA-12
BA020	2	Clinical notes	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-12

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA021	2	Inpatient requests	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-12
BA022	2	Review criteria	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-12
BA023	2	Case history	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-12
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	Tab E - BA	BA-13
BA025	2	Medicaid Management Information System (MMIS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-13
BA026	2	Call Center	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-13

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-20
BA028	2	Medicaid Management Information System (MMIS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-20
BA029	2	Call Center	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-20
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	Tab E - BA	BA-22
BA031	2	Medicaid Management Information System (MMIS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-22
BA032	2	Families and Children Tracking System (FACTS)	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-22

Specifications				Subject Matter Area	Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance		Capability Assessment	Attachment	Section	Page #
BA033	2	Integrated Eligibility Solution (IES), when applicable	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-22
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	Tab E - BA	BA-23
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	Tab E - BA	BA-23
BA036	2	Medical necessity review	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-23
BA037	2	Social necessity review	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-23
BA038	2	Approvals	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-23
BA039	2	Denials	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-23

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-24
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	Tab E - BA	BA-24
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	Tab E - BA	BA-26
BA043	2	Standing referrals	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-26
BA044	2	Expedited utilization review processes	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-26
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	Tab E - BA	BA-27

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-28
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	Tab E - BA	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	Tab E - BA	BA-35
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	Tab E - BA	BA-36
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	Tab E - BA	BA-37

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-38
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	Tab E - BA	BA-38
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	Tab E - BA	BA-49
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	Tab E - BA	BA-53

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-53
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	Tab E - BA	BA-54
BA057	2	Emergency situations	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-54
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	Tab E - BA	BA-54
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	Tab E - BA	BA-55
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	Tab E - BA	BA-56

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA061	2	Admit patients for inpatient care	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-56
BA062	2	Choose the hospital of admission	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-56
BA063	2	Determine that the patient must remain hospitalized	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-56
BA064	2	Schedule or provide ancillary services, such as laboratory testing	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-56
BA065	2	Refer patients to sub-specialists or other providers	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-56
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	Tab E - BA	BA-57
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	Tab E - BA	BA-57

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-57
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	Tab E - BA	BA-58
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	Tab E - BA	BA-60
BA071	1	The Vendor should perform ongoing monitoring of emergency room (ER) usage.	The Vendor should separately describe ongoing monitoring of emergency room (ER)	Benefit Administration	Will Meet	Attachment E - Detailed Specifications	Tab E - BA	BA-61

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
			usage.			Approach		
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	Tab E - BA	BA-61
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	Tab E - BA	BA-62
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	Tab E - BA	BA-63
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	Tab E - BA	BA-64
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	Tab E - BA	BA-64

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-64
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	Tab E - BA	BA-64
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	Tab E - BA	BA-65
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	Tab E - BA	BA-66
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	Tab E - BA	BA-67
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	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-67

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
			when they are provided out of network.					
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	Tab E - BA	BA-68
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	Tab E - BA	BA-68
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	Tab E - BA	BA-69
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	Tab E - BA	BA-70

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-70
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	Tab E - BA	BA-71
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	Tab E - BA	BA-72
BA090	2	Hospitalization	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-72
BA091	2	Emergency room (ER) usage	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-72

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
BA092	2	Change of medication	See the parent specification.	Benefit Administration	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - BA	BA-72
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	Tab E - BA	BA-73
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	Tab E - BA	BA-74
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	Tab E - BA	BA-74
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	Tab E - BA	BA-74

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - BA	BA-74
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	Tab E - BA	BA-74
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	Tab E - CM	CM-4
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	Tab E - CM	CM-5
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	Tab E - CM	CM-6

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-7
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	Tab E - CM	CM-8
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 Healthcare 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	Tab E - CM	CM-10
CM007	2	The application process for providers	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CM	CM-10
CM008	2	Assessment of whether foster care members can continue to receive healthcare in their medical home of origin, and if	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CM	CM-10

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		not, how best to establish and maintain new medical homes						
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	Tab E - CM	CM-10
CM010	2	Annual reporting processes	See the parent specification.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CM	CM-10
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	Tab E - CM	CM-12
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	Tab E - CM	CM-12

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-13
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	Tab E - CM	CM-14
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	Tab E - CM	CM-15
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	Tab E - CM	CM-15
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	Tab E - CM	CM-16
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	Tab E - CM	CM-16

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-18
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	Tab E - CM	CM-19
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	Tab E - CM	CM-20
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	Tab E - CM	CM-21
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	Tab E - CM	CM-21

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-21
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	Tab E - CM	CM-26
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	Tab E - CM	CM-26
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	Tab E - CM	CM-27
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	Tab E - CM	CM-28
CM029	1	The Vendor should incorporate data about social determinants of health into its	The Vendor should describe how it will meet this specification.	Care Management	Will Meet	Attachment E - Detailed Specifications	Tab E - CM	CM-28

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		care coordination services.				Approach		
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	Tab E - CM	CM-30
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	Tab E - CM	CM-31
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	Tab E - CM	CM-32
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	Tab E - CM	CM-33

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-34
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). <i>Note: The Department expects all members to be eligible for care coordination services.</i>	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CM	CM-35
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	Tab E - CM	CM-39

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-40
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	Tab E - CM	CM-40
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	Tab E - CM	CM-42

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-43
CM041	1	The Vendor should identify opportunities on an ongoing basis for activities or linkages with West Virginia (WV) Children with Special Healthcare 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 Healthcare Needs program.	Care Management	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CM	CM-43
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	Tab E - CM	CM-44

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-51
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	Tab E - CM	CM-53
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	Tab E - CM	CM-54

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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 C - Project Organization and Staffing	Tab E - CM	CM-55
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 <i>Note: Care coordinators should be dually trained in both Bureau for Children and Families (BCF) and Bureau for Medical Services (BMS) policies.</i>	Care Management	Will Meet	Attachment C - Project Organization and Staffing	Tab E - CM	CM-55
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	Tab E - CM	CM-56

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-58
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	Tab E - CM	CM-59
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	Tab E - CM	CM-59
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	Tab E - CM	CM-61
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	Tab E - CM	CM-61

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-63
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	Tab E - CM	CM-63
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	Tab E - CM	CM-63

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CM	CM-64
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	Tab E - CM	CM-65
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	Tab E - CM	CM-68
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	Tab E - CM	CM-68
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	Tab E - CS	CS-2

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CS	CS-2
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	Tab E - CS	CS-4
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	Tab E - CS	CS-4

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - CS	CS-4
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	Tab E - CS	CS-9
CS007	2	Child advocacy centers (CACs)	See the parent specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CS	CS-9
CS008	2	Court appointed special advocates (CASAs)	See the parent specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CS	CS-9
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	Tab E - CS	CS-9
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	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CS	CS-10

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
			understanding of the foster care system in the State.					
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. <i>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/</i>	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CS	CS-10
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	Tab E - CS	CS-11
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	Tab E - CS	CS-11
CS014	1	The Vendor should coordinate with child placement agencies to ensure each agency has access to the most up-to-date	The Vendor should describe how it will meet this specification.	Community/Stakeholder Engagement	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - CS	CS-13

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		records, as appropriate.						
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	Tab E - MS	MS-2
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	Tab E - MS	MS-2
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	Tab E - MS	MS-3
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	Tab E - MS	MS-4
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	Tab E - MS	MS-4

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
MS006	2	Appeal processes	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-4
MS007	2	Other member rights and responsibilities	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-4
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	Tab E - MS	MS-5
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	Tab E - MS	MS-5
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	Tab E - MS	MS-6
MS011	1	The Vendor should develop materials for members, including, but not limited to, members with special healthcare needs, in	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-7

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		accordance with federal and State marketing regulations.						
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	Tab E - MS	MS-7
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	Tab E - MS	MS-7
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	Tab E - MS	MS-8
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	Tab E - MS	MS-8
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	Tab E - MS	MS-8

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - MS	MS-9
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	Tab E - MS	MS-10
MS019	2	Updates to the member handbook	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-10
MS020	2	Handbooks requested ad hoc by a member	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-10
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	Tab E - MS	MS-10
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	The Vendor should describe how it will meet this specification.	Member Services	Will Meet	Attachment C - Project Organization and Staffing	Tab E - MS	MS-11

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		disabilities.						
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	Tab E - MS	MS-11
MS024	2	An emergency hotline	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-11
MS025	2	A toll-free number	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-11
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 C - Project Organization and Staffing	Tab E - MS	MS-13
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	Tab E - MS	MS-13
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	Tab E - MS	MS-13

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - MS	MS-14
MS030	2	Serving members with disabilities and chronic conditions	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-14
MS031	2	The culture of disability	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-14
MS032	2	Resources available to members	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-14
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	Tab E - MS	MS-14
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	Tab E - MS	MS-15
MS035	2	Member-to-representative ratios	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications	Tab E - MS	MS-15

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
						Approach		
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	Tab E - MS	MS-16
MS037	2	Call abandonment rate not to exceed five percent (5%)	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-16
MS038	2	Single contact resolution	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-16
MS039	2	Turnaround time for member requests	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-16
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	Tab E - MS	MS-16
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	Tab E - MS	MS-17

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - MS	MS-17
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	Tab E - MS	MS-17
MS044	2	Processing and issuing identification cards	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-17
MS045	2	Distributing member handbooks	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-17
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	Tab E - MS	MS-18
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,	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-18

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
			psychosocial and family histories, trauma history, and developmental and immunizational information.					
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	Tab E - MS	MS-18
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	Tab E - MS	MS-19
MS050	2	Medical records	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-19
MS051	2	Authorization status	See the parent specification.	Member Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - MS	MS-19
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	Tab E - ND	ND-1

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - ND	ND-1
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	Tab E - ND	ND-1
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	Tab E - ND	ND-1
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	Tab E - ND	ND-1
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	Tab E - ND	ND-1
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	Tab E - ND	ND-9
ND008	1	The Vendor should measure and regularly verify network	The Vendor should describe its methods and how often it will	Network Development	Will Meet	Attachment E - Detailed	Tab E - ND	ND-9

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		compliance standards.	verify network compliance standards.			Specifications Approach		
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	Tab E - ND	ND-10
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	Tab E - ND	ND-12
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	Tab E - ND	ND-12
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	Tab E - ND	ND-12
ND013	2	Time/distance	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-12

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND014	2	Appointment timeliness, by provider type	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-12
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	Tab E - ND	ND-14
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	Tab E - ND	ND-14
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. <i>Note: Although not all populations in the specification are included in the 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.</i>	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	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	Tab E - ND	ND-15

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND019	2	Federally Qualified Health Centers (FQHCs)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-15
ND020	2	Rural Health Clinics (RHCs)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-15
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	Tab E - ND	ND-16
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	Tab E - ND	ND-16
ND023	2	Local Health Departments	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-16
ND024	2	Critical Access Hospitals	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-17
ND025	2	Primary Care Centers	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications	Tab E - ND	ND-17

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
						Approach		
ND026	2	School-Based Health Centers (SBHCs)	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-17
ND027	2	Right from the Start (RFTS) Providers	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-17
ND028	2	Bureau for Public Health (BPH) Laboratories	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-18
ND029	2	Children with Special Healthcare Needs (CSHCN) Program	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-18
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	Tab E - ND	ND-18
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	Tab E - ND	ND-18

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - ND	ND-19
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	Tab E - ND	ND-19
ND034	2	Any managed care organization (MCO) approvals required	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-19
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	Tab E - ND	ND-20
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	Tab E - ND	ND-21
ND037	2	Availability of compounds	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-21

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
ND038	2	Availability of specialty drug pharmacies	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-21
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	Tab E - ND	ND-22
ND040	2	High volume	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-22
ND041	2	Rural	See the parent specification.	Network Development	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - ND	ND-22
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	Tab E - ND	ND-22
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	Tab E - ND	ND-23

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - ND	ND-23
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	Tab E - PS	PS-2
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	Tab E - PS	PS-4
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	Tab E - PS	PS-4
PS004	1	The Vendor should coordinate with the member's primary care provider (PCP) and behavioral health provider, for applicable populations, to	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-5

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		ensure each provider has access to the most up-to-date medical records.						
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	Tab E - PS	PS-7
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	Tab E - PS	PS-6
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	Tab E - PS	PS-8

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - PS	PS-8
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	Tab E - PS	PS-9
PS010	2	Which types of claims are automatically paid	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-9
PS011	2	Which types of claims are automatically pended	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-9
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	Tab E - PS	PS-9
PS013	1	The Vendor should educate primary care providers (PCPs) on their responsibility to coordinate a member's overall health, for applicable	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-10

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		populations.						
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	Tab E - PS	PS-10
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	Tab E - PS	PS-12
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,	The Vendor should describe how it will meet this specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-13

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		and Treatment [EPSDT process]), the member should be referred to dental providers, for applicable populations.						
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	Tab E - PS	PS-14
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	Tab E - PS	PS-15
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	Tab E - PS	PS-15
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	Tab E - PS	PS-16
PS021	2	Opportunities for standing referrals	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-16

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - PS	PS-16
PS023	2	Availability of disease management	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-16
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	Tab E - PS	PS-17
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. <i>Note: The Medicaid fiscal agent will provide member eligibility information.</i>	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-18
PS026	2	Medical records	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-18
PS027	2	Authorization status	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - PS	PS-18
PS028	2	Confirmation of services previously provided to avoid	See the parent specification.	Provider Services	Will Meet	Attachment E - Detailed	Tab E - PS	PS-18

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		duplication				Specifications Approach		
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	Tab E - QU	QU-2
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	Tab E - QU	QU-4
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	Tab E - QU	QU-6

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - QU	QU-7
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	Tab E - QU	QU-8
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	Tab E - QU	QU-11
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	Tab E - QU	QU-11
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	Tab E - QU	QU-12
QU009	2	Healthcare Effectiveness Data and Information Set (HEDIS) scores	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-12

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - QU	QU-12
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	Tab E - QU	QU-13
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	Tab E - QU	QU-17
QU013	2	Cost savings	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-17
QU014	2	Reductions in inappropriate utilization of services, including, but not limited to,	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications	Tab E - QU	QU-17

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
		inappropriate admissions and readmissions				Approach		
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	Tab E - QU	QU-19
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	Tab E - QU	QU-20
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	Tab E - QU	QU-21
QU018	2	Access to care	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-21
QU019	2	Demand for services	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-21

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU020	2	Quality of care	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-21
QU021	2	Health outcomes	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-21
QU022	2	Member satisfaction	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-21
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	Tab E - QU	QU-21
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	Tab E - QU	QU-21
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	Tab E - QU	QU-23
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	Tab E - QU	QU-24

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU027	2	Focus groups	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-24
QU028	2	Surveys	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-25
QU029	2	"Secret shopper calls"	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-25
QU030	2	Aggregate utilization monitoring	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-26
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	Tab E - QU	QU-27
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	Tab E - QU	QU-28
QU033	2	What steps will be taken	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-28
QU034	2	Who is responsible for addressing issues	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-28

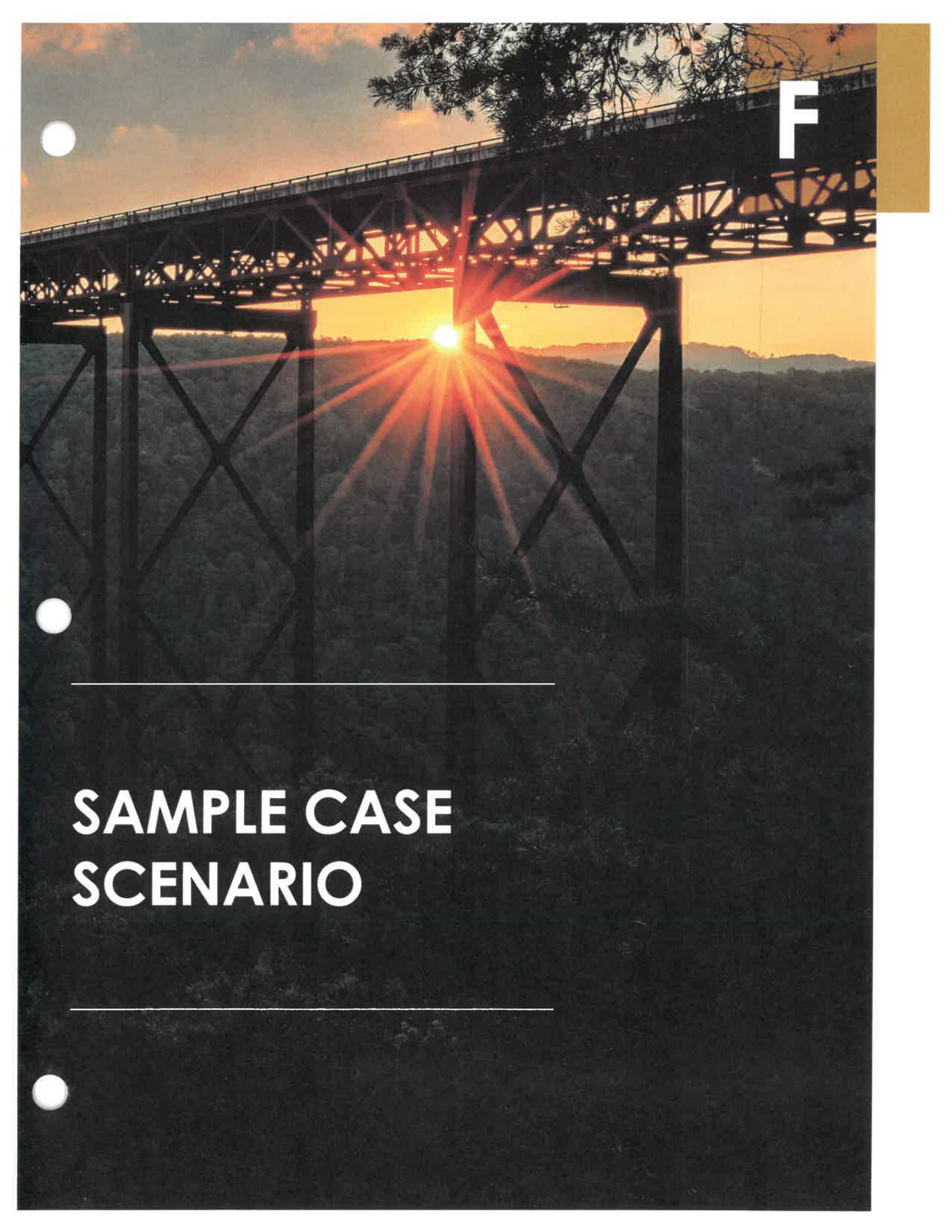
Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
QU035	2	Timeframes for resolution	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-28
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	Tab E - QU	QU-30
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	Tab E - QU	QU-30
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	Tab E - QU	QU-31
QU039	2	Primary care providers (PCPs)	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-31
QU040	2	High-volume specialists	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications	Tab E - QU	QU-31

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
						Approach		
QU041	2	Hospitals	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-32
QU042	2	Other acute care providers	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-32
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	Tab E - QU	QU-32
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	Tab E - QU	QU-33
QU045	2	Complaints and grievances	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-33
QU046	2	Primary care provider (PCP) change requests	See the parent specification.	Quality	Will Meet	Attachment E - Detailed	Tab E - QU	QU-34

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
						Specifications Approach		
QU047	2	Out-of-network referrals	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-34
QU048	2	Emergency room (ER) usage	See the parent specification.	Quality	Will Meet	Attachment E - Detailed Specifications Approach	Tab E - QU	QU-34
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 C - Project Organization and Staffing	Tab E - QU	QU-35
QU050	2	Access to care	See the parent specification.	Quality	Will Meet	Attachment C - Project Organization and Staffing	Tab E - QU	QU-35
QU051	2	Member satisfaction	See the parent specification.	Quality	Will Meet	Attachment C - Project Organization and Staffing	Tab E - QU	QU-35
QU052	2	Continuity of care	See the parent specification.	Quality	Will Meet	Attachment C - Project Organization and Staffing	Tab E - QU	QU-35

Specifications					Vendor Response			
Spec ID #	Hierarchy Level	Specification Text	Vendor Response Guidance	Subject Matter Area	Capability Assessment	Attachment	Section	Page #
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	Tab E - QU	QU-35
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	Tab E - QU	QU-36
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	Tab E - QU	QU-37
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	Tab E - QU	QU-37

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	Tab E - QU	QU-37
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	Tab E - QU	QU-38



F

SAMPLE CASE SCENARIO

F. Sample Case Scenario

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.

THP's Clinical Network Developed for Children Like Ben: The Patient-Centered Medical Home

To address Ben's most urgent and secondary needs, it is important to understand the clinical and case management THP will have in place (also highlighted in responses CM006-008). The clinical network will be built on the patient-centered medical home (PCMH) concept, which THP views as an approach to patient-centric and engaged care that is fundamental to quality primary care—whether delivered by a primary care, internal medicine, or pediatric specialist; community health/behavioral health center; or other integrated delivery system. Furthermore, this PCMH will be tailored to the needs of those foster care children in the system or those entering the system such as Ben. The PCMH will be, in alignment with American Academy of Pediatrics standards:

1. Accessible
2. Comprehensive [in delivering healthcare]
3. Compassionate [in delivering healthcare]
4. An offeror of continuous care
5. An offeror of care that is coordinated
6. Culturally competent
7. Family focused.

THP operates shared savings agreements that allow for the creation of a preferred provider network that incentivizes specialized services aligning with the PCMH attributes listed above. Although THP has extensive experience with complex case management of children and adults, it believes it is essential to partner with community-based resources to expand the PCMH model with localized “boots on the ground” case management services for members.

Leveraging resources and care coordination infrastructure developed through the children with serious emotional disorder waiver under review by the Centers for Medicare and Medicaid Services the negotiated agreement with DOJ, and alternative payment arrangements, THP intends to implement a model incorporating community-based care managers known in the agreement as Wraparound Facilitators and providers to develop intensive case management resources in every locale in West Virginia including the various in home and in community services mandated by the DOJ agreement.

These community-based care managers (Wraparound Facilitators) will be the collaborative link—along with regional THP Care Navigators—to members, the Multi-Disciplinary Treatment Team, other stakeholders, and CPS staff. In addition, the Wraparound Facilitator has the responsibility of coordinating the Child and Family Team, ensuring mandated assessments are performed, and producing the strengths based individual and family service plan.

These care managers will have the capability to assist CPS in developing placement alternatives, identifying Socially Necessary Service Needs, ensuring prompt access to healthcare needs, facilitating communication among and with providers and stakeholders, and participating in MDT meetings. Moreover, the “Wraparound Facilitator” will be an immediate contact with face-to-face capability for parents/guardians/caretakers to assist, educate, and support them as they attempt to provide safe, secure environments for THP foster care members and those at risk. The “Wraparound Facilitator” will work closely with THP’s Care Navigators and the CPS worker to address the child’s global and specific healthcare, developmental, academic, and socioeconomic needs.

THP brings a deep bench of resources to this project, with on-staff pharmacists, physicians, licensed social workers, psychologists and medical and psychiatric nurses that form an Interdisciplinary Team that can provide input, counsel and telephonic staffing resources in a “Grand Rounds” model to the MDT and Family Care Team as needed.

THP Processes Once Notified of Ben’s Removal from the Home

In that context then, once Ben is removed from the home he currently inhabits with his parents, who are both struggling with substance use disorders that have resulted in a neglectful and dangerous environment, he is placed in an emergency shelter.

The DHHR worker will notify THP of the emergency placement within 4 hours. THP has a registered nurse on call 24 hours a day 7 days a week. If the notification occurs after regular business hours or on a holiday, the on call RN will obtain the necessary information from the DHHR worker so that follow up can occur. Specific information needed upon the initial call includes but is not limited to:

- Ben’s full name and date of birth

- Name of shelter, address, contact person, and phone number
- County issuing the placement order
- Judge's name
- Releases of information

Additionally, the DHHR worker will enter the information related to the placement into FACTS.

THP considers emergency shelter placement for a 6 year old to be an inappropriate and potentially unsafe environment. Therefore, once CPS has notified THP of the temporary placement, the case will be opened to complex case management through THPs established policies and procedures and the Care Navigators will immediately begin working the case with a top priority of working with various foster care placement agencies and the CPS staff to locate an emergency foster care placement at the very earliest possible time. If necessary and appropriate, a therapeutic foster care home will be identified.

The Care Navigator will check in with the CPS staff on a regular basis to ensure that the home study is being performed on the potential kinship care placement so as to have enough advance notice to be able to prepare Ben for any change in placements and work in collaboration with CPS staff.

An initial plan of care will be devised by the Care Navigator per THP policy, specifically addressing immediate safety, medical, behavioral health and needed psychosocial supports. The plan will be modified as the case evolves with input from all stakeholders via the MDT process. MDT meetings and status conferences are tracked by THP in COMET. Reminders are set to provide the Care Navigator of any upcoming deadlines.

THP Care Navigator will perform the following immediate tasks:

- The Care Navigator will obtain ROI from the CPS worker (who is the temporary legal guardian empowered by the court to provide legal permissions on behalf of the member) for the school, any known medical or behavioral health providers, family members with knowledge of the member, and the "Wraparound Facilitator" that the MCO intends to designate; (pending the approval of the guardian);
- The Care Navigator will research available data files for all past medical providers, prescriptions, DME authorizations and other information and begin to contact providers to obtain information and records. An important aspect of this search/review will be to ensure that the child's immunizations are up to date;
- With the CPS case manager, the Care Navigator will designate a "Wraparound Facilitator" and begin the collaborative relationship; consideration will be given first to any "Wraparound Facilitator" agency that has an established prior relationship with the child;
- The Navigator will contact the emergency shelter, introduce herself and the "Wraparound Facilitator", supply contact information, and obtain any information the shelter has regarding the child's status. One key aspect of this call will be to ensure that the young child is secure and isolated from older children in the shelter at all times;

Once medical records have been researched (within one day of the placement), the Care Navigator will ensure that the shelter is aware of any prescriptions needed by the member. The

Care Navigator will immediately contact the child's past providers to obtain prescriptions for medications and any needed DME sufficient to last until the child can be seen by a PCP on an urgent basis.

The Care Navigator will make an appointment with a PCP within 72 hours for full evaluation of medical status, utilizing THP partner providers such as WVU Medicine in order to ensure that best effort is made to appoint providers that are trained in trauma informed care principles.

The wraparound facilitator is responsible for ensuring that the required assessments are performed per DHHR implementation plan (yet to be determined). The WF will be assisted in this by the MCO navigator. At the scheduled time identified by the DHHR implementation plan, the WF will coordinate and convene the Child and Family Care Team to do a strengths-based plan of care for the child and the family. This plan will be coordinated with all others by the navigator and posted in the THP "drop box" for the member.

The Care Navigator will ensure that the shelter and the "Wraparound Facilitator" are aware of the appointment and able to transport the member to the appointment. The initial PCP will be provided with all information available to the Care Navigator at the time of the appointment, including immunization records. If the shelter is not able to transport, the "Wraparound Facilitator" will transport. Either way, the "Wraparound Facilitator" will attend the appointment with the member.

The "Wraparound Facilitator" will do a face to face visit with the child within 72 hours of the emergency shelter placement to introduce him/herself and begin to establish a relationship of trust, and will communicate with THP Care Navigator.

THP Care Navigators will work with the CPS case worker to identify a PCP for the child and an initial visit with that PCP and a dentist within 30 days. Once the initial medical and dental evaluations are conducted, an appointment will be scheduled for any necessary on-going treatment, medical and/or dental. Any prescribed DME will be expediently authorized and provided as needed. During the first visit, the Care Navigator will ensure that the PCP conducts an EPSDT review. THP Care Navigators will further ensure that any needs identified by the EPSDT screening will be addressed with an appointment with a provider and will notify the CPS worker of the issues and coordinate with the "Wraparound Facilitator".

If Ben is to attend the public-school system while in the shelter, the "Wraparound Facilitator" will go to the school to speak with the counselor/school psychologist/principal to ensure that staff are aware of the child's circumstances and need for trauma sensitive care and flexibility.

THP intends to create a cloud-based secure drop box type of program, accessible to a limited number of stakeholders, which will make results of any medical evaluations available through a double verification methodology.

A comprehensive behavioral health assessment will be scheduled by THP Care Navigators within one week of the placement. THP will develop a network of providers willing to grant the target population priority access scheduling of these evaluations and will ensure that prior authorizations are readily available to fund the evaluation within a few hours of the request if

made during a work day. If necessary, a more emergent preliminary screening assessment can be conducted immediately, scheduled by the Care navigator with a participating provider.

The "Wraparound Facilitator" will ensure that the CANS, CAFAS and any other assessments are conducted. The ACES trauma questionnaire will be obtained from the PCP if possible and provided to the relevant provider entities however since Ben is only 6 he is most likely not capable of properly addressing the material in the questionnaire.

The "Wraparound Facilitator" may do a school observation on Ben in order to make a recommendation to the school as to school-based services, need for IDEA assessments, and other relevant information. The "Wraparound Facilitator" will participate in any school-based IDT meetings on an on-going basis and will report back to CPS staff and the Care Navigator. These activities will occur in any placement that requires a change in school environment.

All of the information from these assessments will be made available to the MDT as soon as the initial MDT is held. Both THP Care Navigator and the "Wraparound Facilitator" will participate in the MDT and assist in processing the information and making recommendations for care. In the interim, THP Care Navigator will ensure that appointments are made for on-going necessary behavioral health and medical care, that DME as necessary is authorized and provided, and that the "Wraparound Facilitator" accompanies the member to all appointments, transporting as necessary. At any time, THP IDT multidisciplinary staff will be available to the MDT for telephonic consultation and assistance with Ben's case.

Until an emergency foster care placement is identified, the "Wraparound Facilitator" will visit the member twice a week in the first week at the shelter to continue to establish rapport and to ensure that he is safe. Visits will be held as needed afterwards, no less than once per week or as specified by DHHR policy as identified in the implementation plan approved by the DOJ. More frequent visits can be done as necessary.

The MDT will be held within 30 days of the shelter placement. THP Care navigator and the "Wraparound Facilitator" will participate and present the materials that have been amassed regarding Ben's current status. Recommendations will be made. Once the MDT develops the overall plan, the CPS worker, the "Wraparound Facilitator" and the Care navigator will collaborate in ensuring that the plan is implemented with overall monitoring performed by the Care navigator and reported out to the CPS staff.

It is likely in Ben's case that reunification will be the ultimate goal of the interventions. That being the case, the parents will be given information regarding SUD treatment options by the Care navigator. If the parents are THP members, the Care navigator will immediately open THP Care Navigation cases on both parents, with their permission, and will work with them individually to arrange any SUD services, behavioral health services, or medical services that are necessary and appropriate per standard THP policies.

It is also likely that the MDT will mandate parental supervised visitation on a specific schedule and at specific locations. The Care navigator will collaborate with the CPS staff to arrange those visits including authorizing social necessity supports such as transportation, parent

education, and other services recommended by the MDT. The "Wraparound Facilitator" will work with Ben's behavioral health provider to prepare him for the visits and will accompany him as necessary and appropriate.

Since a kinship care placement is being considered, social necessity services that facilitate supervised visitation with the potential kinship providers may be appropriate. In addition, they may need some training in advance on parenting skills, budgeting, and so forth. These needs may be revealed during the home study and will be conveyed from the CPS worker to THP Care Navigator or to the "Wraparound Facilitator" to enable.

Once an emergency foster care placement is identified, Ben's behavioral health provider will be notified to assist him in preparing for the change in placement as would be appropriate in suitably trauma informed care. The HP Care Navigator will notify all relevant medical and other providers of the change in location and circumstance, including the school.

Foster care agencies will be eligible to be part of the PCMH "Wraparound Facilitator" provider pool and movement to the foster care location may necessitate engagement with a new "Wraparound Facilitator", particularly if the foster care location is distant from the shelter location. Care will be taken to introduce Ben gradually to the new "Wraparound Facilitator" as necessary and to ensure that rapport is established prior to the change in case managers. A release of information will be obtained for the foster care providers to enable sharing of information about Ben.

DHHR policy and rule is very specific about the agency requirements for an Initial Placement Conference and the expectations of the foster care agency with regard to evaluations, record collection and fire drills in the new home. Additionally, THP expects further instruction at a future time regarding timelines and specifications from DHHR per the negotiated agreement. If there is an outside "Wraparound Facilitator" or if there is to be a transition to a new "Wraparound Facilitator", they will attend all meetings at the foster care agency. The agency is required to conduct a new professional behavioral health evaluation within 30 days of the placement and the "Wraparound Facilitator" will assist the agency in scheduling that appointment, ensuring that Ben gets to the appointment and ensuring that all relevant information is provided to the professional evaluator.

The foster care agency is also required to develop an initial care plan during the Initial Placement Conference and a more comprehensive plan within 30 days. The "Wraparound Facilitator" will ensure that the plan is conveyed to the MDT, the Child and Family Team and to the CPS staff. The "Wraparound Facilitator" will obtain releases of information for the foster care parents from the CPS staff.

The "Wraparound Facilitator" will visit the proposed foster care home to work with the foster care parents regarding Ben's current or potential medical and behavioral health needs, any potential behavioral problems they may need to be prepared to face and to ensure that the parents are familiar with the concepts and practices of trauma based care, and mental health first aid principles. They will be trained in any behavioral programs or protocols that are in place. If the assessments indicate a need for Ben to have a Positive Behavioral Support Plan,

the plan will be reviewed with the family and modeled by the WF. Once again the "Wraparound Facilitator" will visit the school to notify them of changes in Ben's circumstances prior to his first day in a new school system or prior to the move.

The "Wraparound Facilitator" will visit Ben at least twice the first week in the new foster care home and weekly thereafter, more frequently as needed. The "Wraparound Facilitator" will assist the foster care parents with any evolving concerns, collaborating with the Care navigator in making appointments and obtaining authorizations for any medical or social necessity needs such as parent training or respite. Also, the WF will ensure that the family has the ability to access the Children's Mobile Crisis Response Team as needed for emergency situations.

In the meantime, DHHR has been working on approval of the kinship placement selected for home study by the MDT. Once a kinship placement is identified and approved the Care navigator will work with the CPS staff to identify a new "Wraparound Facilitator" if necessary in the new geographic area of the kinship home. If a new "Wraparound Facilitator" has been contracted, the new "Wraparound Facilitator" will collaborate with the MDT, the Care navigator and the prior "Wraparound Facilitator" to become knowledgeable of the case and to initiate visits with Ben to establish rapport prior to the placement. New PCP, DME suppliers, behavioral health providers and other necessary supports will be identified prior to the change in placement, medical records will be transferred along with suitable releases of information, and initial appointments will be made as soon as the date of transition is identified.

Throughout this time, the supervised visitations are facilitated and monitored by the "Wraparound Facilitator" who reports back to the Care navigator, the CPS staff and the MDT. The Care navigator and the "Wraparound Facilitator" continue to attend MDT meetings, keeping the MDT up to date on appointments, transition issues, and so forth.

The new kinship guardians and household members are visited by the "Wraparound Facilitator" with guardian permission and an assessment is done of training and support needs that is provided to the Care navigator for review. The Care navigator, CPS staff and "Wraparound Facilitator" will collaborate to quickly design a strategy for meeting the preliminary needs of the kinship placement including any training in use of DME or adaptive equipment or structures such as ramps that may be necessary. The kinship parties will be educated as necessary in characteristics of children of trauma, any expected behavioral or medical issues that they may need to address, use of any behavior support plan, methods of contacting the Children's Mobile Crisis team and mental health first aid. They will be trained in any behavioral protocols or programs that may be in place.

Once Ben has been successfully transitioned to the kinship placement, the "Wraparound Facilitator" will visit twice in the first week and weekly thereafter unless more frequent visits are required. If needed the "Wraparound Facilitator" will arrange for respite or other supports as needed.

After 30 days in the placement, a global re-assessment will be performed by the "Wraparound Facilitator" in collaboration with the Care navigator and reported back to CPS and the MDT.

Recommendations will be made to the MDT for any alterations in the MDT case plan. Amendments in the COMET care plan are continually made throughout the progression of the case by the Care navigator, per THP policy.

The "Wraparound Facilitator" will establish a working relationship with the kinship guardians, serving as a resource for any needed information and supports they may need. Additionally, THP Care Navigator will check in with the kinship guardians on a regular basis and will ensure that the guardians know how to contact THP Care Navigator staff and member services.

Assuming that the parents are able to successfully complete the treatment-plans recommended by the court and are gradually returned to guardianship by the legal system, the Care navigator and "Wraparound Facilitator" will facilitate increasingly extended visitation, both supervised and unsupervised, as required by the court and the MDT. If the parents are THP members, the Care Navigator has an open case on them and is fully aware of their compliance with treatment recommendations and has provided necessary supportive services to aid them in their roads to recovery. The biological parents have gradually been integrated into the Child and Family Care Team as permitted by the court and are aware of the overall goals of reunification.

Once the court mandates unsupervised visitation the "Wraparound Facilitator" will provide training and supports to the parents (or parent if only one) in Ben's medical and behavioral health needs and will provide emergency supports if a crisis arises during a visitation. All information is conveyed to the Care Navigator and CPS staff.

If full custody is returned to the parent or parents, the process of transitioning will occur again, with new providers identified as necessary, schools visited, home visits completed in order to identify any home modifications that may be needed, DME suppliers identified, and parents trained in the use of equipment or behavioral protocols.

Again, Ben's identified behavioral health provider will begin working with him on issues relevant to the transition, assisted by the "Wraparound Facilitator". The Child and Family Team meet at every treatment juncture to review and monitor progress and modify the plan of care for Ben as necessary.

The "Wraparound Facilitator" will make home visits at least twice the first three weeks of parental placement and weekly thereafter so long as the member remains on the court's docket. The "Wraparound Facilitator" and the Care Navigator will be available to the parents at any time as needed. Both will continue to attend MDT meetings throughout the period prior to dismissal of the case. MDT meetings are mandated at least quarterly by statute.

As socially necessary needs are identified in any placement (environmental adaptations, parental trainings, supervised visitations, transportation) THP will authorize and facilitate the equipment or funding necessary to address the identified needs.

A photograph of two young children sitting in a grassy field with yellow wildflowers. The child on the left is a young boy with curly brown hair and freckles, wearing a white t-shirt, looking down with a smile. The child on the right is a young girl with dark hair, wearing a white t-shirt and a blue headband, looking towards the boy. The background is a bright, sunny sky with some clouds. There are three white circular marks on the left side of the image: one near the top, one in the middle, and one near the bottom.

G

TERMS AND CONDITIONS RESPONSE TEMPLATE

G. Terms and Conditions Response Template

1. Instructions

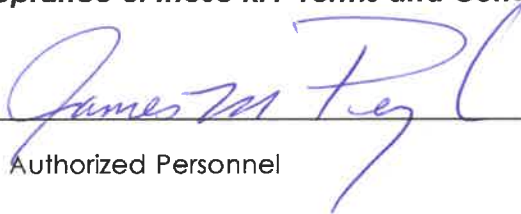
The Vendor should review **Attachment G: Terms and Conditions Response Template**, signing each provided signature block using blue ink in order to note the Vendor's acknowledgement and intent of compliance. The Vendor should identify any exceptions to the Terms and Conditions. If exceptions are not 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.

James M Pennington



8-16-2019

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.

James M Pennington



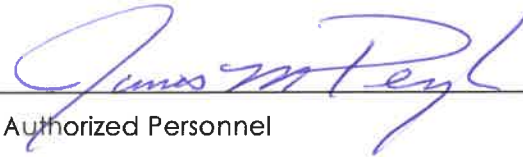
8-16-2019

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.

James M Pennington



8-16-2019

Printed Name / Signature of Authorized Personnel

Date

4. Mandatory Requirements and Terms

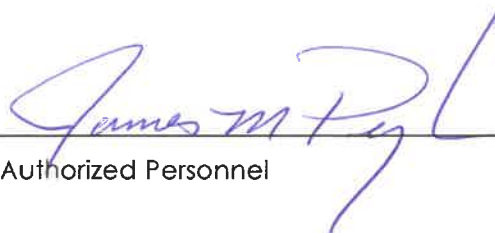
The following items are Mandatory Terms and Documents. Please be advised, the Vendor **should** provide its affirmative acceptance of these items in order to move forward with consideration under this RFP.

- 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.

James M Pennington



8-16-2019

Printed Name / Signature of Authorized Personnel

Date

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.

- The commercial and proprietary materials include our computer software products, namely our HEART system and COMET system are proprietary tools developed by THP. We do not believe these are easily copied.
- We also utilize utilization review guidelines, materials and software from Change Healthcare Technologies, LLC which are referred to as InterQual®. Our use of the guidelines is covered under a license agreement which prohibits copying and distribution of the guidelines except as required as part of the clinical review process.

(BALANCE OF THIS PAGE INTENTIONALLY LEFT BLANK)

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 - <Insert Title of Provision>

Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken)	Vendor 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

NOTES/COMMENTS: <FOR STATE USE ONLY>

6.2 Exception #1 - <Insert Title of Provision>

Document Title (Reference Specific Contractual Document and Section in Which Exception is Taken)	Vendor 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

NOTES/COMMENTS: <FOR STATE USE ONLY>

State of West Virginia

VENDOR PREFERENCE CERTIFICATE

Certification and application is hereby made for Preference in accordance with **West Virginia Code**, §5A-3-37. (Does not apply to construction contracts). **West Virginia Code**, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the **West Virginia Code**. This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Vendor Preference, if applicable.

1. Application is made for 2.5% vendor preference for the reason checked:

☒ Bidder is an individual resident vendor and has resided continuously in West Virginia, or bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia, for four (4) years immediately preceding the date of this certification; or,

☐ Bidder is a resident vendor partnership, association, or corporation with at least eighty percent of ownership interest of bidder held by another entity that meets the applicable four year residency requirement; or,

☐ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; or,

2. Application is made for 2.5% vendor preference for the reason checked:

☒ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; or,

3. Application is made for 2.5% vendor preference for the reason checked:

☐ Bidder is a nonresident vendor that employs a minimum of one hundred state residents, or a nonresident vendor which has an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia and employs a minimum of one hundred state residents, and for purposes of producing or distributing the commodities or completing the project which is the subject of the bidder's bid and continuously over the entire term of the project, on average at least seventy-five percent of the bidder's employees or the bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years and the vendor's bid; or,

4. Application is made for 5% vendor preference for the reason checked:

☒ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; or,

5. Application is made for 3.5% vendor preference who is a veteran for the reason checked:

☐ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; or,

6. Application is made for 3.5% vendor preference who is a veteran for the reason checked:

☐ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

7. Application is made for preference as a non-resident small, women- and minority-owned business, in accordance with West Virginia Code §5A-3-59 and West Virginia Code of State Rules.

☐ Bidder has been or expects to be approved prior to contract award by the Purchasing Division as a certified small, women- and minority-owned business.

8. Application is made for reciprocal preference.

☒ Bidder is a West Virginia resident and is requesting reciprocal preference to the extent that it applies.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) rescind the contract or purchase order; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

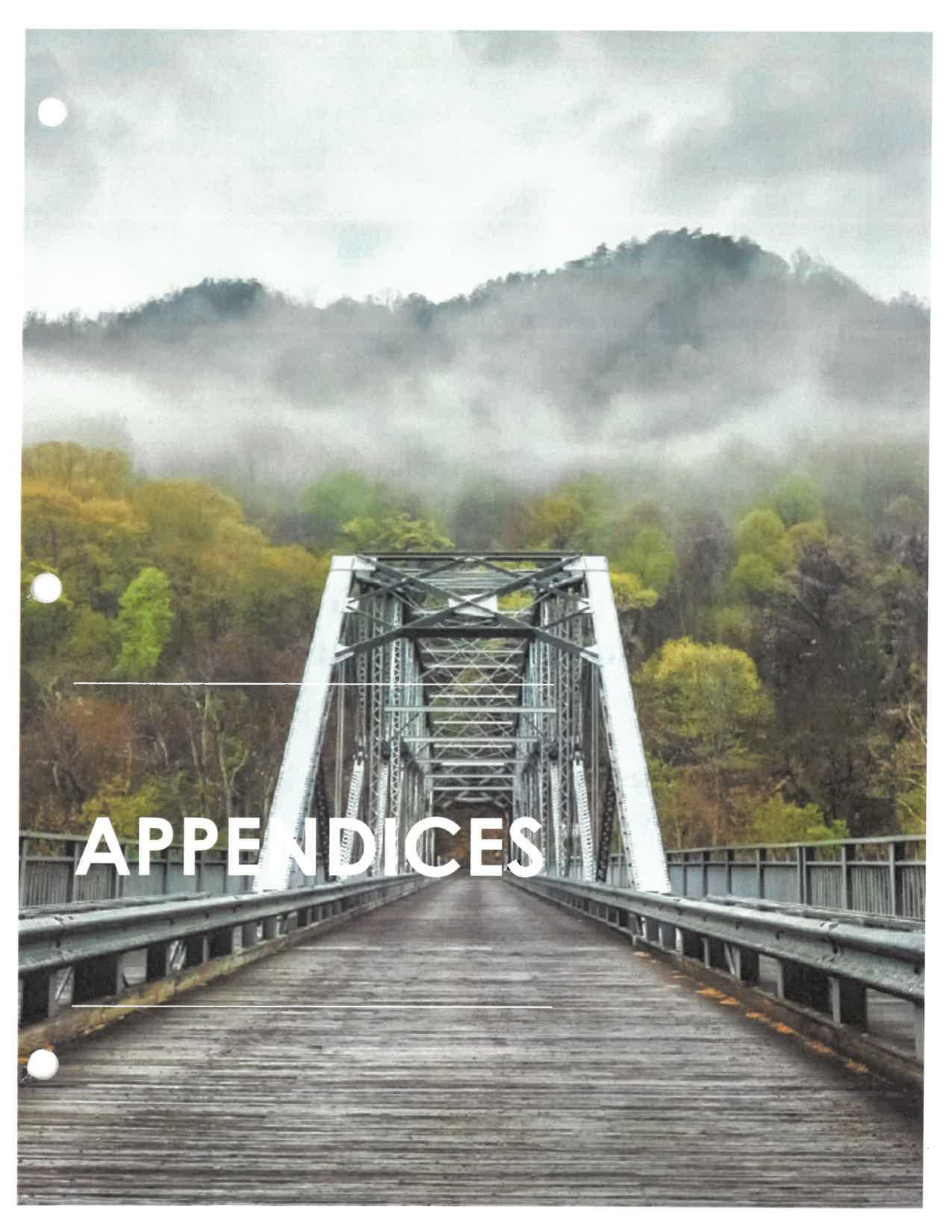
Bidder: The Health Plan

Signed: James M. Hey

Date: 8/16/19

Title: President + CEO

*Check any combination of preference consideration(s) indicated above, which you are entitled to receive.



APPENDICES

1

Appendix

REQUIRED SIGNATURE DOCUMENTS AND ADDENDA

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 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.

The Health Plan
Company
James M. Key
Authorized Signature
8/16/19
Date

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

SOLICITATION NUMBER: CRFP BMS1900000001

Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as CRFP BMS1900000001 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

- ☐ Modify bid opening date and time
- ☐ Modify specifications of product or service being sought
- ☐ Attachment of vendor questions and responses
- ☐ Attachment of pre-bid sign-in sheet
- ☐ Correction of error
- ☒ Other

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith and is specifically incorporated herein by reference.

1. To attach the following exhibits inadvertently omitted from the CRFP BMS1900000001 originally published on 07/01/2019.

Attachments include:

FC_Redacted_Medical_201607_201806.zip
FC_Redacted_Elig_201607_201806.zip
FC_Redacted_Pharmacy_201607_201806.zip

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Specialized Managed Care for Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-01	2019-08-15 13:30:00	CRFP 0511 BMS1900000001	1

BID RECEIVING LOCATION

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON

WV

25305

US

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia

1110 Main Street

Wheeling, WV 26003

1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle

(304) 558-0067

april.e.battle@wv.gov

Signature X

FEIN #

55-0585592

DATE

8/16/19

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

ADDITIONAL INFORMATION:

The West Virginia Purchasing Division is soliciting proposals for a vendor to provide statewide physical and behavioral health managed care services for children and youth in the foster care system and individuals receiving adoption assistance.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Specialized Managed Care for Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 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.

The Health Plan
Company
James M. Tey
Authorized Signature
8/16/19
Date

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

SOLICITATION NUMBER: CRFQ 0511 BMS1900000001
Addendum Number: 2

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

- ☐ Modify bid opening date and time
- ☐ Modify specifications of product or service being sought
- ☐ Attachment of vendor questions and responses
- ☒ Attachment of pre-bid sign-in sheet
- ☐ Correction of error
- ☒ Other

Description of Modification to Solicitation:

- 1) To clarify the bid opening date is August 13, 2019, at 1:30 PM EST; and
- 2) To provide the pre-bid sign-in sheets.

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Addendum No.1 Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-01	2019-08-15 13:30:00	CRFP 0511 BMS1900000001	2

BID RECEIVING LOCATION

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

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia
1110 Main Street
Wheeling, WV 26003
1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X

FEIN #

55-0585592

DATE

8/16/19

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

ADDITIONAL INFORMATION:

Addendum No. 1 - To attach the following exhibits inadvertently omitted from the CRFP BMS1900000001 originally published on 07/01/2019.

Attachments include:

FC_Redacted_Medical_201607_201806.zip

FC_Redacted_Elig_201607_201806.zip

FC_Redacted_Pharmacy_201607_201806.zip

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Addendum No.1 Specialized Managed Care Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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.

The Health Plan
Company
James M. Key
Authorized Signature
8/16/19
Date

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

SOLICITATION NUMBER: CRFP 0511 BMS1900000001

Addendum Number: 3

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

- ☐ Modify bid opening date and time
- ☐ Modify specifications of product or service being sought
- ☐ Attachment of vendor questions and responses
- ☐ Attachment of pre-bid sign-in sheet
- ☐ Correction of error
- ☒ Other

Description of Modification to Solicitation:

To provide the following documents as part of the solicitation:

- 1) 00 – Specialized Managed Care for Children and Youth;
- 2) 01 – Detailed Specifications;
- 3) 03 – SFY20 Draft MCO Foster Care Contract;
- 4) 07 – SFY18 SNS Foster Spend by Category;
- 5) 08 – SFY20 Foster Care Rate Databook Exhibits;
- 6) A – Cost Proposal;
- 7) D – Mandatory Requirements;
- 8) Provider Utilization and Reimbursement Report; and
- 9) Specialized Managed Care RFP Change Log.

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Addendum No.2 Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-16	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	3

BID RECEIVING LOCATION

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

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia
1110 Main Street
Wheeling, WV 26003
1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X

FEIN #

55-0585592

DATE

8/16/19

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

ADDITIONAL INFORMATION:

Addendum No. 2 is issued to:

- 1) clarify the bid opening date is August 13, 2019, at 1:30 PM EST; and
- 2) to provide the pre-bid sign-in sheets.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Addendum No.2 Specialized Managed Care Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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.

The Health Plan
Company
James M. Perry
Authorized Signature
8/16/19
Date

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

SOLICITATION NUMBER: CRFP 0511 BMS1900000001

Addendum Number: 4

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

- ☐ Modify bid opening date and time
- ☐ Modify specifications of product or service being sought
- ☐ Attachment of vendor questions and responses
- ☐ Attachment of pre-bid sign-in sheet
- ☒ Correction of error
- ☐ Other

Description of Modification to Solicitation:

To provide the corrected Schedule of Events information.

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Addendum #3 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-18	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	4

BID RECEIVING LOCATION

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

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia
1110 Main Street
Wheeling, WV 26003
1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X

FEIN #

55-0585592

DATE

8/16/19

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

ADDITIONAL INFORMATION:

Addendum #3 is issued to provide the following documents as part of the solicitation:

- 1) 00 - Specialized Managed Care for Children and Youth;
- 2) 01 - Detailed Specifications;
- 3) 03 - SFY20 Draft MCO Foster Care Contract;
- 4) 07 - SFY18 SNS Foster Spend by Category;
- 5) 08 - SFY20 Foster Care Rate Databook Exhibits;
- 6) A - Cost Proposal;
- 7) D - Mandatory Requirements;
- 8) Provider Utilization and Reimbursement Report; and
- 9) Specialized Managed Care RFP Change Log.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Addendum #3 - Specialized Managed Care Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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.

The Health Plan
Company
James M. Teyl
Authorized Signature
8/16/19
Date

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

SOLICITATION NUMBER: CRFP 0511 BMS1900000001

Addendum Number: 5

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

- ☐ Modify bid opening date and time
- ☐ Modify specifications of product or service being sought
- ☒ Attachment of vendor questions and responses
- ☐ Attachment of pre-bid sign-in sheet
- ☐ Correction of error
- ☐ Other

Description of Modification to Solicitation:

- 1) To provide vendor questions and responses.

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Addendum #4 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-19	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	5

BID RECEIVING LOCATION

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON

WV 25305

US

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia

1110 Main Street

Wheeling, WV 26003

1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle

(304) 558-0067

april.e.battle@wv.gov

Signature X

FEIN #

55-0585592

DATE

8/16/19

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

ADDITIONAL INFORMATION:

Addendum #4 is issued to provide the corrected schedule of events.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Addendum #4 - Specialized Managed Care Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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.

The Health Plan
Company
James M. Foy
Authorized Signature
8/16/19
Date

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

SOLICITATION NUMBER: CRFP 0511 BMS1900000001

Addendum Number: 6

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

- ☒ Modify bid opening date and time
- ☐ Modify specifications of product or service being sought
- ☒ Attachment of vendor questions and responses
- ☐ Attachment of pre-bid sign-in sheet
- ☐ Correction of error
- ☐ Other

Description of Modification to Solicitation:

- 1) To provide the **UPDATED** vendor questions and responses;
- 2) To extend the bid opening date to August 16, 2019, at 1:30 PM EST

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Addendum #5 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-07-31	2019-08-13 13:30:00	CRFP 0511 BMS1900000001	6

BID RECEIVING LOCATION

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

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia
1110 Main Street
Wheeling, WV 26003
1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X

FEIN #

55-0585592

DATE

8/16/19

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

ADDITIONAL INFORMATION:

Addendum #5 is issued to provide the vendor questions and responses.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Addendum #5 - Specialized Managed Care Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

ADDITIONAL INFORMATION:

Addendum #6 is issued:

- 1) to provide the UPDATED vendor questions and responses;
- 2) to extend the bid opening date to August 16, 2019, at 1:30 PM EST.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Vendor's Bid Amount for Managed Care				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Managed Care

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	Vendor's Bid Amount for Administrative Services(SNS)				

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

Vendor's Bid Amount for Administrative Services(SNS)

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-Bid Meeting	2019-07-16
2	Questions Due	2019-07-23

BMS1900000001	Document Phase Final	Document Description Addendum #6 - Specialized Managed Care Children and Youth	Page 3 of 3
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

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 exceeds 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: The Health Plan of West Virginia

Authorized Signature: James M. King

Date: 8-8-19

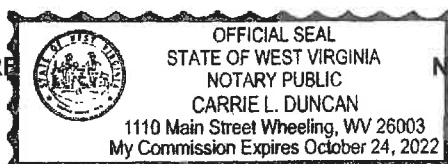
State of West Virginia

County of Ohio, to-wit:

Taken, subscribed, and sworn to before me this 8 day of August, 2019.

My Commission expires OCTOBER 24 2022, 20 .

AFFIX SEAL HERE



NOTARY PUBLIC

Carrie Duncan



Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 583126

Doc Description: Addendum #6 - Specialized Managed Care Children and Youth

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-08-02	2019-08-16 13:30:00	CRFP 0511 BMS1900000001	7

BID RECEIVING LOCATION

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

VENDOR

Vendor Name, Address and Telephone Number:

The Health Plan of West Virginia
1110 Main Street
Wheeling, WV 26003
1.800.624.6961

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X

FEIN #

SS-0585592

DATE

8/16/19

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

2

Appendix

POSITION DESCRIPTIONS

JOB DESCRIPTION

JOB TITLE Administrative Assistant

DEPARTMENT Clinical Services

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Director of Medical and Behavioral
 Management

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Under direction of Director or Managers, the Administrative Assistant is responsible for all clerical tasks within the department. This position maintains all correspondence and recording of minutes for committees.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Coursework in medical secretarial science (and/or medical background) through a high school or community college.
2. Must be proficient in Word, Excel and other related PC usage
3. Demonstration of strong skills in grammar, spelling, and communication.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Three years of related clerical experience or any any experience or training which demonstrates the ability to adequately perform the required skills
2. Prior work experience in a health care setting, insurance or managed care organization preferred
3. Excellent organizational skills, initiative, self-motivation and the ability to interact well with others
4. Strong typing skills (55 words per minute)

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Answers phone for Clinical Services and replies to routine questions/routes calls. Coordinates Peer to Peer Medical reviews. Takes messages and/or distributes calls to appropriate staff. Performs and distributes monthly phone reports for clinical services
- Execution/Completion of special reports and projects as directed by VP, Directors and Management
- Mail: Receives/routes mail to staff, composes letters as requested, completes departmental mailings as directed
- Performs staff production reporting monthly and submits to shared drive for Manager/Director review
- Prepares agendas, records minutes and maintains logs for Committees, Grand Rounds and departmental meetings
- Documents Specialist and Contrated Medical Director reviews and complete related reimbursement sheets
- On Call RN reimbursement
- Contract completion, filing, verifications and updates as directed. Completion of purchase

- orders
- Review and reimburse for requested medical records
- Maintain phone lists and departmental organization charts
-

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 06/07/2019

Review Date: 06/07/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Administrative Assistant

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>R</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>O</u>
Crawling	<u>R</u>	Sitting	<u>F</u>
Crouching	<u>R</u>	Standing	<u>O</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>R</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>R</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>R</u>	Field of Vision	<u>R</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☐ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☒ Manipulating ☒ Operating-Controlling ☐ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Asst. VP Medicaid

DEPARTMENT Government Programs

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO Senior VP Government Programs

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Primary liaison between The Health Plan and the Bureau for Medicaid Services (BMS). Responsible for making recommendations to management on any changes to improve either the actual care provided or the manner in which care is delivered. Provides authority needed to carry out designated task and empowered to make and resolve operational, financial, and policy decisions regarding the Medicaid contract.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. 10 years of Medicaid experience with a fiscal agent or MCO
2. Experience in healthcare insurance operations, public policy development or government relations
3. Leadership/Management experience
4. Experience with Medicaid, Duals, SNPs, DEMOs or other related government product
5. Experience in a position that required analytical, presentation and clear, concise verbal/written communication skills
6. Experience leading, formulating and delivering strategy, building strong connections with people and teams
7. Writing and presentation skills.
8. Experience in government RFP production and delivery.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Bachelor Degree

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Primary liaison between The Health Plan and BMS, including: contract requirements knowledge and oversight and input into contracting process
- Direct contact with BMS on ALL issues related to Medicaid
- Serves as interface with various departments and staff within the organization in order to coordinate delivery of Medicaid requirements
- Provide direction of company resources across all department and divisions as necessary to ensure efficient operations of the Medicaid program
- Responsible for managing, overseeing and supporting a team of direct and indirect reports to foster and develop our strategy around Medicaid programs.
- Coordinate employee, provider and vendor training initiatives ensuring an understanding of

Medicaid needs

- Ensuring achievement of targeted membership growth initiatives
- Identifying product enhancement and improvement opportunities
- Evaluating and seeking opportunities for Medicaid expansions
- Evaluate other opportunities
- Coordinate RFP and RFI processes
- Investigate and resolve access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations and members.
- Monitor MCO formal and informal grievances
- Recommend policy and procedural changes to Health Plan management including those needed to ensure and improve member access to care and quality of care.
- Function as the primary contact for member advocacy groups
- Analyze system functions through meeting with staff
- Organize and provider training and educational materials for Health Plan staff
- Evaluate and Pursue potential Medicaid growth opportunities

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 5/1/2019

Review Date: 5/1/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Assistant VP Medicaid

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

0 = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	R	Lifting	R
Carrying	O	Pushing	O
Climbing	R	Reaching	F
Crawling	R	Sitting	C
Crouching	R	Standing	F
Hearing	C	Stooping	R
Key Board Function	C	Talking	C
Kneeling	R	Walking	F

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	C	Near Distance	C

Vision for Driving		Intensity	Vision for Driving		Intensity
Depth Perception		C	Field of Vision		C

Other	Intensity	Other	Intensity

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing	☒ Diverting	☒ Handling
☒ Comparing	☒ Instructing	☒ Manipulating
☒ Compiling	☒ Mentoring	☒ Operating-Controlling
☒ Computing	☒ Negotiating	☒ Precision Working
☒ Coordinating	☒ Persuading	☒ Setting Up
☐ Synthesizing	☐ Serving	☒ Tending
	☒ Speaking-Signaling	
	☒ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Behavioral Health Medical Director

DEPARTMENT Medical

FLSA STATUS ☐ Exempt ☐ Non-Exempt

REPORTS TO SVP of Clinical Services

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Behavioral Health Medical Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of behavioral health clinical and quality activities of the project.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience in serving as Behavioral Health Lead or Expert for a Medicaid program and five (5) years' experience working in behavioral health clinical care, including trauma and substance use;
2. Active West Virginia Medical License in a related behavioral health specialty;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Should be available for behavioral health service utilization review decisions and should be authorized and empowered to respond to behavioral health clinical issues, utilization review, and behavioral quality of care inquiries.
- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Behavioral Health Medical Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> F </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> F </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> C </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> F </u>	Field of Vision	<u> F </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Referral Coordinator

DEPARTMENT Behavioral Health

FLSA STATUS ☒ Exempt ☒ Non-Exempt

REPORTS TO Director, Behavioral Health

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Referral Coordinator is responsible for the timely and accurate completion of preauthorizations for the Behavioral Health Department. This includes benefit review as well as review of medical necessity and criteria.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. An RN or Bachelors Degree in Psychology or Social Work
2. Ability to deal with issues such as client complaints and protected information in a tactful and confidential manner.
3. Should possess excellent oral, telephonic and interpersonal communications skills, balancing an independent and team working environment.
4. Must be flexible and able to multi-task in a fast-paced environment and adapt to changing processes.
5. Must possess a superior work ethic and commitment to excellence and accountability.
6. Must possess ability to exercise independent and sound judgement in decision making, utilizing relevant information with proactive identification and resolution of issues.
7. Must possess proficient keyboarding skills and computer literacy with ability to navigate through multiple programs;

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Background in coordination of mental health services and /or familiarity of mental health care delivery

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Determines the appropriateness of requested services by using established criteria and /or guidelines, as well as department guidelines.
- Follows established timelines for the review process.
- Reviews and evaluates relevant information including member history, medical records, group contracts, benefit design, plan limitations, exclusions, coordination of benefits and member eligibility in making decisions and recommendations that are consistent with sound medical and managed care practice.
- Facilitates access to care, provides liaison services, advocates for and educates members as needed.
- Utilizes clinical skills to identify those members in need of care, case or disease management and refers accordingly. Identifies members who may need social services interventions and refers them to a Health Plan social worker.

- Follows up with providers regarding denials and requests for information, maintaining open lines of communication.
- Prioritizes assignments appropriately and maintains flexibility as new priorities arise.
- Educates providers, as necessary
- Promotes communication, both internally and externally, to enhance effectiveness of behavioral health services
- Collaborates and shares knowledge and expertise with peers, supervisors and other HP staff.
- Assists in coordination of collaborative relationships with community resources.
- Identifies opportunities for improvement in systems, processes, functions, programs, procedures and makes recommendations to the Director.
- Serves as assigned on departmental or company committees
- Strives to improve quality in all areas of responsibility and cooperates with all departments to improve quality throughout the Health Plan
- Take initiative to solve problems

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 06/18/2019

Review Date: 06/18/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Referral Coordinator

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>R</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>O</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>R</u>	Field of Vision	<u>R</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☐ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☐ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☐ Precision Working ☒ Setting Up ☒ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Care Management Director

DEPARTMENT Medical

FLSA STATUS ☒ **Exempt** ☐ **Non-Exempt**

REPORTS TO SVP Clinical Services

SUPERVISOR ☒ **Yes** ☐ **No**

POSITION SUMMARY:

The Care Management Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of project care management activities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience working as a case manager or care coordinator for a Medicaid program;
2. RN and/or LCSW in West Virginia;
3. Demonstrated ability to communicate with members who have complex medical needs and may have communication barriers;
4. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Oversees care management program operations, including, but not limited to, management and integration of care through the member's PCP, referral processes for Medically Necessary and SNS, provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and health risk assessment completion.
- Establishes and monitors care coordination staffing ratios and related activities.
- Oversees the continuity and coordination of care of members within this program.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Case Management Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Chief Financial Officer

DEPARTMENT Finance

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO SVP Finance

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Chief Financial Officer is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of all financial activities of the project.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience serving as a financial lead for a managed care entity or other health insurance provider;
2. Bachelor's degree or higher;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Is responsible for oversight of the Vendor's provider payment arrangements, including Alternative Payment Models (APMs).
- Signs data certification forms, including, at a minimum, all encounter data and financial data and reporting for payments to contracted providers.
- Certifies payment information to be utilized for rate-setting purposes or any payment-related data required by the Department.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

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I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Chief Financial Office

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

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Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> F </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> F </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> C </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> F </u>	Field of Vision	<u> F </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Claims Analyst – Medicaid

DEPARTMENT Operations – Medicaid

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Manager of Claims – Medicaid

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Under the direction of the Manager of Claims, the reviewer performs initial review of claims, including HCFA 1500 and UB 04 claims. Reviewer must meet or exceed production and quality standards and follow documented policies and procedures. There are 3 levels for this position.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Ability to follow written directions and work independently. Familiarity with medical terminology, CPT and ICD-9/ICD-10 coding is required. Computer and typing experience is required. Experience in billing or physician office experience is preferred.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Previous claims payment experience
2. Ability to understand medical terminology

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- **RESPONSIBILITIES/JOB DUTIES - Level 1**
- Performs initial review of all claim edits as directed. Completes or routes all reviews in accordance with time parameters established by The Health Plan
- Reviews each claim flag in sequence, totally completing one at a time in accordance with established criteria/payment guidelines
- Reports patterns of incorrect billing and utilization to the Self-Funded Claims Manager
- Advises supervisor of items that are unclear or that are not addressed in the established criteria/payment guidelines
- Maintain a quality rating of 90% for 6 consecutive months
- Processes 15-20 claims per hour
- Consistently displays a positive attitude and acceptable attendance
- Participate in external and/or internal trainings as requested
- **RESPONSIBILITIES/JOB DUTIES - Level 2**
- Demonstrates proficiency in Level 1 responsibilities
- Reviews claims from all areas as assigned on a daily basis with departmental standards for productivity, timeliness, confidentiality and accuracy of claims adjudication
- Follows and implements independent review decisions based on established criteria. Identifies areas for further review or investigation and is always cognizant of ways to improve and upgrade review
- Examines coding of operative reports for multiple and complicated surgeries. Assists with review and payment determination for unlisted codes

- Evaluates claims for referral to medical management and makes recommendations for follow-up, further investigation or supporting documentation as necessary
- Responds to questions, telephone calls and documents regarding the company's payment and utilization review decisions
- Maintains a quality rating of 95% for 6 consecutive months
- Processes 21-25 claims per hour
- Consistently displays a positive attitude and acceptable attendance
- Participate in external and/or internal trainings as requested
- **RESPONSIBILITIES/JOB DUTIES - Level 3**
- Demonstrates proficiency in Level 2 responsibilities
- Works claim adjustment queues and makes notations for additional reviewer training
- Provides orientation to new hires within the department
- Organizes and coordinates work of other level reviewers within department unit as requested by the unit manager
- Maintains a quality rating of 98% for 6 consecutive months
- Processes 26 + claims per hour
- Participate in external and/or internal trainings as requested
- Consistently displays a positive attitude and acceptable attendance
- Maintains annual performance evaluations of commendable and distinguished

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 4/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

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I have read and understand the job description and the working conditions.

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Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Claims Analyst

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> R </u>
Carrying	<u> R </u>	Pushing	<u> R </u>
Climbing	<u> R </u>	Reaching	<u> R </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> O </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> F </u>
Kneeling	<u> R </u>	Walking	<u> O </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> F </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> R </u>	Field of Vision	<u> R </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☐ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☐ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☐ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Claims Coordinator – Medicaid

DEPARTMENT Operations - Medicaid

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Manager of Claims - Medicaid

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Claims Coordinator position is responsible for assisting the manager and director with daily operational activities relating to claims payment, development of policy and procedures, customer service including monitoring of inventory levels, reassign work queues as needed, and provide team member guidance and support. Also responsible for the development of newly trained claims processing and customer service team as they exit the classroom training program.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School graduate or equivalent
2. Self-starter and works independently
3. Detail oriented with good problem solving skills
4. Ability to prioritize and meet deadlines
5. Maintains confidentiality
6. Good communication skills
7. Proficient in Microsoft Office products (Word, Excel, Power Point)
8. Easily adapts to changes in work requirements

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Bachelor's degree from a accredited college or university
2. Previous experience with claims processing and/or call center
3. Medical Terminology
4. Knowledge of CPT and ICD-9/ICD-10 coding
5. Knowledge of all claims types and coverage types for medical and hospital claims
6. Knowledge of prescription coding (NDC)
7. Knowledge of state and federal regulations regarding claims payment guidelines
8. Knowledge of HEART system claims processing capabilities and limitations preferred
9. Five (5) years of experience in a claims processing environment with experience in all claims types
10. Strong customer service background, written communication skills, motivation and initiative

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Provides positive leadership and mentorship
- Maintains a positive, caring work relationship with others
- Assess issues and problem solves at root cause level
- Must develop a good understanding of reports, member EOB's and the system drivers that maintain the integrity of these tools

- Performs audits of new and existing claims staff. Tracks results and recommends training to managers
- Responds to written correspondence in a timely, professional and friendly manner
- Develops policy and procedures around claims processing guidelines
- Conducts refresher claims training with Claims Analyst and CSRs
- Speaks with providers or members as callers request escalation
- Reviews and releases high dollar claims according to guidelines of the plan up to \$25,000
- Manages multiple tasks and priorities
- Records and communicates all information clearly and accurately
- Keeps all member protected health information (PHI) confidential
- Participate in external and/or internal trainings as requested
- Consistently displays a positive attitude and acceptable attendance

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 4/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

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Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Claims Coordinator - Medicaid

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = constantly (67-100% of the time)

O = occasionally (1-33% of the time)

F = frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>R</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>R</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>O</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>C</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>O</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>O</u>	Field of Vision	<u>O</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☐ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☐ Operating-Controlling ☐ Precision Working ☒ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Claims Payment Director

DEPARTMENT Operations

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO VP Operations

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Claims Payment Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of all physical and behavioral health claims payment and encounters related activities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience in claims processing and encounters with a health insurer;
2. Bachelor's degree or higher.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Ensures timely and accurate payment of provider claims for physical and behavioral health services, and in general monitors claims processing activities for these services.
- Oversees the reprocessing of claims due to rate changes or claims resubmissions.
- Oversees the submission and data integrity of encounter claims.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

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Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Claims Payment Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

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Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Community Engagement Director

DEPARTMENT Medicaid

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO AVP Medicaid

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Community Engagement Director is expected to be a key staff position throughout the entire contract term. This position is responsible for marketing, public relations, and community engagement activities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' 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;
2. Bachelor's degree or higher;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Develops and maintains Medicaid marketing policies and procedures in adherence to state and federal regulations.
- Develops and submits all marketing materials to the Department.
- Develops a written marketing plan.
- Ensures prohibited marketing activities do not occur, as stated in the contract.
- Engages with the community and provides educational and informational materials at outreach events, in accordance with marketing activity guidelines.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

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WORKING CONDITIONS

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JOB TITLE: Community Engagement Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

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F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Contract Liaison/Medicaid Administrator

DEPARTMENT Medicaid

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO SVP Government Programs

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Contract Liaison/Medicaid Administrator is expected to be a key staff position throughout the entire contract term. This position is responsible for overall delivery of the project. This individual serves as a liaison with the Department during all phases of the contract.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience in Medicaid managed care contract oversight;
2. Substantial experience in health care, experience working with low-income populations, and cultural sensitivity;
3. Bachelor's degree or higher;
4. Based in West Virginia

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers.
- Establishes and maintains a positive client relationship.
- Provides timely and informed responses to operational and administrative inquiries that arise.
- Makes contractual, operational, and financial decisions, including, but not limited to, claims payment, and provider relations/contracting.
- Meets with Department staff or such other person(s) as designated by the Department on a regular basis to provide oral and written status reports and other information as required.
- Able to respond to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy management, medical management, care coordination, and issues related to the health, safety, and welfare of the member.
- Ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member, per 42 CFR § 438.208(b)(1).

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Contract Liaison/Medicaid Administrator

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Customer Service Representative

DEPARTMENT Operations-Govt Medicaid

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Manager, Medicaid

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Medicaid Customer Service Representative is responsible for answering phone calls in a prompt and courteous manner to achieve contractual obligations. Responsible for answering Member's and Provider's questions related to Medicaid with a quick and accurate response. They are also responsible for timely completion of all correspondence and reporting functions associated with the Customer Service Department.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School Graduate: prefer 1-2 years college with interest or concentration in health field
2. Strong ability to relate with a variety of people in a non-judgmental manner
3. Strong organizational, verbal and written communication skills
4. Possess some knowledge of the health care system
5. Personal Computer (PC) and Keyboard skills
6. Proper usage of the English Language
7. Courteous manner/even temperament
8. Excellent communication skills

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Previous call center experience
2. Previous Medicaid experience
3. Medical Terminology
4. CPT and ICD-9 Coding
5. Familiar with medical and hospital claims
6. Familiar with Prescription Coding (NDC)
7. Familiar with Coordination of Benefits Ruling

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- **RESPONSIBILITIES/JOB DUTIES - Level 1**
- Takes an average of 40-60 calls daily
- Has established adequate proficiency in using the application necessary to perform the functions of a Customer Service Representative
- Maintains monthly monitoring score of 90% accuracy or above on the 17 Points of Excellence
- Demonstrates a complete understanding of departmental policies and procedures
- Able to perform assigned tasks with minimal supervision
- Meets requirements on annual performance evaluation
- Consistently displays a positive attitude and acceptable attendance

- Increasing improvement in performance and job knowledge
- Documents calls according to departmental guidelines
- **RESPONSIBILITIES/JOB DUTIES - Level 2**
- Meets all qualifications for Level 1
- Takes up to a potential 70 calls daily
- Able to perform assigned tasks and functions with little or no supervision
- Maintains monthly monitoring scores of 90% accuracy or above on the 17 Points of Excellence
- Maintains an annual performance evaluation of exceeds job requirements
- Consistently displays a positive attitude and exemplary attendance
- Usually able to handle disgruntled or agitated members and resolve their issues
- High level of understanding of job functions and how it relates to other departments
- Will often take on additional tasks and complete them in a timely manner
- **RESPONSIBILITIES/JOB DUTIES - Level 3**
- Meets all qualifications of Level 2 and 4+ years' experience
- Takes up to 100 calls per day
- Maintains monthly monitoring scores of 95% - 100%
- Acts as a resource to others within the unit
- Assists in training new employees
- Has a high level of understanding of the daily customer service functions and how they relate to other departments
- Able to perform tasks without supervision
- Consistently displays exemplary attendance and positive attitude
- Offers to take on additional tasks and completes them in a timely manner
- Has a good understanding of claims process and can readily identify a processing error to submit for correction
- Maintains an annual performance evaluation of exceeds job requirements

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned

Approval/Revision Date: 4/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Customer Service Representative

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> R </u>	Pushing	<u> R </u>
Climbing	<u> R </u>	Reaching	<u> O </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> O </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> O </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> O </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> O </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> O </u>	Field of Vision	<u> R </u>

Other	Intensity	Other	Intensity
_____	<u> </u>	_____	<u> </u>
_____	<u> </u>	_____	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing	☐ Diverting	☒ Handling
☒ Comparing	☒ Instructing	☒ Manipulating
☒ Compiling	☐ Mentoring	☐ Operating-Controlling
☒ Computing	☐ Negotiating	☒ Precision Working
☒ Coordinating	☒ Persuading	☐ Setting Up
☐ Synthesizing	☒ Serving	☐ Tending
	☒ Speaking-Signaling	
	☐ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Dental Director

DEPARTMENT Medical

FLSA STATUS ☒ **Exempt** ☐ **Non-Exempt**

REPORTS TO SVP Clinical Services

SUPERVISOR ☒ **Yes** ☐ **No**

POSITION SUMMARY:

The Dental Director is expected to be a key staff position throughout the entire contract term. This position is responsible for the oversight of the administration of dental services within the contract.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience in serving as a dental manager or director for a Medicaid program;
2. Active license to practice dentistry in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Performs oversight of the utilization of covered dental services under this contract.
- Performs dental utilization review decisions and is authorized to respond to dental clinical issues, utilization review, and dental quality of care inquiries.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Dental Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> F </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> F </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> C </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> F </u>	Field of Vision	<u> F </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Director, Credentialing

DEPARTMENT Network/Provider

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO Director Provider Network
Operations

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

Responsible for Overseeing all aspects of the Credentialing Recredentialing of Practitioners, facilities and ancillary providers in accordance with NCQA, Assure compliance with CMS, WV Medicaid (BMS), Department of Insurance and other regulatory entities. Responsible for annual QI Reports. Responsible for preparation of materials submitted to the Credentials Committee Monthly Meetings for review of Practitioners/Providers with Variances. Preparations and Attendance of HEDIS, WV Medicaid (Delmarva) annual audits, and CMS. Responsible for pre-delegated and annual audits of all Credentialing delegated entities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Must be familiar with Managed Care, State and Federal health care programs and the insurance industry.
2. Knowledge of provider, customer service, and credentialing
3. Experience in medical claims processing (ICD9 /CPT/ HCPCs)
4. Excellent oral and written communication skills
5. BA in Administration or 10 years experience in Health Care

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Must be familiar with Managed Care, State and Federal health care programs and the insurance industry.
2. Knowledge of provider, customer service, and credentialing
3. Experience in medical claims processing (ICD9 /CPT/ HCPCs)
4. Excellent oral and written communication skills
5. BA in Administration or 10 years experience in Health Care
6. Credentialing Certification

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Oversee credentialing functions to assure compliance with NCQA, Medicare/Medicaid and State of Ohio and West Virginia guidelines
- Formulate and updates annually or as needed Credentialing/Recredentialing policies changes implemented by NCQA, State of WV, Medicare guidelines
- Preparation of case summaries to present to Credentialing Committee
- Approval of all monthly and quarterly reports
- Oversight and building of HEART screens for new contracted providers, which includes entering the payclasses

- Maintaining pertinent information for various service indicator and HEDIS reporting.
- Develop written policies for day to day workflow related to credentialing activities not included in Credentials Policies and Procedures
- Coordination of all internal audits by state and federal agencies presenting all Provider Credentialing information during interviewing process.
- Coordinating and editing the quarterly newsletter
- Responsible for updating the Credentialing Section of the Practitioner Procedural Manual
- Provides support to Network/Provider Services and Network Development Staff
- Responsible for all delegated entities and maintenance
- Annual Audits of all Delegated Entities
- Act as a liaison for Provider Network issues with various regulators and review organizations including Medicare, Medicaid, Department of Insurance, NCQA, HEDIS auditors. This includes providing required reporting, responding to inquiries and request and insure policies and procedures are established in compliance with updated guidelines.
- Responsible for ongoing scanning of Document System in the HEART System
- Serve as a Member of the Communications Committee, Medicare OPS Committee, and Credentials Committee..
- Other duties as assigned by the Vice President of Network/Provider Services
- Assist Provider Services with complex provider service issues

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 01/01/2015

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Director, Credentialing

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>F</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>O</u>
Hearing	<u>F</u>	Stooping	<u>O</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>O</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>O</u>	Near Distance	<u>O</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>R</u>	Field of Vision	<u>R</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☐ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☒ Mentoring ☐ Negotiating ☐ Persuading ☐ Serving ☐ Speaking-Signaling ☒ Supervising ☐ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☒ Operating-Controlling ☐ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Medicaid Director

DEPARTMENT Government Programs &
Operations

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO VP Operations

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Director of Medicaid is responsible for the management and administration of the Medicaid products administered by THP. The Director will assist with staff education, communication, problems and procedures and will work closely with the AVP Medicaid to assure all contractual changes and updates impacting Operations are implemented. The Director will manage daily operations of multiple levels of staff and multiple functions including but not limited to:

- Accountable for all aspects of the day to day management of operations functions including but not limited to claims inventory and call center management within the Medicaid team;
 - Management of processes and procedures to assure quality and compliance standards are met or exceeded.
 - Owns process and outcomes of issues and in collaboration with internal business partners is accountable to drive research into determining root cause analysis of issues and to proactively address and communicate with management.
 - Provides leadership both internally and externally (clients, boards, prospects) to our organization;
 - Project management and implementation of various projects as identified;
 - Staff management
 - Works cooperatively with internal THP departments, including Finance, Customer Service, Operations, IT, Medical Management, Internal Audit, QI and Compliance to resolve issues and improve internal processes. Provides authority needed to carry out designated task and empowered to make and resolve operational, financial, and policy decisions regarding the Medicaid contract.
- QUALIFICATIONS REQUIRED:** (Education, Experience, Skills)
- Bachelors Degree or equivalent experience
 - Experience in healthcare insurance operations, public policy development or government relations
 - Leadership/Management experience
 - Experience with Medicaid, Duals, SNPs, DEMOs or other related government product
 - Strong analytical skills, including strong listening skills.

- Clear, concise verbal/written communication skills,
- Experience leading, formulating and delivering strategy, building strong connections with people and teams

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- Integrity--open, honest, ethical and conscientious
- Accountable with ability to deliver on commitments and take ownership for solving problems and creating solutions
- Strong leadership skills
- Desire for continuous improvement and innovation with the ability to embrace change and drive new ideas into business solutions
- The strong desire to achieve high performance in aspects of the job

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Serves as interface with various departments and staff within the organization in order to coordinate delivery of Medicaid requirements
- Responsible for understanding contractual requirements of the Medicaid product as they pertain to the Operations functions within the team.
- Positive leadership of all teams within the scope of responsibility of this position
- Monitors random claims audit results and error reports to improve accuracy of claims, customer service, and other operations functions.
- Reviews high dollar claims and communicates with appropriate levels of management.
- Responsible for reviewing plan design compared to system set up to assure reimbursements are within the scope of contractual requirements for the Medicaid products.
- Ensure that system changes and development are designed, implemented and delivered the stated objective
- Identify and resolve issues related to the Medicaid product suite.
- Coordinate employee training initiatives ensuring an understanding of Medicaid operational needs
- Identifying product enhancement and improvement opportunities
- Monitor formal and informal appeals and grievances
- Organize and provider training and educational materials for Health Plan Operations staff

NON-ESSENTIAL FUNCTIONS:

-
- Perform other related duties as assigned.

Approval/Revision Date: 07/01/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: MEDICAID DIRECTOR

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** — Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	_____	Lifting	_____
Carrying	_____	Pushing	_____
Climbing	_____	Reaching	_____
Crawling	_____	Sitting	F
Crouching	_____	Standing	_____
Hearing	F	Stooping	_____
Key Board Function	O	Talking	F
Kneeling	_____	Walking	_____

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	_____	Near Distance	_____

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	_____	Field of Vision	_____

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing	☒ Diverting	☒ Handling
☒ Comparing	☒ Instructing	☒ Manipulating
☒ Compiling	☒ Mentoring	☒ Operating-Controlling
☒ Computing	☒ Negotiating	☒ Precision Working
☒ Coordinating	☒ Persuading	☒ Setting Up
☒ Synthesizing	☒ Serving	☒ Tending
	☒ Speaking-Signaling	
	☒ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Director Contracting

DEPARTMENT Provider Delivery Systems

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO SVP Provider Delivery Systems

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

Performs duties to coordinate and negotiate hospital, physician and ancillary service agreements that are in accordance with Corporate Health Plan, State, and Federal guidelines in order to maintain and enhance the provider network and to meet/exceed The Health Plan's accessibility, quality and financial goals. Maintain close relationships with Hospitals and key provider groups.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Four (4) year college degree in healthcare administration, business administration, marketing or related field and five (5) years managed care industry experience.
2. Knowledge of contracting/sales, provider customer service, standard credentialing procedures and/or marketing.
3. Knowledge of contracting language, the principles of negotiation and the ability to understand different types of reimbursement models.
4. Experience in healthcare or insurance environment.
5. Must be able to apply corporate policies and procedures to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists.
6. Interpret a variety of instructions in written, oral or diagrammatic form.
7. Ability to negotiate effectively.
8. Ability to use programs including Word, Excel and Outlook.
9. Superior written and oral communication skills.
10. Ability to interpret and compose spreadsheets, reports and presentations.
11. Strong analytical, problem solving and project management skills.
12. Must be able to meet deadlines and work under pressure with little to no direct supervision.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Knowledge of healthcare finance principals
2. Knowledge of healthcare quality initiatives;
3. Knowledge of performance based contracting;
4. Existing WV OR Ohio healthcare relationships

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Establish and maintain trusted relationships with physician, hospital and ancillary network participants.
- Coordinate network development and management with market based strategic and operational leadership.
- Develop market specific network participation and design criteria to ensure access to meet

- product needs, strategic alignment with The Health Plan's business goals and objectives.
- Evaluate and monitor providers' performance standards and financial performance of contracts.
- Willingness to participate in local care management programs and inclusion of high quality, cost effective providers.
- Develop and maintain all provider relations policies and procedures internal to The Health Plan and specific to client needs.
- Oversee communication for network providers and acts as a liaison for high volume key providers.
-

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 06/01/2019

Review Date: 06/14/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Director of Contracting

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>O</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☐ Analyzing ☒ Comparing ☒ Compiling ☐ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☐ Serving ☐ Speaking-Signaling ☐ Supervising ☐ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☐ Operating-Controlling ☐ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Director, Provider Engagement

DEPARTMENT Provider/Network Services

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO Senior VP Administrative Service

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Director of Provider Engagement oversees and directs provider education, training, and guidance for the entire THP provider network. In addition to provider network education, the Director of Provider Engagement develops and ensures continued close community relationships and partners with community organizations to promote THP services within the communities we serve. The Director will lead and manage the development of THP's overall provider relationships within the network.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Bachelor's degree or 7 plus years of experience in managed care/health industry
2. Prior demonstrated ability to effectively lead and manage complex projects
3. Strong analytical skills
4. Claims processing and provider contracting knowledge/experience
5. Experience with HEDIS®, Star Ratings and NCQA
6. Computer experience with Microsoft Word, Excel, Power Point and Outlook
7. Knowledge of ICD and CPT coding
8. Superior knowledge of government programs

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Graduate degree strongly preferred
2. Knowledge of The Health Plan's internal policies, procedures, and systems
3. Excellent communication skills, both oral and written
4. Proven ability to build strong lasting relationships with both internal partners and external providers and community partners
5. Organizational skills and the ability to handle multiple tasks and/or projects at one time
6. Time management skills with the ability to prioritize and schedule daily activities for the most efficient use of time
7. Must have a track record of producing work that is highly accurate, demonstrates attention to detail, and reflects well on the organization

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Develops, coordinates and drives strategic direction and acts as primary point of contact for key provider engagements across all lines of business
- Leads provider engagement team in an effort to achieve desired provider engagement outcomes, to include membership growth and meeting/exceeding cost, quality, and consumer experience targets
- Collaborates with internal departments to carry appropriate messaging to community and

- provider partners
- Works with key leaders within the provider organization to engage with and drive successful performance of the provider engagement
- Drive performance within the provider network
- Evaluate and assess provider network to determine gaps and service needs
- Develop and manage execution of community outreach activities directed to current and future members
- Works closely with the contracting team to identify targeted providers and contract specifications necessary to support new growth

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 06/01/2019

Review Date: 06/14/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

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I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Director, Provider Engagement

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> O </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> O </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> F </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> F </u>	Near Distance	<u> F </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> F </u>	Field of Vision	<u> F </u>

Other	Intensity	Other	Intensity
_____	<u> </u>	_____	<u> </u>
_____	<u> </u>	_____	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing	☒ Diverting	☒ Handling
☒ Comparing	☒ Instructing	☐ Manipulating
☒ Compiling	☒ Mentoring	☐ Operating-Controlling
☒ Computing	☒ Negotiating	☐ Precision Working
☒ Coordinating	☒ Persuading	☐ Setting Up
☐ Synthesizing	☒ Serving	☐ Tending
	☒ Speaking-Signaling	
	☒ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

**JOB TITLE** Information Technology DirectorDEPARTMENT IT FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO SVP Information Technology **SUPERVISOR** ☒ Yes ☐ No

POSITION SUMMARY:

The Information Technology Director is expected to be a key staff position throughout the entire contract term. This position is responsible for all systems, data, and hardware activities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience working in Medicaid IT solutions, with an emphasis in data integrity;
2. At least a bachelor's degree or higher;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Submits required reports, requests for information, documentation, ad hoc reports, data certification forms, or any other data required as requested by the Department within the time frames provided by the contract.
- Maintains reasonable safeguards against the destruction, loss, or alteration of any data in the possession of the Vendor.
- Manages systems configuration, testing and implementation activities.
- Maintains a health information system that collects, integrates, analyzes, and reports necessary data for reporting purposes.
- Oversees all systems related activities, including the Vendor's Electronic Medical Record (EMR), claims processing system, provider data system, etc.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

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description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Information Technology Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Medicaid Claims Manager

DEPARTMENT Medicaid

FLSA STATUS ☒Exempt ☐Non-Exempt

REPORTS TO Medicaid Director

SUPERVISOR ☒Yes ☐No

POSITION SUMMARY:

The Medicaid Manager is responsible for monitoring, educating, training and managing the Medicaid claims unit. The Medicaid Manager will also assist other units and the operations directors with claims payment concerns, special projects, staff education, communication issues and procedures.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Bachelor's Degree or equivalent claims management experience
2. Must be able to work on several projects concurrently
3. Must have excellent organizational skills, initiation, motivation and ability to interact well with others
4. Must be proficient in personal computer software applications such as Word and Excel
5. Must have strong oral and written communication skills
6. Must have cultural sensitivity
7. Must have leadership qualities
8. Must be willing to learn any new software programs to assist with daily tasks

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Proven ability to manage projects and produce deliverables with established timeframes
2. Previous claims processing experience
3. Previous supervisory experience in Government programs
4. Ability to work independently
5. Knowledge of medical terminology, CPT/ICD10 Coding, Medical, dental, vision, and pharmacy claim types.
6. Knowledge of Medicaid and or CHIP claims processing, pricing methodologies, eligibility requirements, and contractual requirements a plus

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Manage and monitor claims analysts to meet Medicaid or State guidelines and regulations
- Coach, counsel, discipline, mentor and train unit staff as needed so to promote expertise of processes, knowledge of plan benefits and Medicaid or State regulations and to maintain positive morale within the unit and team.
- Prepare monthly and quarterly reports as needed
- Create and review policies and procedures as needed
- Coordinate internal training for staff as needed
- Participate and coordinate external and internal claim audits as needed
- Monitor day to day operations to ensure compliance with Medicaid and State regulations

- Attend appropriate training and meetings as required
- Review and coordinate time off for the unit staff
- Participate on the Claims Compliance Committee and other committees as requested
- Complete employee evaluations
- Initiate, Review and monitor employee computer and system capabilities
- Consistently display a positive attitude and acceptable attendance
- Complete company training as required
-

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date:

Review Date: 01/18/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Medicaid Claims Manager

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	R	Lifting	O
Carrying	R	Pushing	R
Climbing	R	Reaching	O
Crawling	R	Sitting	C
Crouching	O	Standing	F
Hearing	C	Stooping	O
Key Board Function	C	Talking	C
Kneeling	R	Walking	O

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	O	Near Distance	C

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	O	Field of Vision	R

Other	Intensity	Other	Intensity

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☒ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☒ Speaking-Signaling ☒ Supervising ☒ Taking Instructions/Helping	☒ Handling ☒ Manipulating ☐ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Manager, Medicaid Customer Service Representative

DEPARTMENT Operations- Medicaid

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO Director of Medicaid

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Medicaid Manager is responsible for monitoring, educating, training and managing the Medicaid CSR unit. The Manager will also help coordinate and assist other departments with special projects; and work with other Operations Managers with staff education, communication, issues and procedures.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Bachelor's Degree or equivalent 5 years Government program experience
2. Must be able to work on several projects concurrently
3. Must have excellent organizational skills, initiation, motivation and the ability to interact will with others
4. Must be proficient in personal computer software applications such as Word and Excel spreadsheets
5. Must have strong oral and written communication skills
6. Must have cultural sensitivity
7. Must have leadership qualities
8. Own transportation is required
9. Must be willing to learn any new software programs to assist with daily tasks

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Proven ability to manage projects and produce deliverables within established timeframes
2. Previous call center supervisory experience
3. Previous claims processing experience
4. Previous Medicaid experience
5. Ability to work independently

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Monitor day to day calls and educate staff immediately as needed
- CSR education to help improve customer experience with The Health Plan
- Oversee and assist with compliance of call answer timeliness, abandonment rates etc.
- Complete performance reviews for staff
- New employee training
- Assist staff with escalated member/provider complaint calls
- Consistently displays a positive attitude and has acceptable attendance
- Other functions as assigned by the Operations Director

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 4/2019

Review Date: 05/01/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

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I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Manager, Medicaid Customer Service

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

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F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> R </u>	Pushing	<u> R </u>
Climbing	<u> R </u>	Reaching	<u> O </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> O </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> O </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> O </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> O </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> O </u>	Field of Vision	<u> R </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☒ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☒ Speaking-Signaling ☒ Supervising ☒ Taking Instructions/Helping	☒ Handling ☒ Manipulating ☐ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Behavioral Health Services, Clinical Manager

DEPARTMENT Behavioral Health Services,
Clinical Manager **FLSA STATUS** ☒ Exempt ☐ Non-Exempt

REPORTS TO Director, Medical and Behavioral
Health **SUPERVISOR** ☒ Yes ☐ No

POSITION SUMMARY:

The Behavioral Health Clinical Manager is responsible for overseeing day-to-day operations of the clinical staff of the Behavioral Health Department. Responsible for assuring proper staffing levels and work assignments, performance evaluation of staff, serving as an expert resource on laws, policies and operational procedures, and ensuring that Behavioral Health clinical operations are consistent with The Health Plan operational standards.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Registered nurse with at least five (5) years experience. Two (2) of those years may be work experience as a nurse's aide, LPN, or behavioral health technician. Must have experience in the Behavioral Health field.
2. Active Ohio and West Virginia licensure which must be maintained throughout employment, including compliance with State Boards continuing education policy. Other licensure required as company expansion warrants.
3. Experience with care coordination, discharge planning, clinical documentation, and utilization review.
4. Experience with care navigation workflow system such as Case Tracker.
5. Knowledge of InterQual criteria and patient status changes.
6. Strong communication and leadership skills.
7. Knowledge of accreditation standards, federal and state standards/regulations.
8. Considerable knowledge of Behavioral Health policies and procedures.
9. Ability to analyze data and employ approved management techniques and statistical tools to obtain maximum effectiveness, efficiency and information.
10. Ability to interpret established policies into operating procedures and to execute complex case navigation programs.
11. Ability to coordinate effectively various functions and activities for maximum cooperation and efficiency.
12. Ability to direct, instruct and advise staff in the approved methods, procedures and practices employed in effective complex case navigation administration.
13. Ability to receive and effectively react to day-to-day problems presented by staff as well as others.
14. Effective organizational, oral and written communications skills, problem solving, program development, computer skills, strong leadership and team building skills.
15. Ability to work with a variety of disciplines and levels of staff across departments.

16. Ability to establish priorities, meet deadlines, develop and manage the department's productivity in the management of work assignments.
17. Ability to form positive, collaborative relationships with members of the management team.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Board Certified in Psychiatric Nursing, Case Management or Managed Care
2. Managed care experience
3. Utilization Management, Quality Improvement or Disease Management experience
4. Active licensure in additional states

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Provide management direction to the behavioral health nurse care/complex case navigators and member advocates.
- Orient new staff to department policies and procedures and system functions.
- Identifies appropriate staffing levels and assignments. Monitor performance criteria for staff members.
- Orient new staff and provide necessary training.
- Assists Director in implementation of Strategic Plan and related reporting.
- Reviews operations of care/complex case navigation to ensure a high level of quality is consistent with The Health Plan's standards.
- Review care/complex case navigation performance in relation to established goals. Implements changes to effect continual improvement in services provided by performance of routine interrater monitoring on nurse navigators and member advocates.
- Reviews BH utilization management functions including preauthorization/referral and inpatient navigation functions to effect continual improvement in services provided by performance of routine interrater monitoring on nurse navigators.
- Interprets laws, policies, procedures and objectives; ensures compliance with requirements.
- Shares with Director the responsibility of collecting, analyzing, evaluating and presenting clinical management and operational data to various audiences.
- Assists the Director in development, implementation and evaluation of yearly work plan.
- Participates on assigned committees.
- Directly responsible for performance evaluations of nurse care/complex case navigators.
- Collaborates with Director to develop mechanisms for staff development and make changes to keep current with new regulations, policies and trends in the complex case navigation field.
- Maintains skills to allow for coverage of a caseload as needed and/or staff shortage;
- Identifies and reports potential high cost cases to the complex case navigators and to the reinsurance carrier by use of hospital review, referral requests or claims cost report.
- Conduct clinical audits and provide necessary feedback.
- Prepares appropriate reports for CQI.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 04/15/19

Review Date: 04/15/19

General sign-off: The employee is expected to adhere to all company policies while employed.

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I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: BEHAVIORAL HEALTH SERVICES CLINICAL MANAGER

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> O </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> O </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> O </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> O </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> R </u>	Field of Vision	<u> R </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☒ Mentoring ☒ Negotiating ☒ Persuading ☐ Serving ☒ Speaking-Signaling ☒ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☐ Operating-Controlling ☒ Precision Working ☒ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Medicaid Appeal Coordinator

DEPARTMENT Medicaid Operations

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Medicaid Manager

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Appeals Coordinator is responsible for gathering all pertinent information necessary for investigating, logging, forwarding in a timely manner to the correct department for review, and tracking the appeal

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School Diploma; college preferred
2. Strong grammatical and letter writing skills
3. Strong communication skills
4. Proficient in Microsoft Office products
5. Detail oriented
6. Ability to prioritize and meet required deadlines

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. CPT and ICD-10 coding
2. Medical Terminology

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Strong ability to multitask
- Strong communication skills
- Strong organizational skills
- Gather and present all information related to the appeal in a clear, concise and timely manner
- Track all appeals and grievances to ensure The Health Plan is meeting state requirements
- Act as a liaison between the member/provider and The Health Plan
- Review appeals and complaints weekly to make sure they are handled appropriately and resolved in a timely manner
- Produce reports requested by management, internal committees and external agencies for audit purposes
- Maintains policies and procedures related to informal appeals and grievances,

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 5/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Appeal/Grievance Coordinator - Operations

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> O </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> O </u>
Hearing	<u> C </u>	Stooping	<u> O </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> O </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> O </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> R </u>	Field of Vision	<u> R </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing	☒ Diverting	☒ Handling
☒ Comparing	☒ Instructing	☐ Manipulating
☒ Compiling	☐ Mentoring	☐ Operating-Controlling
☒ Computing	☐ Negotiating	☒ Precision Working
☒ Coordinating	☒ Persuading	☐ Setting Up
☒ Synthesizing	☒ Serving	☐ Tending
	☒ Speaking-Signaling	
	☐ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Medicaid Coordinator

DEPARTMENT Government Program

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Asst. VP Medicaid

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Under the direct supervision of the AVP of Medicaid, the Medicaid Coordinator will be responsible for operation task within the Medicaid Team and assist the AVP in monitoring and delivering contractual requirements.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School Diploma
2. Prior work experience preferably in a health care setting or insurance field
3. Must possess strong skills in grammar, spelling and communication
4. Must have excellent organizational skills, initiative, motivation and the ability to interact well with others
5. Must be proficient in Microsoft products such as Word, Excel and PowerPoint

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Bachelor Degree
2. Previous experience with a fiscal agent or MCO

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Responsible for special projects within the Medicaid Team
- Assist management in ensuring monthly and quarterly MHT reports are submitted accurately and on time to the state. This would include working with internal team and external subcontractors on delivery of reports.
- Responsible for notification to BMS on a monthly basis for member exemptions, such as transplants, member moves out of state and incarcerations.
- Work with various teams in ensuring yearly contract checklist are completed accurately and on time.
- Assist in the creation of the yearly member handbook
- Assist in maintaining subcontractor monitoring plan and updating monthly binders
- Monitor monthly reports submitted by subcontractors and identify trends or issues
- Work with finance department in resolving outstanding cap and kick payment issues
- Develop departmental policies and procedure

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 5/2/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Medicaid Coordinator

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>R</u>
Carrying	<u>R</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>R</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>C</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>C</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>O</u>	Field of Vision	<u>O</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☐ Persuading ☐ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☒ Manipulating ☒ Operating-Controlling ☐ Precision Working ☒ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Medicaid Enrollment Service Representative

DEPARTMENT Medicaid Unit

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Medicaid Unit Manager

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Medicaid Enrollment Service Representative is responsible for timely processing of enrollments using BMS guidelines and policies. They are also responsible for timely completion of all correspondence and enrollment reporting functions associated with the Medicaid unit and have knowledge of how the unit functions affect other plan units and departments. The Medicaid Enrollment Representative will serve as a backup to customer service by answering phone calls in a prompt and courteous manner (to achieve abandonment standards) and answering member and provider questions with a quick and accurate response.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School Diploma
2. Typing & computer skills
3. Self starter, detail oriented, ability to prioritize and meet deadlines
4. Maintain confidentiality
5. Good communication skills
6. Easily adapts to changes in work requirement

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Familiar with Medicaid Enrollment/Disenrollment process
2. CPT and ICD-9 and ICD-10 coding
3. Medical and hospital claims knowledge
4. Prescription coding (NDC)
5. Medical terminology
6. Familiar with BMS Regulations and Guidelines

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Complete a variety of Enrollment functions
- Knowledge of how the Enrollment functions affect other units and departments
- Complete a variety of reports in accordance with BMS requirements and guidelines

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 5/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Medicare Enrollment Rep

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>R</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>R</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>O</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>C</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>O</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>O</u>	Field of Vision	<u>O</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☒ Synthesizing	☐ Diverting ☐ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☐ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☐ Operating-Controlling ☐ Precision Working ☒ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Medicaid Member Advocate

DEPARTMENT Medicaid

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO AVP Medicaid

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience in health care, working with low income and foster care populations, and cultural sensitivity;
2. Bachelor's degree or higher;
3. Based in West Virginia;

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Collaborates with the Care Management Director, care coordinators, and the SNS Liaison.
- Provides member support related to enrollment, access, and continuity of care issues.
- Supports members throughout any grievances or appeals activities.
- Assists members in obtaining materials in alternative formats, as applicable.
- Supports and addresses needs of children and youth in foster care.
- Interacts with members in a culturally sensitive manner.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Medicaid Member Advocate

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Medical Director

DEPARTMENT Medical

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO SVP Clinical Services

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Medical Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of medical and care coordination activities of the project.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience in serving as Medical Director for a Medicaid program and five (5) years' experience working in pediatric care;
2. An active West Virginia Medical License;
3. Professional liability insurance in the amount of at least one million dollars (\$1,000,000);
4. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers.
- Responds to requests of the Department's Medical Director or Contract Administrator within three (3) business days.
- Performs utilization management activities in collaboration with the Medical Management Director and Behavioral Health Medical Director.
- Oversees or participates in the Quality Assurance and Performance Improvement (QAPI) Committee.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

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I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Medical Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Medical Management Director

DEPARTMENT

FLSA STATUS ☐ Exempt ☐ Non-Exempt

REPORTS TO

SUPERVISOR ☐ Yes ☐ No

POSITION SUMMARY:

The Medical Management Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of utilization management activities of the project.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience working as a utilization management manager or specialist for a Medicaid program;
2. Registered Nurse (RN) or Licensed Clinical Social Worker (LCSW) in West Virginia;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Is responsible for the operations of the utilization management program, including oversight and management of processing referrals and pre-authorization requirements, as well as familiarity with appeal procedures.
- Responds to requests of the Department's Medical Director or Contract Administrator within three (3) business days.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Medical Management Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Member Advocate 1 – Clinical Services

DEPARTMENT Clinical Service, Medical or
Behavioral

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Manager or Supervisor, Clinical
Service Medical or Behavioral as
appropriate

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Under the general direction of the Unit Manager or Unit Supervisor, the Member Advocate is responsible for completing outreach activities for member engagement into the program. The Member Advocate is responsible for coordinating administrative functions within the program which may include but not limited to: administering Health Risk Assessments, scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. • High School Diploma required.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Post high school course work in business, social service, health care, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred.
2. Should possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently.
3. Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Takes incoming calls on a direct or ACD line as per unit and job function
- Performs outbound outreach calls to members and HRA calls, educates members within scope of practice, refers to needed health services internally and externally and facilitates access to or arranges community resources as appropriate
- Has established adequate proficiency in using THP applications necessary to perform the functions of an Member Advocate, i.e. various programs & assessments in HEART and Case Tracker
- Maintains monthly monitoring scores of 82% accuracy or above on unit MA interrater
- Demonstrates a complete understanding of departmental policies and procedures
- Able to perform assigned tasks with minimal supervision
- Maintains an annual performance evaluation of meets requirements
- Works with Navigators and Social Workers to coordinate care and service for members, may obtain consultations, reports or diagnostics from providers; files and notifies requesting staff
- Facilitates or arranges transportation services or personal care services

- Works towards meeting monthly productivity standards
- Consistently displays a positive attitude and acceptable attendance
- Increasing improvement in performance and job knowledge
- Work during core hours and on site

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 04/15/19

Review Date: 04/15/19

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE:

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> R </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> O </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> O </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> O </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> R </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> R </u>	Field of Vision	<u> R </u>

Other	Intensity	Other	Intensity
_____	<u> </u>	_____	<u> </u>
_____	<u> </u>	_____	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☐ Analyzing ☐ Comparing ☒ Compiling ☐ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☐ Operating-Controlling ☒ Precision Working ☒ Setting Up ☐ Tending

Employee Initials _____



JOB DESCRIPTION

JOB TITLE Member Advocate 2 – Clinical Services

DEPARTMENT Clinical Service, Medical or
Behavioral

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Manager or Supervisor, Clinical
Service Medical or Behavioral as
appropriate

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Under the general direction of the Unit Manager or Unit Supervisor, the Member Advocate 2 is an experienced level and is responsible for completing outreach activities for member engagement into the program as well as performing additional program, unit and interdepartmental support functions. The Member Advocate is responsible for coordinating administrative functions within the program which may include but not limited to: administering Health Risk Assessments, scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School Diploma required.
2. Managed Care Experience and demonstrates meets all Member Advocate Level 1 qualifications, functions and responsibilities

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Post high school course work in business, social service, health care, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred.
2. Should possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently.
3. Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Takes incoming calls on a direct or ACD line as per unit and job function
- Performs outbound outreach calls to members and HRA calls, educates members within scope of practice, refers to needed health services internally and externally and facilitates access to or arranges community resources as appropriate
- Has established adequate proficiency in using THP applications necessary to perform the functions of an Member Advocate, i.e. various programs & assessments in HEART and Case Tracker
- Maintains monthly monitoring scores of 85-90% accuracy or above on unit MA interrater
- Demonstrates a complete understanding of departmental policies and procedures
- Able to perform assigned tasks with little or no supervision
- Maintains an annual performance evaluation of exceeds requirements

- Works with Navigators and Social Workers to coordinate care and service for members, may obtain consultations, reports or diagnostics from providers; files and notifies requesting staff
- Facilitates or arranges transportation services or personal care services
- Works towards meeting monthly productivity standards
- Consistently displays a exemplary attitude and attendance
- Able to diffuse tense situations/angry members and resolve issues
- Displays high level understanding of job functions and navigates with interrelated departments within The Health Plan
- Ability to take incoming calls from member and provider services line to address calls related to claims, eligibility and benefits
- Will often take on additional tasks and complete them in a timely manner, volunteers for community activities
- Represent THP in offsite Medicaid functions such as baby showers, health fairs, school visits, conferences, etc.
- Meet or exceed monthly production standards
-

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 04/15/19

Review Date: 04/15/19

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE:

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	R	Lifting	R
Carrying	O	Pushing	O
Climbing	R	Reaching	O
Crawling	R	Sitting	C
Crouching	R	Standing	O
Hearing	C	Stooping	R
Key Board Function	C	Talking	C
Kneeling	R	Walking	O

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	R	Near Distance	C

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	R	Field of Vision	R

Other	Intensity	Other	Intensity
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☐ Analyzing	☐ Diverting	☐ Handling
☐ Comparing	☒ Instructing	☐ Manipulating
☒ Compiling	☐ Mentoring	☐ Operating-Controlling
☐ Computing	☐ Negotiating	☒ Precision Working
☒ Coordinating	☐ Persuading	☒ Setting Up
☐ Synthesizing	☒ Serving	☐ Tending
	☒ Speaking-Signaling	
	☐ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Member Advocate 3 – Clinical Services

DEPARTMENT Clinical Service, Medical or
Behavioral

FLSA STATUS ☐ Exempt ☒ Non-Exempt

REPORTS TO Manager or Supervisor, Clinical
Service Medical or Behavioral as
appropriate

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Under the general direction of the Unit Manager or Unit Supervisor, the Member Advocate 3 is an advanced level and is responsible for completing outreach activities for member engagement into the program as well as performing additional program, unit and interdepartmental support functions. This employee may function as a lead or senior worker or special accounts person. The Member Advocate is responsible for coordinating administrative functions within the program which may include but not limited to: administering Health Risk Assessments, scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. High School Diploma required.
2. Managed Care Experience and demonstrates meets all Member Advocate Level 2 qualifications, functions and responsibilities

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Post high school course work in business, social service, health care, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred.
2. LPN is desirable.
3. Should possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently.
4. Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Takes incoming calls on a direct or ACD line as per unit and job function
- Performs outbound outreach calls to members and HRA calls, educates members within scope of practice, refers to needed health services internally and externally and facilitates access to or arranges community resources as appropriate
- Has established adequate proficiency in using THP applications necessary to perform the functions of an Member Advocate, i.e. various programs & assessments in HEART and Case Tracker
- Maintains monthly monitoring scores of >95% accuracy on unit MA interrater
- Demonstrates a complete understanding of departmental policies and procedures

- Acts as a resource to others within their unit
- Assists in training new employees
- Maintains an annual performance evaluation of exceeds requirements
- Works with Navigators and Social Workers to coordinate care and service for members, may obtain consultations, reports or diagnostics from providers; files and notifies requesting staff
- Facilitates or arranges transportation services or personal care services
- Consistently displays a exemplary attitude and remarkable attendance
- Able to diffuse tense situations/angry members and resolve issues
- Displays high level understanding of job functions and navigates with interrelated departments within The Health Plan
- Displays a high level understanding of contracts and benefits for programs and lines of business and teaches peers to take incoming calls from member and provider services line to address calls related to claims, eligibility and benefits
- Will often take on additional tasks and complete them in a timely manner, volunteers for community activities, understands compliance and may assist with reporting/fact gathering
- Displays a good understanding of claims process and can readily identify processing errors and direct for correction
- Displays good time management and multitasking skills
- Shows desire to advance employment status and pursues additional educations and/or licensure
- Exceeds monthly average production standards
- May be eligible for work from home
-

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 04/15/19

Review Date: 04/15/19

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE:

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>R</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>O</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>O</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>O</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>R</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>R</u>	Field of Vision	<u>R</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☐ Analyzing ☐ Comparing ☒ Compiling ☐ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☐ Negotiating ☐ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☐ Operating-Controlling ☒ Precision Working ☒ Setting Up ☐ Tending

Employee Initials _____



JOB DESCRIPTION

JOB TITLE Member Services Director

DEPARTMENT Operations

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO VP Operations

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Member Services Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of activities related to call center operations, grievances, and other member related inquiries and matters.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience working with the public in an educational capacity on health insurance-related matters;
2. Experience working in or overseeing a call center;
3. Bachelor's degree or higher;
4. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Oversees the Member Services Department to assist members in obtaining covered services.
- Interfaces with members, CPS workers, foster care parents, and providers to handle questions and complaints.
- Ensures that the member services phone line meets the minimum performance requirements.
- Oversees the enrollment and onboarding activities of members.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Member Services Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Network Development Director

DEPARTMENT Network

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO SVP Network Services

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Network Development Director is expected to be a key staff position throughout the entire contract term. This position is responsible for network development and contracting activities for physical and behavioral health services.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience serving as a network manager in a health insurance role;
2. Bachelor's degree or higher.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Establishes and maintains the provider network in geographically accessible locations for the population.
- Ensures sufficient provider contracts for physical and behavioral health services to maintain access to care in accordance with the Department's Medicaid managed care network standards.
- Develops and submits written documentation of the adequacy of the MCO's provider network as per contractual requirements.
- Facilitates physical health and behavioral health provider contracting activities, including creative payment arrangements and APMs.
- Oversees physical health and behavioral health provider contracting documents and addenda.
- Supports the oversight of physical health and behavioral health provider credentialing activities.
- Reports to the Department on access to care and network development needs for SNS providers.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job

description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Network Development Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Nurse Navigator

Clinical Services
Medical Unit

DEPARTMENT Behavioral Health Unit

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO Manager

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

Responsible to conduct systematic admission, concurrent and retrospective hospital reviews for severity of illness and length of stay, implements discharge planning, and to maintain system census with required data and pertinent clinical information with intervention and follow-up.

and/or

Coordinates and integrates through review, all services that require pre-authorization including all new technology that requires review by the T&T Committee

and/or

Responsible for the navigation and advocacy of identified members. These members require coordinated care and integration. This may include navigation beyond the specific case or situation, providing the member with a wide spectrum of services directed at not only medical or behavioral changes but healthy lifestyles and optimal outcomes assuring quality and continuity within the managed care system

and/or

Responsible for those identified members normally on a short term, episodic or situational basis, or those members with a life altering illness or injury.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Level 1: 5-9 Year RN Clinical Experience (AD or Diploma, 2 may be as LPN, CNA or Clinically related field all else must be RN), Ohio and WV license upon hire, all others within 1 year as necessitated by LOB
2. Level 2: BSN (or other 4 year BA/BS degree combined with RN) with 5+ Year Clinical Experience (2 of them may be as LPN, AD, OR Diploma RN, OR 10-14 Year RN Clinical Experience (AD, Diploma) OR 3+ Year Managed Care RN Experience (in addition to total RN clinical experience of at least 5 years, may be THP or outside) AND Ohio and WV license upon hire, all others within 1 year as necessitated by LOB

3. Level 3: BSN (or other 4 year degree BA/BS combined with RN) with 10+ Year Clinical Experience OR RN with 15+Year Clinical RN Experience OR Advance Practice Nurse (MSN, FNP, PNP, CNM, PHD) with minimum 5 year RN Clinical AND Managed Care Experience AND Certification in area of clinical expertise related to current work (CDE, CCM, CMCN, Gerontology, Mental Health, Oncology, etc) with proof of maintenance AND Ohio and WV License upon hire, all others within 1 year as necessitated by LOB AND Maintains satisfactory evaluation and interrater meets benchmarks
4. Level 4: BSN (or other 4 year degree BA/BS combined with RN) with 10+ Year Clinical Experience OR RN with 15+ Year Clinical Experience OR Advance Practice Nurse (MSN, FNP, PNP, CNM, PHD) with 5+ year RN Clinical Experience AND Managed Care Experience (of 2+ years at The Health Plan) and demonstrated expertise in a particular program, protocol, workflow or line of business supported by a letter of recommendation from your direct supervisor AND Certification in area of clinical expertise related to current work (CDE, CCM, CMCN, Gerontology, Mental Health, Oncology, etc) with proof of maintenance AND Satisfactory completion one year at level 3 with documentation of successful project/analysis AND Ohio and WV License upon hire, all others within 1 year as necessitated by LOB AND Satisfactory annual evaluation and interrater meets benchmarks AND Documented annual participation/attendance at community events, professional organizations, health fairs, community action committees at 8 hours per year (events preapproved) AND Intention to apply: Written Summary of Preapproved Clinical Service/THP Improvement Project(self-proposed or as requested by Supv/Clinical Manager-See attached) monthly/quarterly updates as appropriate and annual documentation of clinical support projects with analysis at annual performance evaluation AND Participate in mentoring and staff training as assigned and submit log of hours demonstrating staff training/mentoring annually.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Any Registered Nurse with a combination of academic education, professional training or work experience which demonstrates the ability to perform the duties of the position would be considered. Utilization Management, Quality Improvement, Case Management, Disease Management or other Managed Care experience would be helpful.
2. Should possess excellent oral, written, telephonic and interpersonal skills, balancing an independent and team working environment.
3. Should be flexible and able to multi-task, work in a fast-paced environment and adapt to changing processes.
4. Should possess a superior work ethic and a commitment to Excellence and Accountability.
5. Should possess ability to exercise independent and sound judgment in decision making, utilizing all relevant information with proactive identification and resolution of issues.
6. Should possess proficient keyboarding skills and computer literacy with the ability to navigate through multiple systems.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Conducts telephonic and/or on-site admission, concurrent or retrospective review of all inpatient admissions and observation stays.
- Enters data timely and updates principle/secondary diagnoses and procedures, medical histories, and consults.
- Investigates missed admissions obtaining pertinent details and refers to the Medical Director as appropriate with completion of documentation and follow up.
- Determines appropriateness of admission and continued stay using established clinical criteria.

- Refers admissions/continued stays with questionable medical necessity to the Medical Director with completion of documentation and follow-up.
- Coordinates care in collaboration with the member, family, health care team members, hospital utilization review, social workers, and other resources to intervene proactively to identify needed medical services, utilization and discharge issues, modifiable risk factors, educational needs and available resources to affect individual health care outcomes positively.
- Identifies members requiring discharge planning and facilitates interventions to coordinate care and services.
- Identifies members that may need chronic disease navigation, complex case navigation, social service intervention and refers appropriately.
- Acts as a liaison between member, provider and The Health Plan.
- Collaborates and shares knowledge and expertise with peers, supervisors and other staff.
- Serves as assigned on departmental or company committees and attends departmental or work-group meetings as scheduled.
- Promotes communication, both internally and externally, to enhance effectiveness of medical management services.
- Identifies opportunities for improvement in systems, processes, functions, programs, procedures and makes recommendations to the appropriate management staff.
- Prioritizes assignments appropriately and maintains flexibility as new priorities arise.
- Identifies potential quality issues, variances, hospital acquired conditions and never events and refers to QI Department.
- Identifies requests for new technology using available resources and refers to the New Technology and Transplant Committee Coordinator.
- Takes after-hours and weekend call on rotation as assigned.
- Strives to improve quality in all areas of responsibility and cooperates with all departments to improve quality through The Health Plan
- .Determines appropriateness of pre-authorizations using established clinical criteria and/or guidelines.
- Reviews and evaluates relevant information including member history, medical records, group contracts, benefit design, plan limitations, exclusions, coordination of benefits and member eligibility in making decisions and recommendations that are consistent with sound medical and managed care practice.
- Facilitates access to care, provides liaison services, advocates for, and educates members as needed.
- Educates providers when indicated.
- Promotes communication, both internally and externally, to enhance effectiveness of medical management services.
- Develops and implements personalized care plans and uses specific assessment tools and revises these accordingly.
- Reinforces appropriate self-care teaching and monitoring and provides up-to-date medical or behavioral health care information to help facilitate the members understanding of his/her options.
- Helps member actively and knowledgably participate with their provider in their own health care decision-making.
- Identifies and reports potential high cost cases to the reinsurance or stop loss carrier through hospital review, referral requests, care or complex case navigation or claims cost reports.
- Utilizes clinical skills to assess, plan, implement, coordinate, monitor and evaluate each individual case, including those members identified by, but not limited to, Pharmacy Reporting,

Depression Screening, Health Risk Assessments, Discharge Surveys, Readmission Reports and CCGroup Reporting.

- Provide telephonic guidance and support to members, physicians and other health care providers to facilitate the best options to meet an individual's health care needs.
- Contact and engage member participation in the appropriate chronic disease navigation program.
- Assess and stratify on the appropriate intervention level and assess and monitor member status through scheduled outbound calls and inbound calls.
- Utilize critical thinking skills to manage and evaluate member status and current treatment regime against The Health Plan's evidence-based approved guidelines.
- Complete contacts in a timely and effective manner according to protocols and make adjustments to frequency and types of contacts to meet program goals.
- Facilitate proactive interventions to include the application of appropriate therapies and systematic surveillance of appropriateness of medication, education and counseling about daily self management and symptom management.
- Perform screening and assessment of potential chronic disease navigation cases.
- Demonstrate a working knowledge and adherence to contractual guidelines of The Health Plan.
- Assist in the development, implementation, and coordination of new and ongoing chronic disease navigation programs and projects.
- Achieve optimal clinical and quality outcomes by effectively managing care and resources.
- Participate in quality improvement activities to achieve program outcomes.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 5/5/19

Review Date: 5/5/19

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: NURSE NAVIGATORR

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>R</u>
Carrying	<u>F</u>	Pushing	<u>R</u>
Climbing	<u>F</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>O</u>
Crouching	<u>R</u>	Standing	<u>O</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>R</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>R</u>	Field of Vision	<u>R</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☒ Diverting ☒ Instructing ☒ Mentoring ☒ Negotiating ☒ Persuading ☐ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☒ Operating-Controlling ☐ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Program Integrity Lead

DEPARTMENT Compliance

FLSA STATUS ☐ Exempt ☐ Non-Exempt

REPORTS TO VP of Compliance and Internal Audits

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

The Program Integrity Lead is expected to be a key staff position throughout the entire contract term. This position is responsible for all compliance, program integrity, and fraud related activities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience working on Medicaid fraud projects;
2. Bachelor's degree or higher;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Creates internal controls, policies, and procedures to prevent and detect fraud and abuse.
- Develops a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones.
- Establishes and maintains a Special Investigations Unit (SIU) to investigate possible acts of fraud, waste, or abuse for all services provided under the contract.
- Serves as the primary contact person for all Department Program Integrity and MFCU record requests.
- Monitors provider fraud for underutilization of services and member/provider fraud for overutilization of services.
- Establishes written policies and procedures for maintaining the confidentiality of data to protect members from unauthorized disclosures.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I

understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Program Integrity Lead

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	R	Lifting	O
Carrying	O	Pushing	O
Climbing	R	Reaching	F
Crawling	R	Sitting	C
Crouching	R	Standing	F
Hearing	C	Stooping	R
Key Board Function	C	Talking	C
Kneeling	R	Walking	F

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	C	Near Distance	C

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	F	Field of Vision	F

Other	Intensity	Other	Intensity

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Provider Engagement Representative - Level 1

DEPARTMENT Provider/Network Services **FLSA STATUS** ☒ **Exempt** ☐ **Non-Exempt**

REPORTS TO Regional Manager of Provider Engagement **SUPERVISOR** ☐ **Yes** ☒ **No**

POSITION SUMMARY:

Under the direction of the Regional Manager of Provider Engagement, the Provider Engagement Representative provides education, training and guidance for providers in the assigned provider network; responsible for performing on-site reviews of new and re-credentialed providers within their assigned territory; identify and educate providers requiring additional education (performed on-site, via conference call and/or via webinar)

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. College degree or 3-4 years' experience in a physician's office, payer agency, community agency or other health care environment
2. Valid driver's license
3. Previous customer service experience with exposure to claims and benefits interpretation and provider networking
4. Knowledge of medical coding
5. Knowledge of HEDIS® and Star Ratings
6. Computer experience with Microsoft Word, Excel, Power Point and Outlook

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Strong verbal and written communication skills with the ability to communicate (oral and written) effectively
2. Strong project management skills
3. Must be able to perform presentations for small and large audiences in person and remotely
4. Organizational skills with the ability to handle multiple tasks and/or projects at one time
5. Customer service skills with the ability to interact professionally and effectively with providers, and staff
6. Time management skills with the ability to prioritize and schedule daily activities for the most efficient use of time
7. Problem resolution skills
8. Ability to work under little supervision and act as a team member
9. Familiar with current managed care, State and/or Federal healthcare programs (Medicare, Medicaid) and the insurance industry
10. Experience in managed care, State and/or Federal health programs
11. Certified Medical Insurance Specialist

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Professional dress, appearance and speech
- Held accountable for servicing providers within their assigned territory
- Evaluate and monitor providers' performance standards and financial performance of contracts as requested to support THP goals
- Make regular visits to providers and act as primary resource for problem solving
- 75 - 95 % travel required. Some overnight may be necessary
- Ability to cover a large geographic area
- Outreach to contracted provider offices to educate as necessary on other participating providers (i.e., laboratory / hospitals)
- Knowledge of standard credentialing procedures
- Knowledge of provider contract language and various payment methods
- Assist Contracting Department with negotiating & renegotiating contracts and amendments
- Communicate changes and updates to providers
- Assist other departments with outreach to contracted provider offices as needed to schedule medical record audits
- Provide training and technical assistance to contracted providers
- Facilitate contracted provider meetings
- Familiar with all product lines, including education on billing services necessary to enhance company initiatives
- Routinely attend FRN meeting once a quarter; participate in community events as assigned

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 02/22/2018

Review Date: 05/31/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Provider Engagement Representative - Level 1

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>R</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>O</u>
Crawling	<u>R</u>	Sitting	<u>O</u>
Crouching	<u>R</u>	Standing	<u>O</u>
Hearing	<u>F</u>	Stooping	<u>O</u>
Key Board Function	<u>F</u>	Talking	<u>F</u>
Kneeling	<u>R</u>	Walking	<u>O</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>F</u>	Near Distance	<u>F</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☐ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☐ Operating-Controlling ☐ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Provider Relations Director

DEPARTMENT Network

FLSA STATUS ☒ **Exempt** ☐ **Non-Exempt**

REPORTS TO SVP Provider Network

SUPERVISOR ☒ **Yes** ☐ **No**

POSITION SUMMARY:

The Provider Relations Director is expected to be a key staff position throughout the entire contract term. This position is responsible for interfacing with the provider community and supports ongoing provider relationships.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience in serving as a provider relations manager or specialist in a health insurance role;
2. Bachelor's degree or higher;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Monitors and responds to provider inquiries, complaints, and communications.
- Develops training for contracted providers and their staff in relation to the requirements of this contract and the special needs of the population.
- Designs, develops, and implements an annual provider satisfaction survey.
- Ensures the development, distribution, and maintenance of a provider manual.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Provider Relations Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Quality Director

DEPARTMENT Compliance

FLSA STATUS ☒ **Exempt** ☐ **Non-Exempt**

REPORTS TO VP of Compliance and Internal
Audits

SUPERVISOR ☒ **Yes** ☐ **No**

POSITION SUMMARY:

The Quality Director is expected to be a key staff position throughout the entire contract term. This position is responsible for oversight of the quality assurance program and related activities.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least five (5) years' experience in overseeing a Medicaid quality program, either with an MCO, an ASO, a state Medicaid agency, or an external quality review organization;
2. Bachelor's degree or higher;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Develops, administers and oversees the QAPI program.
- Oversees and supports accreditation activities, such as NCQA.
- Oversees or participates in the QAPI Committee.
- Initiates and maintains quality improvement projects that focus on one or more quality indicators.
- Develops an approach to monitoring provider performance, in collaboration with Network and Provider Relations Staff.
- Engages in activities related to APMs as they relate to quality of care measures and performance indicators.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job

description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Quality Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Sr. VP Government Programs

DEPARTMENT Government Programs

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO President/CEO

SUPERVISOR ☒ Yes ☐ No

POSITION SUMMARY:

Directs, Manage and Coordinates all activities related to the development, implementation, contracting and coordination of various programs in the governmental areas including but not limited to Medicare and Medicaid.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Bachelor's degree in business, management or healthcare related field with Master's degree preferred.
2. Ten years experience in healthcare related field preferably in a managed care organization setting
3. Five years experience with Medicare and/or Medicaid programs
4. Writing and presentation skills.
5. Experience in government RFP production and delivery.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Experience dealing with state and federal policy makers and legislative process with emphasis on Medicare and Medicaid policy.
2. Ability to analyze financial and budgetary statistics and perform financial analysis relevant of the position.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Oversee all aspects of Medicare product development and implementation including contracting, marketing, sales, monitoring, reporting, bid preparation, and other aspects ensuring product delivery consistent with Medicare requirements.
- Oversee all aspects of Medicaid product development and implementation including contracting, marketing, monitoring, reporting and overall contract performance consistent with regulatory requirements.
- Provide leadership and direction to Government Program staff including focus on staff development and growth within the organization.
- Develop strategies to enhance and expand the companies government related revenue sources through growth and expansion of current product lines and development of new product lines and capabilities.
- Serve as a liaison between the organization and the regulatory bodies who oversee the various aspects of Government Program activities.

- Monitoring, evaluation and response to government RFP opportunities as well as opportunities to leverage The Health Plan's experience in the government business line to secure administrative service opportunities.
- Participate in formulating and administering company policies and developing long-range goals and objectives.
- Provide review and analysis of information regarding the company's activities in the Government Programs areas to determine department progress toward stated goals and objectives.
- Serve as a member of the Executive Management Team, providing input to the overall goals and objectives of the organization including involvement and oversight as designated in the organization's Corporate Compliance and Quality Improvement Programs.
- Confer with President and other Executive staff to review achievements and discuss required changes in goals or objectives resulting from current status and conditions of the organization as a whole.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 5/1/2019

Review Date: 5/1/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

The Health Plan of West Virginia, Inc. is an EO employer. Qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, sexual orientation, gender identity, disability or protected veteran status.

WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: SENIOR VP GOV'T PROGRAMS

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time) O = Occasionally (1-33% of the time)
F = Frequently (34-66% of the time) R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>R</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>C</u>	Field of Vision	<u>C</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing	☒ Diverting	☒ Handling
☒ Comparing	☒ Instructing	☒ Manipulating
☒ Compiling	☒ Mentoring	☒ Operating-Controlling
☒ Computing	☒ Negotiating	☒ Precision Working
☒ Coordinating	☒ Persuading	☒ Setting Up
☐ Synthesizing	☐ Serving	☒ Tending
	☒ Speaking-Signaling	
	☒ Supervising	
	☒ Taking Instructions/Helping	

Employee Initials _____

JOB DESCRIPTION

JOB TITLE SNS Liaison

DEPARTMENT Medical

FLSA STATUS ☐ Exempt ☐ Non-Exempt

REPORTS TO Social Services Director

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The SNS Liaison is expected to be a key staff position throughout the entire contract term. This position is responsible for coordinating all SNS.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience working with SNS providers;
2. Bachelor's degree or higher in a related field;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Monitors the utilization of SNS and ensures access to SNS.
- Collaborates and interfaces with BCF and all SNS providers to facilitate member access to care and positive health and social outcomes to maintain safety, permanency and well-being.
- Supports the administration of retrospective reviews of SNS providers.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: SNS Liaison

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>O</u>
Carrying	<u>O</u>	Pushing	<u>O</u>
Climbing	<u>R</u>	Reaching	<u>F</u>
Crawling	<u>R</u>	Sitting	<u>C</u>
Crouching	<u>R</u>	Standing	<u>F</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>F</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>C</u>	Near Distance	<u>C</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>F</u>	Field of Vision	<u>F</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____



JOB TITLE Social Services Director

DEPARTMENT medical

FLSA STATUS ☐ Exempt ☐ Non-Exempt

REPORTS TO SVP Clinical Services

SUPERVISOR ☐ Yes ☐ No

POSITION SUMMARY:

The Social Services Director is expected to be a key staff position throughout the entire contract term. This position will be an expert in Multidisciplinary Team (MDT) efforts, and will serve as the Child Protective Services (CPS) Coordinator.

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. At least three (3) years' experience in supporting a child welfare program, interacting with local and state social services agencies and strong understanding of behavioral health needs of vulnerable children, youth, and families requiring specialized care;
2. Master Level Social Worker (MSW) or LCSW in West Virginia;
3. Based in West Virginia.

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

- 1.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Performs oversight of activities relating to social services referrals, connections, and services.
- Serves as the Vendor's subject matter expert (SME) related to MDTs and CPS.
- Serves as a resource to caseworkers throughout the MDT process to facilitate appropriate and effective treatment options.
- Oversees and collaborates with the SNS Liaison.
- Ensures organizational awareness and connectivity to social services and CPS resources for the population.

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 07/24/2019

Review Date:

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

JOB TITLE: Social Services Director

PHYSICAL DEMANDS

- ☒ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

TYPICAL 8-HOUR DAY TO PERFORM ESSENTIAL RESPONSIBILITIES:

INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u> R </u>	Lifting	<u> O </u>
Carrying	<u> O </u>	Pushing	<u> O </u>
Climbing	<u> R </u>	Reaching	<u> F </u>
Crawling	<u> R </u>	Sitting	<u> C </u>
Crouching	<u> R </u>	Standing	<u> F </u>
Hearing	<u> C </u>	Stooping	<u> R </u>
Key Board Function	<u> C </u>	Talking	<u> C </u>
Kneeling	<u> R </u>	Walking	<u> F </u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u> C </u>	Near Distance	<u> C </u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u> F </u>	Field of Vision	<u> F </u>

Other	Intensity	Other	Intensity
<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☒ Computing ☒ Coordinating ☐ Synthesizing	☐ Diverting ☒ Instructing ☐ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☐ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☒ Handling ☐ Manipulating ☒ Operating-Controlling ☒ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

JOB DESCRIPTION

JOB TITLE Social Worker

DEPARTMENT Clinical Services

FLSA STATUS ☒ Exempt ☐ Non-Exempt

REPORTS TO Clinical Services Manager or
Supervisor

SUPERVISOR ☐ Yes ☒ No

POSITION SUMMARY:

The Social Worker collaborates with Nurse Navigators, Medical Directors, Pharmacists, Member Advocates and external providers to access resources and address all psychosocial needs and social determinants of health impacting member care and outcomes

QUALIFICATIONS REQUIRED: (Education, Experience, Skills)

1. Social Work or related undergraduate degree with active licensure as a social worker in Ohio and West Virginia with demonstrated compliance with Board of Social Workers continuing education policy.
2. Minimum 5-7 years practice in a hospital, SNF, medical outpatient unit or related setting

QUALIFICATIONS DESIRED: (Education, Experience, Skills)

1. Should possess and maintain in depth knowledge and skills related to care resources, community resources, discharge planning and health care financial environments through continuing education at conferences, workshops, and profession networking.
2. Should possess excellent oral, written, telephonic and interpersonal skills, balancing an independent and team working environment.
3. Should be flexible and able to multi-task, work in a fast-paced environment and adapt to changing processes.
4. Should possess a superior work ethic and a commitment to Excellence and Accountability.
5. Should possess ability to exercise independent and sound judgment in decision making, utilizing all relevant information with proactive identification and resolution of issues.
6. Should possess proficient keyboarding skills and computer literacy with the ability to navigate through multiple systems
7. Masters of Social Work desired but not required.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES:

- Identifies members at risk for psychosocial needs related to health care status through direct communication with hospital social workers and discharge planners, network practitioners, The Health Plan staff, and The Health Plan members or supportive others.
- Completes contacts via telephone calls, as appropriate, to follow-up on referrals received, assesses for psychosocial needs and provides concrete or supportive interventions.
- Assists The Health Plan members and/or their supportive others, The Health Plan staff, or practitioners in making community resource referrals. Also provides appropriate follow-up regarding the outcome of a referral.

- Performs research to identify appropriate community resources and maintains information of available resources to meet various member needs.
- Completes accurate and timely documentation of contacts, needs assessments, interventions and outcomes in Case Tracker. Researches and obtains member information
- Collaborates with Health Plan staff in providing practitioner and facility education regarding available support services to assist members with complex care needs.
- Works with The Health Plan staff to develop and implement programming for social intervention consistent with identified needs of specific member populations i.e. Medicare and Medicaid.
- Maintains a level of competency to deal with chronic disease navigation and health maintenance issues by attendance at regularly scheduled health education meetings.
- Strives to improve quality in all areas of responsibility and cooperate with all departments to improve quality throughout The Health Plan.
- Serves as assigned on departmental or company committees.
- Promotes communication, both internally and externally, to enhance effectiveness of medical management services.
- Identifies opportunities for improvement in systems, processes, functions, programs, procedures and makes recommendations to the Assistant Director, Medical Management.
- Prioritizes assignments appropriately and maintains flexibility as new priorities arise.
- Participates in Grand Rounds, Transitional Care and Post Discharge Outreach

NON-ESSENTIAL FUNCTIONS:

- Perform other related duties as assigned.

Approval/Revision Date: 06/07/2019

Review Date: 06/07/2019

General sign-off: The employee is expected to adhere to all company policies while employed.

I understand this job description and its requirements. I understand that this is not an exclusive list of the essential functions and responsibilities and that I am expected to complete all duties as assigned. I understand the essential functions and responsibilities may be changed. I understand that this job description in no way constitutes an employee agreement and that I am an at-will employee.

I have read and understand the job description and the working conditions.

Employee Signature: _____ **Date:** _____

Print Name: _____

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WORKING CONDITIONS

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JOB TITLE: Social Worker

PHYSICAL DEMANDS

- ☐ **LIGHT WORK** – Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

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INSTRUCTIONS: Choose which intensity applies to each responsibility:

C = Constantly (67-100% of the time)

O = Occasionally (1-33% of the time)

F = Frequently (34-66% of the time)

R = Rarely

Physical Demands	Intensity	Physical Demands	Intensity
Balancing	<u>R</u>	Lifting	<u>R</u>
Carrying	<u>R</u>	Pushing	<u>R</u>
Climbing	<u>R</u>	Reaching	<u>R</u>
Crawling	<u>R</u>	Sitting	<u>F</u>
Crouching	<u>R</u>	Standing	<u>O</u>
Hearing	<u>C</u>	Stooping	<u>R</u>
Key Board Function	<u>C</u>	Talking	<u>C</u>
Kneeling	<u>R</u>	Walking	<u>O</u>

Vision and Ability to see Far Distance	Intensity	Vision and Ability to see far Distances	Intensity
Far Distance	<u>R</u>	Near Distance	<u>F</u>

Vision for Driving	Intensity	Vision for Driving	Intensity
Depth Perception	<u>R</u>	Field of Vision	<u>R</u>

Other	Intensity	Other	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

WORKING FUNCTIONS

INSTRUCTIONS: Check the box by functions performed in each category.

DATA	PEOPLE	THINGS
☒ Analyzing ☒ Comparing ☒ Compiling ☐ Computing ☒ Coordinating ☒ Synthesizing	☐ Diverting ☒ Instructing ☒ Mentoring ☒ Negotiating ☒ Persuading ☒ Serving ☒ Speaking-Signaling ☐ Supervising ☒ Taking Instructions/Helping	☐ Handling ☐ Manipulating ☐ Operating-Controlling ☐ Precision Working ☐ Setting Up ☐ Tending

Employee Initials _____

3

Appendix

AUDIT REPORT AND CORRECTIVE ACTION PLAN



Ms. Kerri Tomer
Director Clinical Quality
1110 Main Street
Wheeling, WV 26003

RE: System Performance Review Exit Letter

Dear Ms. Tomer:

Qlarant performed an on-site Systems Performance Review (SPR) of The Health Plan (THP) on March 20, 2019. The purpose of the SPR is to provide an annual assessment of the structure, process, and outcomes of THP's programs. Through this systems review, the team is able to identify, validate, quantify, and monitor any issues identified.

Qlarant will provide a preliminary report to THP that details the strengths of its programs, notes areas of improvement and progress, identifies any concerns, as well as opportunities for improvement. As stated during the exit conference, THP is provided the opportunity to forward any additional supportive documentation for review to Qlarant within 10 business days of receipt of this letter. Such information may include documents requested by Qlarant while on-site that were not available or documents, as determined by THP, that support the MCO's position regarding the standard, element, or component. Any documents submitted must pertain to THP's systems in place during the review period of January 1, 2018 through December 31, 2018.

The following is a listing of the elements/components reviewed during the interim desk on-site SPR and identified concerns noted by the review team:

Grievance and Appeal System

Requirement	GAD 6. - Timing—Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.
Preliminary Finding	The Member Handbook states, "As a member of The Health Plan, you have the right to file a grievance at any time". The Medicaid Complaint/Grievance policy does not include the

	language that an enrollee may file a grievance with the MCO at any time. In order to receive a finding of Met in the next review, the Medicaid Complain/Grievance policy must be updated to include the language that an enrollee may file a grievance with the MCO at any time.
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Requirement	GAD 9. - Procedures—Appeal. The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.
Preliminary Finding	The Member Handbook states, "you can file an appeal by calling Member Services at 1.888.613.8385 or you can do so in writing." The Medicaid Appeal policy states, "Expedited appeals may be submitted orally or in writing. When submitted orally they do not require written confirmation or the member's written consent to have the practitioner file on behalf of the member." This statement is incorrect, however because an oral appeal must be followed by a written, signed appeal. To receive a finding of met in the next review, THP must change the Medicaid Appeal policy to state that oral appeals must be followed by a written, signed appeal.

Requirement	GAD 17.f - Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.
Preliminary Finding	Within the Medicaid Appeals policy, there is no language that includes that if the MCO fails to adhere to the notice and timing requirements of the appeals process, the enrollee is deemed to have exhausted the MCO's appeals process and may initiate a State fair hearing.

	In order to receive a finding of Met in the next review, THP must update the Medicaid Appeals policy to include the language of deemed exhaustion. If THP does not meet the notice and timing requirements of the appeals process, the enrollee may initiate a State fair hearing. This information must also be included in the Member Handbook, Provider Manual and in the Appeal extension letters.
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Requirement	GAD 23. - Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.
Preliminary Finding	Within the Medicaid Appeals policy, there is no language that indicates that if the MCO fails to adhere to the notice and timing requirements of the appeals process, the enrollee is deemed to have exhausted the MCO's appeals process, and may initiate a State fair hearing. In order to receive a finding of Met in the next review, THP must update the Medicaid Appeals policy to include the language of deemed exhaustion. If THP does not meet the notice and timing requirements of the appeals process, the enrollee may initiate a State fair hearing. This information must also be included in the Member Handbook, Provider Manual and in the Appeal extension letters.

I hope that this information is helpful to THP. Please do not hesitate to contact me at (410) 763-6288 or fritzsche@qlarant.com if you have any questions.

Sincerely,





Kathryn Fritzsche
Project Manager

cc: Dana Pate, Quality Improvement Project Director
Laura Poynor, Project Manager
Susan Hall, Director, Office of Managed Care, BMS
Jeff Wiseman, Assistant to the Deputy Secretary, BMS

CAP Report**Date Printed:** 7/19/2019

CAP Title: Medicaid Qlarant Systems Performance Review Corrective Actions	
Origination Source: External Audit	
Origination Details: Qlarant conducted an onsite audit of THP's appeals and grievances process on March 20, 2019. Identified deficiencies were documented in the Systems Performance Review Exit Letter dated April 3, 2019.	
ID: 20664	Last Updated By: Medley, Jill
Date Due: 04/30/2019	Date Last Updated: 04/29/2019
Reporting Period: April 3, 2019	Reviewer: Medley, Jill
CAP Owner: Liberati, Angela	Approved Date: 4/29/2019 12:00:00AM
Functional Area: Medicaid	Date Closed: 4/29/2019 12:00:00AM
Issue: Deficiencies were related to the following requirements: GAD 6 Timing—Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. GAD 9. - Procedures—Appeal. The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. GAD 17.f - Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing. GAD 23. - Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.	
Action Required: (Completed by Creator): GAD 6: In order to receive a finding of Met in the next review, the Medicaid Complain/Grievance policy must be updated to include the language that an enrollee may file a grievance with the MCO at any time. GAD 9: To receive a finding of met in the next review, THP must change the Medicaid Appeal policy to state that oral appeals must be followed by a written, signed appeal. GAD 17.f: In order to receive a finding of Met in the next review, THP must update the Medicaid Appeals policy to include the language of deemed exhaustion. If THP does not meet the notice and timing requirements of the appeals process, the enrollee may initiate a State fair hearing. This information must also be included in the Member Handbook, Provider Manual and in the Appeal extension letters. GAD 23: In order to receive a finding of Met in the next review, THP must update the Medicaid Appeals policy to include the language of deemed exhaustion. If THP does not meet the notice and timing requirements of the appeals process, the enrollee may initiate a State fair hearing. This information must also be included in the Member Handbook, Provider Manual and in the Appeal extension letters.	
Action Plan: (Completed by Stakeholder) GAD 6: Update grievance policy GAD 9: Update appeal	

Attachments:

<u>Description</u>	<u>Updated By</u>	<u>Date Last Updated</u>
Medicaid Appeal Extension Letter	Liberati, Angela	4/5/2019 1:02:57PM
Member Handbook	Liberati, Angela	4/5/2019 1:02:30PM
Appeals and Grievances Provider Manual	Liberati, Angela	4/5/2019 1:02:11PM
Provider Manual- Appeals and Grievances	Liberati, Angela	4/5/2019 12:57:29PM
Appeal Extension Letter	Liberati, Angela	4/5/2019 12:46:42PM
Member Handbook	Liberati, Angela	4/5/2019 12:43:32PM
Medicaid Appeal Policy	Liberati, Angela	4/5/2019 12:39:36PM
Medicaid Appeal Policy	Liberati, Angela	4/5/2019 12:36:19PM
Medicaid Appeal Policy	Liberati, Angela	4/5/2019 12:24:59PM
Medicaid Complaint/Grievance Policy	Liberati, Angela	4/5/2019 12:14:33PM
THP exit letter MY 2018	Medley, Jill	4/4/2019 1:00:23PM

Notes:

<u>Updated By</u>	<u>Date</u>	<u>Note</u>
Medley, Jill	04/29/2019	Closed changed from No to Yes on 04/29/2019 by jmedley@healthplan.org
Medley, Jill	04/29/2019	Approved changed to Yes on 04/29/2019 by jmedley@healthplan.org
Medley, Jill	04/29/2019	Ready For Closeout changed from No to Yes on 04/29/2019 by jmedley@healthplan.org
Liberati, Angela	04/23/2019	Ready For Approval changed from No to Yes on 04/23/2019 by aliberati@healthplan.org
Medley, Jill	04/04/2019	Due Date changed from to 04/30/2019 on 04/04/2019 by jmedley@healthplan.org

Tasks:

<u>Task ID</u>	<u>Title</u>	<u>Owner</u>	<u>% Complete</u>	<u>Date Due</u>
109736	GAD 9	Liberati, Angela	100	04/30/2019

Instruction

To receive a finding of met in the next review, THP must change the Medicaid Appeal policy to state that oral appeals must be followed by a written, signed appeal.

<u>Note</u>	<u>Date Updated</u>	<u>Note By</u>
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 100 to 0 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
Appeal Policy is updated in Policy Stat on the intranet.	04/05/2019	Liberati, Angela

109735	GAD 6	Liberati, Angela	100	04/30/2019
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Instruction

In order to receive a finding of Met in the next review, the Medicaid Complain/Grievance policy must be updated to include the language that an enrollee may file a grievance with the MCO at any time.

<u>Note</u>	<u>Date Updated</u>	<u>Note By</u>
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 100 to 0 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
Grievance Policy uploaded to Policy Stat.	04/05/2019	Liberati, Angela

109738	GAD 23	Liberati, Angela	100	04/30/2019
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Instruction

Within the Medicaid Appeals policy, there is no language that indicates that if the MCO fails to adhere to the notice and timing requirements of the appeals process, the enrollee is deemed to have exhausted the MCO's appeals process, and may initiate a State fair hearing.

<u>Note</u>	<u>Date Updated</u>	<u>Note By</u>
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 100 to 0 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 100 to 0 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
Appeal Policy updated and can be found in Policy Stat on the intranet.	04/05/2019	Liberati, Angela

109737	GAD 17.f	Liberati, Angela	100	04/30/2019
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Instruction

Within the Medicaid Appeals policy, there is no language that includes that if the MCO fails to adhere to the notice and timing requirements of the appeals process, the enrollee is deemed to have exhausted the MCO's appeals process and may initiate a State fair hearing.

<u>Note</u>	<u>Date Updated</u>	<u>Note By</u>
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 100 to 0 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
% Complete change from 0 to 100 on 04/05/2019 by Liberati, Angela	04/05/2019	Liberati, Angela
Appeal Policy updated and can be found in Policy Stat on the intranet.	04/05/2019	Liberati, Angela

Overall % Complete: 100

Workgroup:

Liberati, Angela

Medley, Jill

Stanich, Katie

Linked Objects:

ID

Object

Description

4

Appendix

SUBCONTRACTOR AGREEMENT AND LETTERS OF INTENT

**LETTER OF INTENT BETWEEN
THE HEALTH PLAN OF WEST VIRGINIA, INC. AND
WEST VIRGINIA UNITED HEALTH SYSTEM, INC.**

This Letter of Intent, effective as of August 15, 2019 ("Effective Date"), is entered into by and between The Health Plan of West Virginia, Inc., a not-for-profit corporation organized under the laws of the state of West Virginia ("THE HEALTH PLAN"), and West Virginia United Health System, Inc. dba West Virginia University Health System ("WVUHS"), a not-for-profit corporation organized under the laws of the state of West Virginia.

WHEREAS, THE HEALTH PLAN is a not-for-profit corporation organized for the purpose of facilitating and promoting the delivery of cost effective health care services by providing a vehicle through which health maintenance organizations, managed care entities, and other purchasers of health care may contract with qualified providers and practitioners of health care services (including hospital and medical services); and

WHEREAS, WVUHS is an integrated health care delivery system that includes facility, professional, and ancillary providers that are duly licensed, certified, and registered, as applicable, to perform health care services in West Virginia; and

WHEREAS, THE HEALTH PLAN has acknowledged and shared with WVUHS its intention to respond to the West Virginia Department of Health and Human Resources' ("DHHR") Request for Proposals for transitioning West Virginia foster care children to a managed care organization ("RFP").

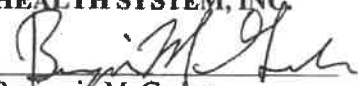
NOW, THEREFORE, THE HEALTH PLAN and WVUHS agree as follows:

The parties to this Letter of Intent shall continue to work in good faith to enter into a mutually acceptable contract for the provision of services related to Medicaid-covered children in the West Virginia foster care system ("Definitive Agreement"). The intent of the Definitive Agreement will be to promote a collaborative relationship between THE HEALTH PLAN and WVUHS that aligns with the goals and needs set forth in the RFP and as outlined in Attachment A.

THE HEALTH PLAN and WVUHS each acknowledge and agree that this Letter of Intent is neither a contract nor an offer of a contract and that neither party to this document shall have a legal obligation to the other with respect to the transaction proposed herein unless and until both parties have executed and delivered the Definitive Agreement. Further, this Letter of Intent shall have no effect on any other agreements that may be in place at this time.

Unless extended by the parties, this Letter of Intent shall terminate on the earlier of: (1) the execution of the Definitive Agreement; (2) a decision by DHHR or other applicable West Virginia agency that THE HEALTH PLAN has not been selected as the Vendor within the meaning set forth in the RFP; (3) one hundred and eighty (180) days after THE HEALTH PLAN has been selected as a Vendor within the meaning of the RFP; or (4) written notice of termination by either party without cause, which notice may be sent via electronic mail.

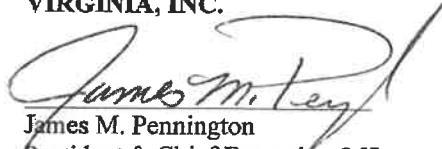
**WEST VIRGINIA UNITED
HEALTH SYSTEM, INC.**


Benjamin M. Gerber

Vice President, Payer Strategy & Contracting

Date: 8/7/19

**THE HEALTH PLAN OF WEST
VIRGINIA, INC.**

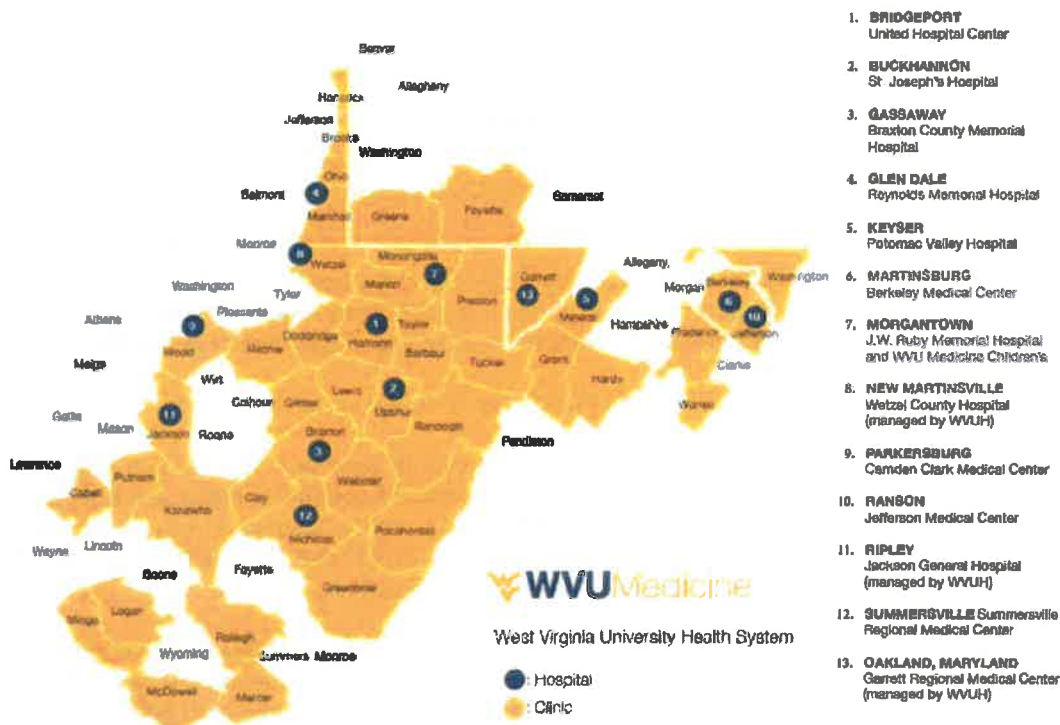

James M. Pennington

President & Chief Executive Officer

Date: 8/8/19

West Virginia University Medicine

West Virginia University Health System (WVUHS) operates under the brand of WVU Medicine (WVUM), as the largest integrated healthcare delivery system in the state of West Virginia, will provide THP with significant clinical expertise and access to existing services. Furthermore, they will aid in the development of needed services across the state of West Virginia.



WVUM is comprised of ten (10) hospitals – its flagship academic medical center, West Virginia University Hospitals, including a behavioral and mental health services center known as Chestnut Ridge in Morgantown; Berkeley Medical Center in Martinsburg; Braxton County Memorial Hospital in Glassaway; Camden Clark Medical Center in Parkersburg; Jefferson Medical Center in Ranson; Potomac Valley Hospital in Keyser; Reynolds Memorial Hospital in Glen Dale; St. Joseph's Hospital in Buckhannon; Summersville Regional Medical Center in Summersville; and United Hospital Center in Bridgeport. WVUM also provides management services to Wetzel County Hospital in New Martinsville; Jackson General Hospital in Ripley; Wheeling Hospital in Wheeling; Garrett Regional Medical Center in Oakland, Maryland; and Barnesville Hospital in Barnesville, Ohio. WVUM also includes five institutes – the WVU Cancer Institute, the WVU Critical

Care and Trauma Institute, the WVU Eye Institute, the WVU Heart and Vascular Institute, and the WVU Rockefeller Neuroscience Institute.

WVUM broke ground on a new tower to house the pediatric and women's services of WVUM Children's in 2018. The 150-bed, nine-story facility is scheduled to be completed in 2021. WVUM Children's continues to focus on improving the health of our youngest and most vulnerable population and has opened a Neurodevelopmental Center (NDC) to evaluate and treat children with a wide variety of neurodevelopmental disabilities, including Autism Spectrum Disorder, developmental delay, cerebral palsy, neuromuscular disorders, and Tourette syndrome.

WVUM has over two thousand two hundred (2,200) billing professional providers offering services in thirty-six (36) of West Virginia's fifty-five (55) counties and continues to expand. They build new partnerships with providers across the state to bring high quality care to the people of West Virginia and the surrounding region so that patients do not have to travel great distances or even out of state to receive needed care.

Our partnership with West Virginia University Medicine will provide a unique opportunity for provider/payer collaboration which will enhance and improve the care and services provided to the foster care populations. Some of the key areas of innovation and collaboration for this population include:

- **TELEMEDICINE**—as the leading provider of telemedicine services in the state, WVUM already has several telemedicine projects that will benefit the foster care population. Such programs include:
 - telepsychiatry program providing psychiatric and psychological consultation and crisis assistance.
 - real-time urgent care
 - remote patient monitoring
 - specialist evaluations
 - medication reconciliation
 - Project ECHO resources to provide specialty support for rural communities.

Further, WVUM is committed to development of telemedicine capabilities to meet the needs of the foster care population

- **PREDICTIVE MODELING**— In order for WVUM to redesign care WVUM has transitioned to one electronic medication record, EPIC, across the system that has one patient ID, one record and is one unified system of care. Having a unified system allows WVUM to seamlessly coordinate care regardless of clinic or hospital location. In conjunction with the clinical chart data in EPIC, WVUM has the capability to enhance predictive analytics by incorporating external claims data into the EPIC platform. THP and WVUM will collaborate to integrate historical claims and other relevant information to enable WVUM providers to ascertain high risk patients early in the process using predictive analytics. THP is also able to share data from our CAVE system directly with WVUM providers through an electronic interface allowing them a broader "picture" of the child by integrating both the clinical chart data and the plan claims data.
- **SOCIAL SERVICE RESOURCES**—Social determinants of health have a significant impact on the Foster Care population. While THP employs social workers to assist with needed services, Care Managers in the WVUM practices settings have robust resources around the various social services in the various communities. The Care Management program through their healthcare system incorporates a PCMH/Population Health model that evaluates the whole patient and identifies social determinants of health. Additionally, WVUM employs social workers who are very knowledgeable on community resources and connects patients to those resources. THP will integrate

these resources along with our established resources to capitalize on the broader knowledge base of the delivery system.

- **PCMH CAPABILITIES**—WVUM has significant PCMH resources in many of its practices which are established and integrated into the delivery system. Integration of Population Health information between THP and WVUM PCMH practices will ensure a more coordinated approach to care delivery and will avoid duplication of services across the care continuum.
 - The Foster Care population with significant behavioral health needs, would benefit from a PCMH approach in the comprehensive behavioral health center setting. United Summit Center, a behavioral health center within the WVUM system provides an opportunity for development of a PCMH approach for the foster care population.

For those services not delivered through WVUM partner providers, WVUM and THP will work in collaboration with network providers to develop patient care management resources to enable deliver of PCMH care throughout the network. The provider/payer partnership will facilitate the development of a model of care that facilitates effective patient management within the primary care practice as well as in the specialty practice setting when appropriate.

- WVUM and THP can work jointly with small primary care practices that may have limited resources to deliver a PCMH model of care through varied means and provide support resources.
- **SPECIALTY CARE** - WVUM has significant specialty provider resources available to meet the complex needs of the Foster Care membership. The collaborative partnership will provide for prompt access to needed specialty care in addition to resources for clinical review and evaluation of data to establish best practices.
- **URGENT/EMERGENT RESOURCES**—WVUM will work with THP to establish a statewide network of providers able to provide crisis services to Foster Children when needed.
- **WVU BEHAVIORAL Health** resources are the most comprehensive in the state of West Virginia. The team at WVUM is committed to development of new and needed resources and have vast experience with children including foster care populations.
- **TRAINING RESOURCES**—WVUM will act as a training resource for providers, families, staff, stakeholders with some of the following developed training protocols, not limited to:
 - Trauma Informed Care
 - Mental Health First Aid
 - SANE – Sexual Assault
 - Pressley Ridge Trauma Training
 - Trauma Systems Therapy
 - Life-skills trainings – Vocational services, etc.

**LETTER OF INTENT
BETWEEN
THE HEALTH PLAN OF WEST
VIRGINIA, INC., AND KVC WEST
VIRGINIA, INC.**

This Letter of Intent, effective as of 8/8/2019 ("Effective Date"), is entered into by and between The Health Plan of West Virginia, Inc., a not-for-profit Corporation organized under the laws of the states of West Virginia and Ohio ("THE HEALTH PLAN"), and KVC West Virginia organized under the laws of the state of West Virginia,

WITNESSETH:

WHEREAS, THE HEALTH PLAN is a not-for-profit corporation organized for the purpose of facilitating and promoting the delivery of cost effective health care services by providing a vehicle through which health maintenance organizations, managed care entities, and other purchasers of health care may contract with qualified providers and practitioners of health care services (including hospital and medical services):

WHEREAS, KVC West Virginia is a duly licensed, certified, and/or registered, as applicable, to perform other health care services under applicable West Virginia and federal statutes and regulations:

WHEREAS, THE HEALTH PLAN has acknowledged and shared with its intention to respond to the West Virginia Department of Health and Human Resources' ("DHHR") Request for Proposals for transitioning West Virginia foster care children to a managed care organization ("RFP").

NOW, THEREFORE, THE HEALTH PLAN and KVC WV, in consideration of the mutual promises and the terms and conditions provided herein, agree as follows:

The parties to this Letter of Intent shall continue to work in good faith to enter into a mutually acceptable contract/arrangement for the provision of services related to Medicaid-covered children in the West Virginia foster care system.

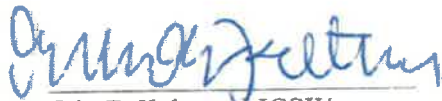
The parties further agree that said amendment will promote a collaborative relationship between THE HEALTH PLAN and KVC WV, which align with the goals and needs set forth in the RFP and as outlined in Attachment A.

THE HEALTH PLAN and KVCWV each acknowledge and agree that this Letter of Intent is neither a contract nor an offer of a contract and that neither party to this document shall have a legal obligation to the other with respect to the transaction proposed herein unless and until both parties have executed and delivered a definitive agreement. Further this Letter of Intent shall have no effect on any other agreements that may be in place at this time.

Unless extended by the parties, this Letter of Intent shall terminate on the earlier of: (1) the execution of the Definitive Agreement; (2) a decision by DHHR or other applicable West Virginia agency that THE HEALTH PLAN has not been selected as the Vendor within the meaning set forth in the RFP; (3) one hundred and eighty (180) days after THE HEALTH PLAN has been selected as a Vendor within the meaning of the RFP; or (4) written notice of termination by either party without cause, which notice may be sent via electronic mail.

IN WITNESS WHEREOF, THE HEALTH PLAN and KVCWV have caused this Letter of Intent to be made and entered into by their duly authorized officers to become effective as of the Effective Date.

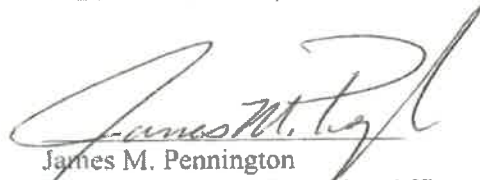
KVC WEST VIRGINIA



Erin E. Keltner, LICSW
Vice President of Operations

8/8/2019
Date

THE HEALTH PLAN OF
WEST VIRGINIA, INC.



James M. Pennington
President & Chief Executive Officer

8/8/19
Date

KVC West Virginia

KVC, as the largest private foster Care provider entity in WV, will provide the support that The Health Plan needs to integrate evidence-based guidelines into our management of the foster children in WV. KVC has been an active partner with the state of Kansas since 1996 around privatization of Foster Care Services where they have shown significant improvement in outcomes as a result of the privatization. Some key statistics:

- **Foster Children in Group Setting:**
 - In Kansas 30% in 1996 reduced to 5.3% in 2015 with KVC rate at 4%
 - WV current rate is 14.5% based on April 2019 Foster Care Placement Report
- **Kansas is now the second safest child welfare system in the country**
 - National Standard 94.6%
 - Kansas 98.5%
 - KVC/Kansas 99.8%
- **General Experience of KVC Across Multiple States For Calendar Year 2018:**
 - In Kansas, 12,479 youth and families were served. 9,963 children and families received family preservation services. 1,006 children were reunified with families after participating in foster care.
 - In Nebraska, 817 youth were served in their foster care program and 129 were safely reunified with their families.
 - In Kentucky, over 6,000 children received family preservation services. 97.4% of children served either maintained safely with or were reunified with their families after receiving family preservation or reunification services.
 - In West Virginia, 335 children were served by KVC foster homes. Nearly 50% of these youth returned to their families. KVC served 188 families in Safe at Home.

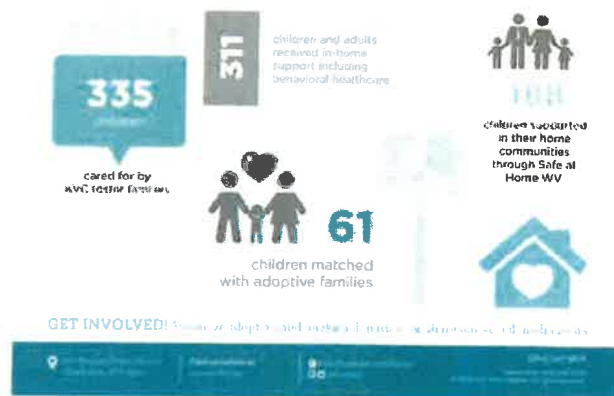
Our partnership with KVC will allow us to utilize their expertise with the following functions:

- Facilitate the involvement of current WV Foster Care providers and community stakeholders in the implementation of THPs Foster Care Program including:
 - establishment of an advisory committee/group with Foster Care service providers

KVC West Virginia



Over the last year, we helped people in many ways:



- o provide guidance and support around community resources relevant to the foster populations
 - o act as liaison with Foster Care provider network and help to establish and implement needed services to improve outcomes
 - home visits
 - Wrap Around Services
 - o Identification of resources and capabilities for each county
- Provide resources for the review, approval and payment of Socially Necessary Services
 - o evidence based criteria development
 - o review of authorization requests
 - o monitoring of providers of socially necessary services and evaluation of effective delivery of such services
- Develop reporting structures for Socially Necessary Services
- Provide a mechanism for to handle Foster Care crisis intervention services by facilitating the TRIAGE piece for 24/7 access
 - o Model after program in Kansas that facilitated calls and then locates resources –potentially using Kansas at start up and then developing similar resource in WV.
 - o Work with Foster organizations to identify organizations services by county in WV and facilitate process for after hours
 - o Work with THP to identify clinical care after hours resources
- Coordinate with various entities and work on the identification and development of services and providers in West Virginia to service foster children
- Provide educational resources in identified areas of expertise for:
 - o Providers
 - o Members
 - o Staff

As a current provider in West Virginia, KVC is familiar the current foster Care system and the needs of the population. As an integrated partner with THP, we will be able to collaborate to identify obstacles and create innovative solutions. THP will use KVC as an integral resource to bring stakeholders to the table in a meaningful manner. While KVC will continue to act as a provider of socially necessary services and foster care, the strategic partnership with THP shall not impact the delivery of those services nor the ability to obtain those services from the provider of the member's choosing.

The heart of KVC's work is helping people. - That's what drives us. The inherent worth of each person defines our purpose, informs our work and guides our culture. Our purpose is to help children, adults and families in all communities and neighborhoods. Families from any background can face struggles or even find themselves in crisis but hope and help can guide a family back to firm -footing.

Our nationwide team of expert professionals and volunteers are here to help.

KVC offers innovative, effective and compassionate care to every individual we serve:

- Innovative because persistent problems can only be solved using new thinking;
- Effective because outcomes matter greatly in child welfare and behavioral healthcare; and

- Compassionate because true caring is both the destination and the means to get there.

The work KVC do is often in people's homes where they are comfortable to experience transformation and repair relationships. The extent of community need is often unknown because this work is unseen, but the changes are visible to those close to it. KVC help families in crisis find the resources that will keep them safely together. KVC helps people overcome addiction to drugs or alcohol through treatment and strengthening supportive relationships. KVC gives adults the practical parenting skills needed to stop the cycles of violence and trauma and create a healthy, loving family. People are the heart of everything KVC does.

KVC Institute

21+ Million - Over 21 million people indirectly impacted by KVC Institute training or consultation

To make real change in communities, KVC works in small ways and big ways, both at the individual level and at the highest organizational levels. Through the KVC Institute for Health Systems Innovation, KVC works to transform the experience of childhood for all children, developing creative solutions to social problems by providing consulting, creating curriculum and online learning, training professionals, and influencing public policy. KVC ensure KVC are doing our best work through our Safe & Connected™ integrated child welfare practice model, guiding practitioners in the application of research into practice and ultimately maximizing human potential.

- Over 1,000 people received direct training or consultation on best practices
- Agencies in 9 U.S. states

Foster Care:

6869 children cared for by relative caregivers or foster families

KVC provide 24/7 support to children who have experienced abuse and neglect — giving food, a bed and a caring family to youth going through heartache and separation. Foster care is a necessary intervention so that a family can work to overcome obstacles and challenges and learn parenting and communication skills in order for their child to safely return home. Foster care is meant to be temporary and for as short of a time as safely possible because KVC know that any disruption to a child can negatively affect their development.

That is why KVC look to find relatives, neighbors or other trusted adults that the child knows to become his or her foster caregivers. If KVC are unable to find a known adult to care for the child, KVC have a network of highly trained, loving foster families that become caregivers for the child. These families provide a safe, caring environment for the child to heal from the trauma they have experienced.

In-Home Support:

28,128 children and adults benefited from our in-home services such as family therapy, behavioral healthcare and skill-building

In any neighborhood, individuals and families can struggle with challenges that are hard to overcome without help from caring professionals. Economic hardship, mental illness, abuse or neglect, substance abuse, domestic violence, divorce, incarceration and parenting challenges are some of the primary types of adversity that can affect how a family function.

KVC work to stabilize and strengthen families with in-home supports before the need for foster care arises. Our therapists and social workers support parents and children in their home rather than an office setting because the family setting is where challenges exist and where change must occur. In partnership with the family, KVC create and implement a treatment plan. KVC also connect them to community resources including jobs, housing, substance use treatment, medical care, psychiatric treatment and parenting education.

Children 'S Psychiatric Hospitals & Residential Treatment

2,869 youth and adults treated at our psychiatric hospitals

Over the past decade, the number of children and teens who have been hospitalized for suicidal ideation has doubled. Unfortunately, it's become a national health crisis and KVC don't have to look far to find someone who has been affected by the loss of a friend or family member. Children and teens all across the country are struggling with depression, anxiety, trauma, the effects of stress, mental illness, substance use and other sources and types of psychiatric crisis.

KVC offer a safe place for families who are going through one of most frightening and heartbreaking times in their lives. We're putting Resilience Centers in our hospital locations and in communities to teach kids about brain science and what's happening in their brains when they get angry, scared or sad. KVC teach coping skills and use virtual reality as a highly interactive way of helping children experience safety and healing. Our treatment is trauma-informed which addresses the individual and their experiences but also includes their family and home environment as key contributors to their health and wellness.

- **8,603** individual therapy sessions provided to youth
- **403** therapeutic virtual reality sessions conducted
- **42,128** patient

**LETTER OF INTENT
BETWEEN
THE HEALTH PLAN OF WEST
VIRGINIA, INC., AND
PRESTERA CENTER FOR MENTAL
HEALTH SERVICES, INC.**

This Letter of Intent, effective as of May 15, 2019 ("Effective Date"), is entered into by and between The Health Plan of West Virginia, Inc., a not-for-profit Corporation organized under the laws of the states of West Virginia and Ohio ("THE HEALTH PLAN"), and Prestera Center for Mental Health Services, Inc., a not-for-profit Corporation organized under the laws of the state of West Virginia ("PRESTERA CENTER").

WITNESSETH:

WHEREAS, THE HEALTH PLAN is a not-for-profit corporation organized for the purpose of facilitating and promoting the delivery of cost effective health care services by providing a vehicle through which health maintenance organizations, managed care entities, and other purchasers of health care may contract with qualified providers and practitioners of health care services (including hospital and medical services);

WHEREAS, PRESTERA CENTER is a not-for-profit corporation duly licensed, certified, and/or registered, as applicable, to perform behavioral health, substance use, and other health care services under applicable West Virginia and federal statutes and regulations;

WHEREAS, THE HEALTH PLAN and PRESTERA CENTER are parties to a Behavioral Health Center Provider Agreement effective since October 25, 2015 (the "BHCP Agreement"); and

WHEREAS, THE HEALTH PLAN has acknowledged and shared with PRESTERA CENTER its intention to respond to the West Virginia Department of Health and Human Resources' ("DHHR") Request for Proposals for transitioning West Virginia foster care children to a managed care organization ("RFP").

NOW, THEREFORE, THE HEALTH PLAN and PRESTERA CENTER, in consideration of the mutual promises and the terms and conditions provided herein, agree as follows:

The parties to this Letter of Intent shall continue to work in good faith to enter into a mutually acceptable amendment to the BHCP Agreement for the provision of services related to Medicaid-covered children in the West Virginia foster care system.

The parties further agree that said amendment will promote a collaborative relationship between THE HEALTH PLAN and PRESTERA CENTER, which incorporates value-based reimbursement strategies, as well as wrap around, comprehensive care services that align with the goals and needs set forth in the RFP.

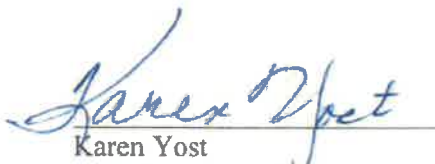
THE HEALTH PLAN and PRESTERA CENTER each acknowledge and agree that this Letter of Intent is neither a contract nor an offer of a contract and that neither party to this document shall have a legal obligation to the other with respect to the transaction proposed

herein unless and until both parties have executed and delivered a definitive amendment ("Definitive Amendment"); further this Letter of Intent shall have no effect on the BHCP Agreement.

Unless extended by the parties, this Letter of Intent shall terminate on the earlier of: (1) the execution of the Definitive Amendment; (2) a decision by DHHR or other applicable West Virginia agency that THE HEALTH PLAN has not been selected as the Vendor within the meaning set forth in the RFP; (3) one hundred and eighty (180) days after THE HEALTH PLAN has been selected as a Vendor within the meaning of the RFP; or (4) written notice of termination by either party without cause, which notice may be sent via electronic mail.

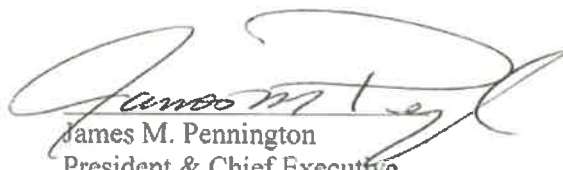
IN WITNESS WHEREOF, THE HEALTH PLAN and PRESTERA CENTER have caused this Letter of Intent to be made and entered into by their duly authorized officers to become effective as of the Effective Date.

PRESTERA CENTER


Karen Yost
Chief Executive Officer

5/14/19
Date

**THE HEALTH PLAN OF
WEST VIRGINIA, INC.**


James M. Pennington
President & Chief Executive
Officer

8/7/19
Date

**LETTER OF INTENT
BETWEEN
THE HEALTH PLAN OF WEST
VIRGINIA, INC., AND
WESTBROOK HEALTH
SERVICES, INC.**

This Letter of Intent, effective as of 7/3/2019 ("Effective Date"), is entered into by and between The Health Plan of West Virginia, Inc., a not-for-profit Corporation organized under the laws of the states of West Virginia and Ohio ("THE HEALTH PLAN"), and Westbrook Health Services, Inc., a not-for-profit Corporation organized under the laws of the state of West Virginia ("WHS").

WITNESSETH:

WHEREAS, THE HEALTH PLAN is a not-for-profit corporation organized for the purpose of facilitating and promoting the delivery of cost effective health care services by providing a vehicle through which health maintenance organizations, managed care entities, and other purchasers of health care may contract with qualified providers and practitioners of health care services (including hospital and medical services);

WHEREAS, WHS is a not-for-profit corporation duly licensed, certified, and/or registered, as applicable, to perform behavioral health, substance use, and other health care services under applicable West Virginia and federal statutes and regulations;

WHEREAS, THE HEALTH PLAN and WHS are parties to a Behavioral Health Center Provider Agreement effective since July 1, 2015 (the "BHCP Agreement"); and

WHEREAS, THE HEALTH PLAN has acknowledged and shared with WHS its intention to respond to the West Virginia Department of Health and Human Resources' ("DHHR") Request for Proposals for transitioning West Virginia foster care children to a managed care organization ("RFP").

NOW, THEREFORE, THE HEALTH PLAN and WHS, in consideration of the mutual promises and the terms and conditions provided herein, agree as follows:

The parties to this Letter of Intent shall continue to work in good faith to enter into a mutually acceptable amendment to the BHCP Agreement for the provision of services related to Medicaid-covered children in the West Virginia foster care system.

The parties further agree that said amendment will promote a collaborative relationship between THE HEALTH PLAN and WHS, which incorporates value-based reimbursement strategies, as well as wrap around, comprehensive care services that align with the goals and needs set forth in the RFP.

THE HEALTH PLAN and WHS each acknowledge and agree that this Letter of Intent is neither a contract nor an offer of a contract and that neither party to this document shall have a legal obligation to the other with respect to the transaction proposed herein unless and until both parties have executed and delivered a definitive amendment ("Definitive Amendment"); further this Letter of Intent shall have no effect on the BHCP Agreement.

Unless extended by the parties, this Letter of Intent shall terminate on the earlier of: (1) the execution of the Definitive Amendment; (2) a decision by DHHR or other applicable West Virginia agency that THE HEALTH PLAN has not been selected as the Vendor within the meaning set forth in the RFP; (3) one hundred and eighty (180) days after THE HEALTH PLAN has been selected as a Vendor within the meaning of the RFP; or (4) written notice of termination by either party without cause, which notice may be sent via electronic mail.

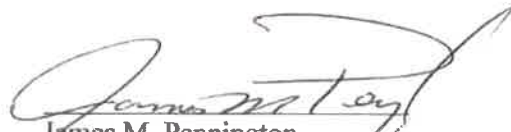
IN WITNESS WHEREOF, THE HEALTH PLAN and WHS have caused this Letter of Intent to be made and entered into by their duly authorized officers to become effective as of the Effective Date.

**WESTBROOK HEALTH
SERVICES, INC.**


Kevin Trippett
Chief Executive Officer

7.22.17
Date

**THE HEALTH PLAN OF
WEST VIRGINIA, INC.**


James M. Pennington
President & Chief Executive Officer

8/7/19
Date

**LETTER OF INTENT
BETWEEN
THE HEALTH PLAN OF WEST
VIRGINIA, INC., AND
SOUTHERN HIGHLANDS
COMMUNITY MENTAL HEALTH
CENTER, INC.**

This Letter of Intent, effective as of May 28, 2019 ("Effective Date"), is entered into by and between The Health Plan of West Virginia, Inc., a not-for-profit Corporation organized under the laws of the states of West Virginia and Ohio ("THE HEALTH PLAN"), and Southern Highlands Community Mental Health Center, Inc., a not-for-profit Corporation organized under the laws of the state of West Virginia ("SHCMHC").

WITNESSETH:

WHEREAS, THE HEALTH PLAN is a not-for-profit corporation organized for the purpose of facilitating and promoting the delivery of cost effective health care services by providing a vehicle through which health maintenance organizations, managed care entities, and other purchasers of health care may contract with qualified providers and practitioners of health care services (including hospital and medical services);

WHEREAS, SHCMHC is a not-for-profit corporation duly licensed, certified, and/or registered, as applicable, to perform behavioral health, substance use, and other health care services under applicable West Virginia and federal statutes and regulations;

WHEREAS, THE HEALTH PLAN and SHCMHC are parties to a Behavioral Health Center Provider Agreement effective since July 1, 2015 (the "BHCP Agreement"); and

WHEREAS, THE HEALTH PLAN has acknowledged and shared with SHCMHC its intention to respond to the West Virginia Department of Health and Human Resources' ("DHHR") Request for Proposals for transitioning West Virginia foster care children to a managed care organization ("RFP").

NOW, THEREFORE, THE HEALTH PLAN and SHCMHC, in consideration of the mutual promises and the terms and conditions provided herein, agree as follows:

The parties to this Letter of Intent shall continue to work in good faith to enter into a mutually acceptable amendment to the BHCP Agreement for the provision of services related to Medicaid-covered children in the West Virginia foster care system.

The parties further agree that said amendment will promote a collaborative relationship between THE HEALTH PLAN and SHCMHC, which incorporates value-based reimbursement strategies, as well as wrap around, comprehensive care services that align with the goals and needs set forth in the RFP.

THE HEALTH PLAN and SHCMHC each acknowledge and agree that this Letter of Intent is neither a contract nor an offer of a contract and that neither party to this document shall have a legal obligation to the other with respect to the transaction proposed herein unless and until both parties have executed and delivered a definitive amendment ("Definitive Amendment"); further this Letter of Intent shall have no effect on the BHCP Agreement.

Unless extended by the parties, this Letter of Intent shall terminate on the earlier of: (1) the execution of the Definitive Amendment; (2) a decision by DHHR or other applicable West Virginia agency that THE HEALTH PLAN has not been selected as the Vendor within the meaning set forth in the RFP; (3) one hundred and eighty (180) days after THE HEALTH PLAN has been selected as a Vendor within the meaning of the RFP; or (4) written notice of termination by either party without cause, which notice may be sent via electronic mail.

IN WITNESS WHEREOF, THE HEALTH PLAN and SHCMHC have caused this Letter of Intent to be made and entered into by their duly authorized officers to become effective as of the Effective Date.

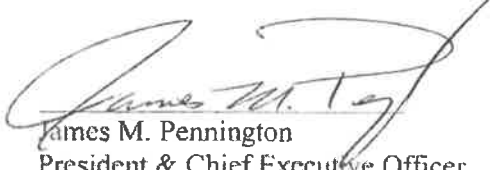
**SOUTHERN HIGHLANDS COMMUNITY
MENTAL HEALTH CENTER, INC.**



Lisa Jones
Chief Executive Officer

Date

**THE HEALTH PLAN OF
WEST VIRGINIA, INC.**



James M. Pennington
President & Chief Executive Officer

8/7/19

Date

MEDICAID CONTRACTOR AGREEMENT

This Medicaid Contractor Agreement, together with all exhibits and attachments hereto (collectively, the "Agreement") is made and entered into as of **July 1, 2018** ("Effective Date") by and between **The Health Plan of West Virginia, Inc.** ("Company") and **Superior Vision Benefit Management, Inc.** (formerly known as Block Vision, Inc.) (hereinafter "Provider").

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers to provide access to such health care services to Members; and

WHEREAS, Provider has established a network of vision care service providers ("Subcontracted Providers"), under contract with Provider, to provide Covered Services to Members; and

WHEREAS, Company and Provider mutually desire to enter into an arrangement whereby Provider, through its Subcontracted Providers, will provide and arrange for the provision of Covered Services to Members; and

WHEREAS, Company shall delegate to Provider the following functions: claims administration, credentialing, network development and management, and customer service, which duties and obligations of the Parties related to such delegated services are set forth in the Delegated Claims Administration Addendum, Delegated Credentialing Addendum, Delegated Network Development and Management Addendum, and Delegated Customer Service Addendum attached hereto; and

WHEREAS, in return for Provider's arranging for the provision of Covered Services by Subcontracted Providers, Company will provide payment to Provider for Covered Services and the delegated services in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 **Affiliate.** Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with either party to this Agreement.

1.2 **Confidential Information.** Any information that identifies a Member and is related to the

Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information," as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999, as applicable. Confidential Information includes all information that is obtained through performance under this Agreement.

1.3 Copayment. A charge required under a Plan that must be paid by a Member at the time of the service. Copayments are determined by BMS based on the Member's family income. Copayments are also referred to as "Cost-Sharing."

1.4 Covered Services. Those services covered by the Plan, which are identified in Exhibit D, Covered Services Schedule, provided by Subcontracted Provider and for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.5 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid. There are no deductibles under the West Virginia Medicaid program.

1.6 Emergency Medical Condition. A medical condition where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the individual's health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

1.7 Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

1.8 Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

1.9 Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s). The Bureau for Medical Services of the West Virginia Department of Health and Human Resources ("BMS") is the Government Sponsor for the West Virginia Medicaid Program.

1.10 Medically Necessary. A determination that items or services furnished or to be furnished to a patient are reasonable and necessary for the diagnosis or treatment of illness or injury, to improve the functioning of a malformed body member, to attain, maintain or regain functional capacity, for the prevention of illness, or to achieve age-appropriate growth and development.

1.11 Member/Enrollee. An individual covered by or enrolled in a Plan and entitled to such Covered Services offered by the Plan.

1.12 Participating Vision Care Provider ("PVCP"). A duly licensed ophthalmologist, optometrist or an optician who has an agreement in effect with Superior Vision to provide Covered Services to Members. PVCP is also referred to as a Subcontracted Provider.

1.13 Party. Company or Provider, as applicable.

1.14 Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in Exhibit A, Program Participation Schedule.

1.15 Policies. The policies and procedures promulgated by Provider (and, where applicable, Government Sponsor) which relate to the duties and obligations of Provider under the terms of this Agreement, including, but not limited to: (a) quality improvement; (b) claims payment review; (c) member grievances; (d) provider credentialing; (e) initial and continuing authorizations of services, if applicable; and (f) the confidentiality of data, including medical records, Member information, and adolescent appointment records, in accordance with the privacy requirements in 45 CFR parts 160 and 164, as applicable. Provider will submit copies of the Policies to Company for review upon request.

1.16 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Notwithstanding the foregoing, the following shall not constitute Proprietary Information: (a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient); (b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party; (c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives; (d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or (e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

1.17 State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the Program Participation Schedule.

1.18 Subcontracted Provider. A vision care service provider under contract with Provider to provide Covered Services to Members and who meets the requirements of the West Virginia Medicaid Program. Subcontracted Provider is also referred to as a PVCP.

2.0 PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services. Provider will make available and provide to Members through Provider's network of Subcontracted Providers those Covered Services in the service areas, as set forth in Exhibit B, Compensation Schedule, for the Plans listed on Exhibit A, Program Participation Schedule. The parties may mutually agree in a written amendment to the Agreement to modify the Covered Services made available to Members under this Agreement, subject any

required approval of the Government Sponsor.

2.2 Non-Discrimination. Provider agrees to arrange for, and require Subcontracted Providers to provide, Covered Services to Members with the same degree of care and skill as customarily provided to individuals who are not Members ("non-Members"), according to generally accepted standards of practice. Provider and Company agree that Members and non-Members should be treated equitably; to that end, Provider agrees not to discriminate against Members on the basis of race, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, color, national origin, place of residence, health status, source of payment for services, cost or extent of Covered Services required, or any other grounds prohibited by law or this Agreement. The Parties shall comply with all applicable federal and state laws relating to non-discrimination, including but not limited to: Title VI of the Civil Rights Act of 1964, (42 U.S.C. § 2000d et seq.); 45 CFR Part 80 or 7 CFR Part 15, as applicable; Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794); Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.); Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107); Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688); Food Stamp Act of 1977 (7 U.S.C. § 200 et seq.); Executive Order 11246 and its implementing regulations at 41 CFR Part 60; Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or 7 CFR Part 16; The Immigration Reform and Control Act of 1986 (8 U.S.C. § 1101 et seq.). Company and Provider may not discriminate in enrollment, delivery of health care, or any other activity against enrollees on the basis of health status, conditions of or type of enrollment in the geographic areas within the managed care initiative, or need for health care services.

2.3 Party Representations. As set forth herein, Provider represents, warrants and covenants (and shall require each Subcontracted Provider to represent, warrant and covenant) and Company represents, warrants and covenants, as applicable, the following: (a) Provider and Company have and shall maintain throughout the term of this Agreement all applicable license(s) and certification(s) mandated by governmental regulatory agencies; (b) Provider and Company are, and will remain throughout the term of this Agreement, in compliance with all applicable federal and state laws and regulations related to this Agreement and the services to be provided hereunder; (c) this Agreement has been executed by duly authorized representatives of Provider and Company; and (d) executing this Agreement and performing its obligations hereunder shall not cause Provider or Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed. Provider may not acquire any interest, direct or indirect, which would conflict or compromise in any manner or degree with the performance of its services hereunder.

2.4 Provider's Insurance. During the term of this Agreement, Provider shall procure and maintain, with respect to the activities in which Provider and its employees engage pursuant to this Agreement, such policies of general and managed care errors and omissions liability and other insurance at minimum levels required from time to time by Company, but in no event less than: (a) managed care errors and omissions liability insurance at a minimum level of \$1 million per claim, \$3 million annual aggregate; and (b) comprehensive general liability insurance at a minimum level of \$1 million per claim \$3 million annual aggregate. Such insurance coverage shall cover the acts and omissions of Provider, and each of Provider's employees. Provider agrees to deliver memorandum copies of such policies to Company upon request. Provider agrees to make

best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies. In addition to the above, Provider shall require that each Subcontracted Provider shall maintain throughout the term of a Subcontracted Provider's agreement with Provider professional liability insurance with minimum coverage requirements of \$1 million per individual episode and \$1 million in the aggregate or in such other amounts that are reasonable (but in no event less than the amounts required by applicable law) in light of those Covered Services, provided by Subcontracted Provider, to Members.

2.5 Off-Shoring of Services. In no event shall Provider, without Company's prior written approval, perform any services under the Agreement through any individual or entity (including, but not limited to, any employee, Subcontracted Provider, subcontractor, agent, representative or other individual or entity), if such individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Entity"). The parties shall comply with the requirements of Section 6505 of the PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States." No payments shall be made for services or items by Company or Provider to any entity or financial institution outside of the United States. All information obtained by Company or Provider under this Agreement must be stored and maintained within the United States.

2.6 Non-Segregated Facilities. Provider does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained. As used in this certification, the term "segregated facilities" must include any waiting rooms, restaurants and other eating areas, parking lots, drinking fountain, recreation or entertainment areas, transportation, and housing facilities provided for employees which are segregated on the basis of race, color, religion, or national origin, because of habit, local custom, national origin, or otherwise.

2.7 Reports. Providers agrees to provide Company the reports described in Exhibit E, Reports Schedule.

3.0 COMPANY OBLIGATIONS

3.1 Company shall provide Members with a means to identify themselves to Subcontracted Providers (e.g., identification cards), and a general description of products. Company shall provide Provider with a means to check eligibility, including providing Provider with eligibility files in a HIPAA-compliant electronic format by the 2nd day of each month under this Agreement, and/or in accordance with such other delivery schedule mutually agreed to by the Parties. Company will use best efforts to assure the accuracy and currency of that information.

3.2 The Parties acknowledge and agree that any agreement in which Company receives rebates, recoupments, discounts, payments, incentives, fees, free goods, bundling arrangements, or any other consideration from a subcontractor or any other third party as related to the State Contract must be in writing, and Company must allow BMS or its authorized agents to examine the

subcontract or agreement and all related records.

3.3 Company is responsible for any damages, penalties, or disallowances imposed on the Company arising from any non-compliance or non-performance related to the delivery of the Covered Services or deliverables under the State Contract by Company, its subcontractors, or agents.

3.4 Delegation. All delegated functions must have a written agreement between Company and Provider, which specifies the delegated activities and reporting responsibilities of Provider. Company may revoke the delegation or impose other remedies for inadequate performance in accordance with the terms of the delegation agreements. Company shall obtain any necessary approvals from BMS relating to the delegation. Company shall submit to BMS any delegation agreements subject to review and approval by BMS. Company shall include in any delegation agreements any applicable requirements of the State Contract that are appropriate to the services being delegated, and must assure that all delegated duties under the delegation agreement are performed to the same extent as if such were performed by Company. Any delegation shall not terminate the legal liability of Company under the State Contract, including, but not limited to Section 6 of the State Contract. Company must evaluate Provider's ability to perform the delegated activities prior to delegation, monitor the Provider's performance on an ongoing basis, and formally review performance at least annually. BMS or Company may evaluate the performance of Provider and require a corrective action if performance is not satisfactory, which may include revoking the delegation or imposing other sanctions, as set forth in the delegation agreements, if Provider's performance is inadequate and Provider is unable to cure such non-compliance within a reasonable timeframe. If Company delegates selection of providers to Provider, Company retains the right to approve, suspend, or terminate any Subcontracted Provider selected by Provider for the benefit plans administered by Company.

3.5 Site Visits and Audits.

a. An audit of Provider's services and a separate audit of Provider's credentialing services described in this Agreement are to be conducted by Company's internal audit staff or by a mutually agreeable third party/external audit firm. Audits shall not be conducted by contingency fee auditors/consultants. Audits of Provider services and Provider credentialing services are not to exceed an annual frequency with the exception of re-audits focused on validation of remediation efforts. Audits will be conducted during normal business hours, Monday through Friday, 8:30 a.m. to 5:00 p.m.

b. Company shall provide Provider with written notice sixty (60) calendar days prior to an audit commencing, unless state or federal agencies, or NCQA or URAC accreditation entities require a shorter timeframe. Company shall provide Provider with a scope letter to include all required documentation to support the requested audit within forty-five (45) calendar days of the start of the audit. All subsequent or *ad hoc* documentation requests shall require a minimum of ten (10) business days for fulfillment.

c. Results of Company's audit shall be reported to Provider, in writing, within sixty (60) calendar days of the audit's conclusion, including a corrective action plan if deficiencies are noted.

Provider shall respond to Company's audit report and, where indicated, to Company's corrective action plan within thirty (30) calendar days of receipt. The corrective action plan responses will delineate reasonable completion dates based upon risk and complexity. Company will review and provide Provider with Company's approval of the submitted corrective action plan within thirty (30) calendar days of receipt.

d. For all re-audits (tied to validation of remediation), all notification timeframes stated above apply, with the exception of shorter timeframes required by state or federal agencies, or NCQA or URAC accreditation entities.

3.6 Prohibitions on Inappropriate Physician Incentives. Company must comply with regulatory requirements regarding physician incentives as specified in 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, 42 CFR 422.210, and any additional rules regarding physician incentives released by CMS.

4.0 COMPENSATION; MEMBER BILLING

4.1 Compensation. Company shall provide Compensation to Provider for Covered Services and the administrative services delegated by Company to Provider hereunder in accordance with the terms of Exhibit B, Compensation Schedule.

4.2 Member Billing.

a. Provider agrees, and Provider will require that Subcontracted Providers agree, to bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised.

b. Provider shall require that Subcontracted Providers not charge Copayments to the following West Virginia Medicaid Members:

1. Members under age 21;
2. Pregnant women (including the 60-day postpartum period following the end of pregnancy);
3. American Indians and Alaska Natives;
4. Members who have met their household maximum limit for the cost-sharing obligations per calendar quarter;
5. Members who have met their annual maximum limit for the cost-sharing obligations.

c. Provider shall require that Subcontracted Providers not charge Copayments for the following Covered Services for West Virginia Medicaid Members:

1. Emergency services;
2. Family planning services;
3. Pregnancy-related services;

4. Services furnished to women who are receiving medical assistance on the basis of the breast or cervical cancer eligibility group;
5. Preventive services for the members under age 18;
6. Any additional members or services excluded under the State Plan authority; and
7. Services for provider-preventable conditions.

d. Emergency care providers must educate the Member of the amount of his or her Copayment for non-emergency services provided in the emergency department prior to providing non-emergency services. The emergency care provider must be required to provide a Member with the name and location of an available and accessible alternative non-emergency services provider.

e. Subcontracted Providers must reduce the amount owed by the amount of the Member's Copayment, regardless of whether the Subcontracted Provider successfully collects the Copayment. Subcontracted Providers may not routinely waive required Copayments. Subcontracted Providers shall not bill enrollees any amount greater than would be owed if Company provided the services directly, if applicable. Subcontracted Providers are prohibited from collecting Copayments for missed appointments.

4.3 **Hold Harmless.** Provider shall, and shall require Subcontracted Providers to, hold BMS or Members harmless in the event of the insolvency of Company. Provider and Company agrees to indemnify, defend, and hold harmless the State of West Virginia and BMS, its officers and employees from and against: (a) any claims or losses for services rendered by any Subcontracted Provider, person or firm performing or supplying services, materials, or supplies in connection with the performance of this Agreement; (b) any claims or losses to any person or firm injured or damaged by the erroneous or negligent acts, including without limitation, disregard of federal or state Medicaid statutes or regulations of Company, Provider, Subcontracted Providers, their officers, employees, or subcontractors in the performance of this Agreement; (c) any claims or losses resulting to any person or entity injured or damaged by Company, Provider, Subcontracted Providers, their officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data used under this Agreement in a manner not authorized by the State Contract, or by federal or state statutes or regulations; and (d) any failure of Company, Provider, Subcontracted Providers, their officers, employees, or subcontractors to observe state and federal laws, including but not limited to labor and minimum wage laws. Subcontracted Providers shall hold Members harmless for the costs of all Medicaid-Covered Services provided except for applicable Cost-Sharing obligations. Subcontracted Providers must inform Members of the costs for non-covered services prior to rendering such services.

5.0 COMPLIANCE WITH POLICIES

5.1 **Policies.** Provider agrees to comply with Policies and to provide copies of the Policies to Company upon Company's request. Provider will establish procedures and promulgate policies to safeguard the privacy of any information that identifies a particular Member by ensuring that such information may be released only to authorized individuals; to restrict access by unauthorized individuals; to release such information only in accordance with federal or state law, court orders,

or subpoenas; and to abide by all federal and state laws regarding confidentiality and disclosure such information.

5.2 Notices and Reporting. To the extent neither prohibited by law nor violative of applicable privilege, Provider agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any litigation brought against Provider or any of its employees, that is related to the provision of Covered Services and could have a material impact on the Covered Services provided to Members; (b) any investigation initiated by any government agency or program against or involving Provider or any of its employees that does or could materially impact and/or adversely affect Provider's eligibility to participate in Medicare, Medicaid or other Government Programs; and (c) any material change in services provided by Provider and Subcontracted Providers or licensure status related to such services that has a material impact on the delivery of services under this Agreement. Provider agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Provider described in this Section 5.2. Provider agrees to provide immediate notice to Company of any of the following against Provider: (a) whistleblower or qui tam actions, complaints, or litigation; (b) class-action complaints or lawsuits; (c) legal actions or governmental investigations, alleging fraud or the possibility of fraud; (d) bankruptcy proceedings or petitions where Provider is named as a debtor; and (e) criminal actions brought against Provider.

5.3 Information and Records. Provider shall, and shall require Subcontracted Providers to, to the extent applicable, maintain an appropriate record system regarding the services performed hereunder. Provider must maintain books and records relating to West Virginia's Medicaid managed care program services and expenditures, including reports to BMS and source information used in preparation of these reports, as applicable. These reports may include, but are not limited to, financial statements, records relating to quality of care, and medical records, as applicable. Provider will submit information to BMS in a manner that maintains the confidentiality of involved parties (e.g., blacking out members' and providers' names). Provider must comply with the applicable record retention requirements of 45 CFR 74.21 through 74.23. Such records, with the exception of medical records and member and provider quality assurance and quality improvement records when confidentiality is protected by law, are the property of BMS. Upon nonrenewal or termination of this Agreement, Provider must turn over or provide copies to the BMS, or to a designee of BMS, all documents, files and records relating to persons receiving services and to the administration of this Agreement that BMS may request, except patient medical records. Provider must provide at no cost to BMS or its designee, prompt, reasonable, and adequate access to any records, books, documents, papers and files that are related to performance under the Agreement.

5.4 Maintenance of Records. All records required to be maintained by this Agreement must be retained for at least (10) ten years from the date of expiration of this Agreement. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the five year period, the records must be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five year period, whichever is later.

5.5 Accreditation and Review Activities. Provider agrees to cooperate with any review of

Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or federal agency with authority over Company and/or the Plan, as applicable. Provider must provide the State of West Virginia, CMS, the Office of the Inspector General, and any other legally authorized governmental entity or their authorized representatives, the right to enter Provider's premises, physical facilities, and equipment or other places where work under this Agreement is performed to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Agreement at any time upon reasonable notice to Provider.

5.6 Proprietary Information. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party, except to governmental authorities having jurisdiction and to third party employees and contractors requiring the information and bound by the requirements of this Section. Except as otherwise required under applicable federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. This Section shall survive the termination of this Agreement, regardless of the cause of termination.

5.7 Privacy Laws. Provider shall, and shall require Subcontracted Providers to, comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et seq.*, and applicable state and federal privacy laws, must maintain the confidentiality of medical record information, and shall release the information only in accordance with applicable law.

6.0 TERM AND TERMINATION

6.1 Term. This Agreement shall be effective for an initial term of one (1) year from the Effective Date (the "Initial Term"), and thereafter shall automatically renew for subsequent additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause. This Agreement may be terminated without cause at any time by either Party upon at least ninety (90) days prior written notice to the other Party.

6.3 Termination for Breach. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period. Notwithstanding the foregoing, (a) in the event the material breach is nonpayment by Company of amounts due Provider hereunder, Provider may terminate this Agreement upon thirty (30) days prior written

notice of such termination, unless such breach is cured within thirty (30) days of the notice of termination.

6.4 Immediate Termination or Suspension. Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Provider, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any federal, state or local license, certificate, approval or authorization of Provider the loss of which has a material impact on Provider's performance of this Agreement; (b) the bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors; (c) a reasonable determination by Company that Provider's continued provision of Covered Services could result in harm to Members and that such potential harm cannot be avoided by other means, such as the termination of a Subcontracted Provider; (d) the debarment or suspension of Provider or any of Provider's Affiliates from participation in any governmental sponsored program, including, but not limited to, Government Programs, Medicaid and Medicare and, in the case an Affiliate is debarred or suspended, Provider fails to terminate such Affiliate's role in providing of services under this Agreement immediately upon learning of such fact, or (e) a requirement by the applicable Government Sponsor that this Agreement be terminated (as to such Government Program). A Government Sponsor may also require Provider participate in a corrective action plan for breaches of this Agreement by Provider. Any of the following events shall result in the immediate termination or suspension of this Agreement by Provider, upon notice to Company, at Provider's discretion at any time: (a) the withdrawal, expiration or non-renewal of any federal, state or local license, certificate, approval or authorization of Company the loss of which has a material impact on Company's performance of this Agreement; or (b) the bankruptcy or receivership of Company, or an assignment by Company for the benefit of creditors. BMS may require the replacement of any subcontractor found by BMS to be unacceptable and unable to meet the requirements of the State Contract and to object to the selection of a subcontractor.

6.5 Obligations Following Termination. Upon notice of expiration or termination of this Agreement or of a Plan, Provider shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other service vendors providing Covered Services.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status: Indemnification. The relationship between Company and Provider and any Government Sponsor, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. The parties hereby agree to indemnify and hold each other harmless, including any Affiliates, officers, employees and agents, against any loss, liability, damage, costs and expenses (including any attorneys' fees) suffered or incurred by the other in connection with any (including any threatened or proposed) third party action, suit, proceeding, regulatory proceeding, demand, assessment, judgment to the extent arising out of or related to the indemnifying party's acts and/or omissions under the terms of this Agreement. Provider also agrees to indemnify the applicable Government Sponsor for any losses to such Government Sponsor to the extent caused by Provider's services hereunder. This provision shall survive the expiration or termination of this Agreement, regard less of the reason for termination.

7.2 Use of Name. Provider consents to the use of Provider's name and other, non-trademark, identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Provider may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

8.0 MISCELLANEOUS

8.1 Amendments. Any changes, amendments, or alterations to the Agreement shall be effective only if in writing and signed by both Parties.

8.2 Waiver. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged.

8.3 Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of West Virginia.

8.4 Severability. Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement.

8.5 Successors; Assignment. This Agreement relates solely to Provider's provision of the delegated services specified herein and Provider's arrangement for the provision of Covered Services by Subcontracted Providers and does not apply to any other organization which succeeds to Provider's assets, by merger, acquisition or otherwise. Neither Party may assign its rights or delegate its duties and obligations under this Agreement, except as specifically provided herein, without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that either party may assign its rights or delegate its duties and obligations to an Affiliate so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of the other party.

8.6 Headings. The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

8.7 Notices. Unless otherwise specified herein, any notice required to be given pursuant to the terms and provisions hereof shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this section). Each Party shall notify the other Party of any changes in their respective information provided below.

to Provider at: 939 Elkridge Landing Road, Suite 200
Linthicum, MD 21090

and to Company at: 1110 Main Street
Wheeling, West Virginia 26003

8.8 Non-Exclusivity. This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Provider. Notwithstanding the foregoing, during the term of this Agreement, Company shall not contract with any vision benefits manager other than Provider to arrange or provide Covered Services to Members enrolled in the Plans and other health benefit products/programs listed on Exhibit A, Program Participation Schedule.

8.9 Force Majeure. If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This section shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

8.10 Survival. Those provisions which by their terms survive expiration or termination of this Agreement shall survive expiration or termination of this Agreement.

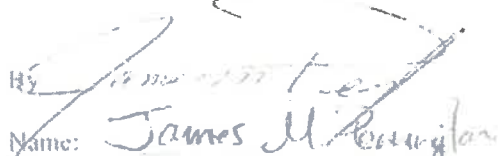
8.11 Entire Agreement. This Agreement (including any attached exhibits, addenda and schedules) constitutes the complete and sole contract between the Parties regarding the subject hereof and supersedes any and all prior or contemporaneous oral or written representations and agreements, including, without limitation, that certain Vision Care Administrative Service Agreement between the parties, effective as of January 1, 2008, communications, proposals or agreements not expressly included herein and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. There are no oral agreements between the Parties.

8.12 Counterparts. This Agreement may be executed in separate counterparts, each of which shall be deemed an original, but both of which together shall constitute one and the same instrument. This Agreement shall become binding when one or both counterparts hereof, individually or taken together, shall bear the signatures of the Parties, and shall be effective as of the Effective Date.

8.13 Incorporation of Recitals. The Parties incorporate the recitals into this Agreement as representations of fact to each other.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

The Health Plan of West Virginia, Inc.
COMPANY

By: 
Name: James M. Boufford
Title: President + CEO
Date: 8/2/18

Superior Vision Benefit Management, Inc.
PROVIDER

By: 
Name: Jonathan E. Dickrell
Title: CEO
Date: 8/2/18

Exhibits to Agreement

Exhibit A	Program Participation Schedule
Exhibit B	Compensation Schedule
Exhibit C	Service Area Schedule
Exhibit D	Covered Services Schedule
Exhibit E	Reports Schedule
Exhibit F	Delegated Claims Administration Addendum
Exhibit G	Delegated Credentialing Addendum
Exhibit H	Delegated Network Development and Management Addendum
Exhibit I	Delegated Customer Service Addendum
Exhibit J	Subcontracted Provider Agreement Requirements West Virginia Medicaid
Exhibit K	Service Level Agreements

Exhibit A

PROGRAM PARTICIPATION SCHEDULE

Provider agrees to participate in the Plans and other health benefit programs listed herein, in the Service Area described on Exhibit C, Service Area Schedule:

- Mountain Health Trust – TANF Group # 0140 (Medicaid)
- Mountain Health Trust – SSI Group # 0142 (Medicaid)
- West Virginia Health Bridge – Expansion Group # 0141 (Medicaid)

Exhibit B

COMPENSATION SCHEDULE

Provider shall provide those delegated services and those Covered Services, as set forth herein, at the rates set forth below.

1. **Covered Services.** Provider shall arrange for the provision, within the Service Area to eligible Members through Provider's network of Subcontracted Providers, those Covered Services set forth in Exhibit D, Covered Services Schedule, and that are within the scope of and appropriate to the license and certification to practice of the applicable Subcontracted Provider (the "Compensated Services").

2. **Compensation.** Company shall pay to Provider for the Compensated Services (the "~~Capitated Amount~~") in accordance with the terms of this Agreement, as listed below:

~~Capitated Amount shall be determined by the following table:~~

3. **Compensation Terms and Conditions.**

a. Company shall pay to Provider, by the 10th of each month, the Capitated Amount for each Member in the eligibility file delivered by the 2nd of the month in accordance with Section 3.1 of this Agreement. Company also agrees to pay Provider retroactively, for a period of ninety (90) days, for each Member who was eligible but not included in the eligibility data delivered by Company to Provider. Company may also offset from future payments to Provider, for a period of ninety (90) days, an amount equal to the capitation payments previously made for each Member who was determined to be ineligible but was included in the eligibility data less the Subcontractor Costs for such Member while such Member was shown in the Eligibility Data as eligible but was not eligible. Each Capitation Payment shall be accompanied by a remittance summary. The remittance summary shall identify the total Capitation Payment payable and those Members for whom the Capitation Amount is being paid pursuant to this Agreement.

b. Subcontracted Provider Claims Payment: Subject to Company's obligation to pay Provider, Provider shall be responsible, in full, for the payment of all Subcontracted Provider claims, including Subcontractor Costs. The term "Subcontractor Costs" refers to the actual amount paid by Provider directly to the Subcontracted Providers for the provision of Covered Services to Members in accordance with the terms of this Agreement. The terms of Provider's duty to pay such Subcontracted Provider claims is set forth in Exhibit F, Delegated Claims Administration Addendum.

c. Member Verification: Subject to any applicable provisions of the Plan and applicable law, Company shall electronically submit updated data files in a HIPAA compliant format of adds, changes, and deletes to Provider of all Members who are eligible for the month to receive Covered Services by the 2nd day of the month for such month. Subcontracted Providers may contact Provider to verify Member eligibility upon Member request for

services to be scheduled. Provider will use Company's monthly membership file to verify eligibility. Provider shall be entitled to conclusively rely on the most recent monthly membership file provided to it and Company shall pay for all Covered Services provided to persons shown as Members on such file, even if such information is inaccurate or out of date or the Member is retroactively disenrolled; provided, further, Company shall not retrospectively deny payment for such services.

Exhibit C

SERVICE AREA SCHEDULE

Company's Service Area for this Agreement is comprised of the following counties in West Virginia:

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

Exhibit D

COVERED SERVICES SCHEDULE

The Covered Services shall include the vision services as specifically described in Section II below, which shall be provided in accordance with the West Virginia Medicaid Programs requirements and the standards described in Section I below, as applicable, when performed by a Subcontracted Provider.

I. VISION CARE PROGRAM - ROUTINE VISION CARE SERVICE STANDARDS

A. Vision Examination Requirements:

1. Case History;
2. Visual Acuities;
3. Ocular Health;
4. Preliminaries;
5. Refraction;
6. Binocular coordination Testing; and
7. Diagnosis, Prognosis and Patient Instructions.

B. Eyewear Dispensing Standards

1. Frame size;
2. Appropriate lens material;
3. Appropriate tints, when indicated;
4. Pupillary distance;
5. Base curve of lens, when indicated;
6. Follow-up adjustments for a period of six months;
7. Verification of eyewear after fabrication (compliance with ANSI standards-Z80).

C. Contact Lens Evaluation (as applicable):

1. Additional test/procedures as required for the fitting and assessment of contact lenses.
2. A contact lens examination and fitting will include, at a minimum the following:
 - a. Keratometry or ophthalmometry;
 - b. History relating to lens wear;
 - c. Fitting or assessment of fit with slit lamp;
 - d. Visual acuities with lenses in place.
3. The Member will also receive the following:
 - a. Instruction on insertion and removal of lenses;
 - b. Appropriate care (disinfection) system and its use;
 - c. Wearing instructions;
 - d. Follow-up care as appropriate.
4. Contact Lens Standards

- a. Diagnostic evaluation prior to the time of dispensing.
- b. A sixty-day (60) clinical adaptation period will be used for all patients who are newly fitted for contact lenses.
- c. A thorough evaluation will be made of all contact lens users at each follow-up visit.
- d. All contact lens patients will have written instructions, which advise them of proper wear, hygiene and maintenance of their lenses.

II. COVERED VISION SERVICES

A. The wellness vision comprehensive eye examination and eyewear benefits described below are available to all Members up to the age of 21 and are covered in accordance with Chapter 525 - Vision Services of the West Virginia Medicaid Program Manual issued by the Bureau for Medical Services ("BMS Vision Care Services Manual"). Members up to the age of 21 years will also receive coverage for Primary Eye Care services as described below and as set forth in the BMS Vision Care Services Manual. Wellness vision services are not covered for adults age 21 and older.

B. Vision Program Coverage:

Service/Item	Schedule of Covered Services
Comprehensive Eye Examination	Covered once every 12 months, with the benefit period measured from the date of service. Eye examination(s) are based upon Early Periodic Screening, Diagnosis and Treatment (EPSDT) referral(s), American Academy of Pediatrics (AAP) and Bright Futures requirements. Additional exams covered in accordance with EPSDT and/or other applicable state guidelines.
Eyeglass Frame	Covered once every 12 months, member receives a \$70 retail allowance toward the purchase of any frame offered by a PVCP. Benefit period is measured from the date of service. Vision services for the purpose of prescribing glasses/contact lenses, fitting, adjusting and replacing glasses/contact lenses are covered. Frames must have a limited warranty.
Eyeglass Lenses	The following standard lens types are covered once every 12 months, with the benefit period measured from the date of service: - Single Vision - Bifocal – FT-25, FT-28, Round - Trifocal – 7x25 or 7x28 - Aspheric-Lenticular – Single Vision

Service/Item	Schedule of Covered Services
	or Round Bifocal Single, Bifocal, Trifocal Glass or Plastic Lens Lenses and Variable Asphericity Glass or Plastic Lens are covered. Replacement of lens is based on the following criteria: 1. Vertical prism change of 1 prism diopter or greater; 2. Horizontal prism change of 3 prism diopter or greater; 3. A change of .50 in the spherical equivalent of the Member's prescription; 4. A change of the cylinder axis of at least: 10 degrees for under 1.00D cylinder, 5 degrees for 1.00D to 2.00D cylinder or 2 1/2 degrees for 2.25D cylinder or greater; 5. Any change which gives at least 1 line improvement on the standard vision acuity chart; 6. Breakage or loss of lens; or 7. Change in specific eye conditions.
Contact Lenses	Contact lenses are covered only when determined to be necessary by the examining PVCP in accordance with the BMS Vision Care Services Manual. Contact lenses are not covered when eyeglasses can be worn. The fitting, adjusting, and dispensing of contact lenses are included in the payment of the lenses. Replacement of contact lenses is covered when the lenses can no longer be used. Contact lenses must have a limited warranty. A limited warranty must be utilized for replacement of contact lenses when the warranty is applicable and cost effective. Contact lenses (hard, soft and gas-permeable) for children are limited to the following: 1. Refractive error which is 9 diopters or greater in any meridian; 2. Keratoconus; 3. Anisometropia when the difference in power between 2 eyes is 3 diopters or greater; 4. Aniseikonia

Service/Item	Schedule of Covered Services
	5. Aphakia
Replacement Eyewear	Covered in accordance with the BMS Vision Care Services Manual. Replacement of frames is covered when the frames can no longer be used (e.g., broken) and repair costs exceed replacement costs. A limited warranty must be utilized for frame replacement/repair when the warranty is applicable and cost effective.
Non-Standard Services/Eyewear	Non-standard services and eyewear are covered in accordance with the BMS Vision Care Services Manual.
Primary Medical Optometry Services – Medical eye care services that are within the scope of an optometrist’s State license and set forth in the BMS Vision Care Services Manual. See Appendix 1 of this Exhibit D for the CPT code listing.	Covered in accordance with the applicable THP coverage guidelines and the BMS Vision Care Services Manual.
Orthoptics – Visual Training	Covered for children up to ten years of age only for treatment of strabismus and other disorder of binocular eye movements in accordance with the applicable THP coverage guidelines and the BMS Vision Care Services Manual. Therapy is limited to a total of 6 sessions per calendar year. If improvement is not noted after 4 sessions, the Member must be referred to an appropriate professional (e.g., neurologist or ophthalmologist) for further evaluation. A treatment plan is required. The therapy treatment plan and regimen, such as patching, lens fogging, red/green/Polaroid filters, other lens devices, is to be taught to the Member, family, foster parents and/or caregiver during the therapy treatments. Training is considered complete when one of the following goals is attained: 1. Subsequent services would be for maintenance of a functional ability; or 2. When the Member has demonstrated no progress at two consecutive visits.
Photochromatic Lenses	Photochromatic Lenses are limited to diagnoses of albinism and pupillary defects.

III. NON-COVERED VISION SERVICES

The following items or services are not covered services:

- A. Glasses with a prescription that is equal to or less than ± 0.25 diopters in both eyes;
- B. Contact lenses when eyeglasses can be worn;
- C. Sunglasses or tinted lenses;
- D. Safety frames and lenses;
- E. Anti-reflective lenses;
- F. Polycarbonate lenses (will be covered only when medically necessary)
- G. Tinted lenses, other than for aphakia and pseudo-aphakia, and photo-chromatic lenses/transitions;
- H. Two pairs of frames and lenses in lieu of bifocals or trifocals in a single frame;
- I. Aniseikonic lenses, blended or progressive bifocals, special occupational lenses, special coatings (i.e., hard, anti-reflective), high index lenses, oversize lenses, lamination of a lens or lenses, facets or other cosmetic grinds or polishes;
- J. Lens styles and/or eyewear not listed as a covered benefit or exceeding the stated allowances;
- K. Special mountings (other than standard plastic, standard metal or standard half-eyes);
- L. Non-prescription (plano) eyewear;
- M. Any examination or corrective eyewear required by an employer as a condition of employment;
- N. Conditions covered by Worker's Compensation;
- O. Fitting of spectacle mounted low vision aids, single element systems, telescopic or other compound lens;
- P. Designer frames;
- Q. Other optional/deluxe features;
- R. Cleaning supplies, cases, or miscellaneous items for glasses or contact lenses;
- S. Fitting, adjustment, dispensing of eyeglasses and contact lenses, measurement of the Member's anatomical facial characteristics, preparation of the prescription form, writing of laboratory specifications, ordering the prescription, adjusting the visual axes and anatomical topography, and other materials that make up the eyeglasses or contact lenses;
- T. An evaluation and management and comprehensive or intermediate eye exams on the same day for the same Member by the same provider;
- U. Determination of the refractive state as it is included in an ophthalmological examination and may not be billed as a separate service;
- V. Extra or spare pairs of glasses or contacts;
- W. Bifocals and trifocals segments over 28 mm including executive;
- X. Prosthetic eye and cataract surgery.

Appendix 1 to Exhibit D

Procedure Code List for Primary Eye Care Services

Procedure Codes	Description
92015	Determination of Refractive state (not payable in conjunction with an eye examination code)
92020	Gonioscopy
92025	Corneal Topography
92060	Sensorimotor Exam
92065	Vision Therapy
92071	Contact Lens Fitting For Treatment of Ocular Surface Disease
92072	Fitting Contact Lens For Management Of Keratoconus
92081	Visual Field Simple
92082	Visual Field Intermediate
92083	Visual Field Comprehensive
92100	Serial Tonometry
92132	Ant Segment Imaging
92133	GDX / OCT for glaucoma
92134	GDX / OCT for retina
92136	A-Scan
92140	Proacative tests for glaucoma with interpret and report(no tonography)
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report
92225	Ophthalmoscopy Extended Initial
92226	Ophthalmoscopy Extended Retinal Drawing I&r Sbs
92227	Remote retinal imaging with physician supervision/report
92228	Remote retinal imaging with physician review/report
92230	Fluorescein angiography
92235	Fluorescein angiography (multi frame)
92240	ICG
92250	Fundus Photography
92260	Ophthalmodynamometry
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes
92270	EOG
92275	Electroretinography
92283	Color Vision Test
92284	Dark Adaptation
92285	External Photography
92286	Endothelial Cell Count
92287	Ant Seg Imaging with FA

Appendix 2 to Exhibit D

Procedure Code List for Primary Eye Care Services

Other Procedures

Procedure Codes	Description
65205	Conj. FB Removal, superficial, external eye
65210	Removal FB, conjunctival, embedded (incl concretions), subconj or scleral non-perf
65220	Remove foreign body cornea w/o slit lamp
65222	foreign body cornea with slit lamp
65430	Corneal Culture
65435	Curette/treat Cornea/debride
66761	YAG Iridotomy
67820	Epilation by Forceps
68761	Punctal Plugs Temp
68801	Dilation of Puncta
68810	Probing of Nasolacrimal Duct
68840	Probing of Lacrimal Canalic.
76512	B-scan
76514	Pachymetry
76519	Echo Exam Of Eye
83861	Tear Osmolality
95060	Eye Allergy
95930	Visual Evoked Potential Test
99201	Problem Focused-Straight Forward (New Patient)
99202	Expanded Straight Forward (New Patient)
99203	Detailed-Low Complexity
99204	Comprehensive-Moderate Complexity
99205	Comprehensive-High Complexity – New 60 Minutes
99211	Office or Other outpatient exam
99212	Focused-Straight Forward (Established)
99213	Expanded-Low Complexity
99214	Detailed-Moderate Complexity
99215	Comprehensive-High Complexity (Established)

Exhibit E

REPORTS SCHEDULE

Report	Frequency	Due Date
HEDIS Report	Annually	On or before June 15
Claims Encounter Data	Monthly	Within 30 days of end of month
Provider Network Data	Monthly	Within 30 days of end of month
Provider Satisfaction Survey	Annually	Within 45 days of end of quarter (by the 15th day of the second month following the end of the reporting period)
Annual Financial Statements	Annually	On or before June 1
Recovery of Overpayments Report	Annually	On or before October 1
Fraud and Abuse Reporting	Quarterly	Within 30 days after end of quarter
Disclosure of Ownership Reporting	Annually	On or before July 1, or 35 days upon request, or 35 days upon change in ownership
Fraud and Abuse Compliance Plan	Annually	On or before October 1
Business Continuity Plan	Ad hoc	Within 10 business days of BMS written request
Disaster Recovery Plan	Ad hoc	Within 10 business days of BMS written request
Information Security Plan	Ad hoc	Within 10 business days of BMS written request
System Quality Assurance Plan	Ad hoc	Within 10 business days of BMS written request
Subcontractor Monitoring Plan	Ad hoc	Within 10 business days of BMS written request

Data Accuracy and Completeness Plan	Annually	On or before October 1
Call Statistics	Monthly	The 10 th of each month (to include all events from the prior month)
Claims Accuracy Report	Monthly	The 10 th of each month (to include all events from the prior month)
Claims Activity Report	Monthly	The 10 th of each month (to include all events from the prior month)
Complaint Log	Monthly	The 10 th of each month (to include all events from the prior month)
Utilization by Age & Type of Service	Monthly	The 10 th of each month (to include all events from the prior month)
Geo Access Report	Quarterly Annually	Within 45 days of end of quarter Within 120 days after year end
Member Satisfaction Survey	Annually	Within 120 days after year end
Appointment Wait Time Study	Annually	Within 120 days after year end

Exhibit F

DELEGATED CLAIMS ADMINISTRATION ADDENDUM

A. Description of Claims Administration Services. Provider will provide the claims administration and management services for Subcontracted Provider claims for Covered Services as described below. Provider may be referred to as "Delegated Entity" in this Addendum.

1. Procedures. Delegated Entity agrees to establish procedures to ensure consistent and accurate management of claims, to provide such procedures to Company upon request, and to follow such procedures in its management of claims under this Agreement.

2. Prompt Pay. Subject to payment of compensation described in this Agreement, Delegated Entity agrees to comply with applicable prompt pay laws and regulations and other applicable laws and regulations relating to the payment of claims in its provision of claims management services under this Agreement. With regard to claims for West Virginia Medicaid Members, -Delegated Entity must pay or deny in-network clean claims for covered services within thirty (30) calendar days of receipt of such claims, except to the extent the Subcontracted Provider has agreed to later payment in writing. Delegated Entity must pay all electronic out-of-network clean claims within thirty (30) days and all paper out-of-network clean claims within forty (40) days from the date of receipt, except to the extent the provider has agreed to later payment in writing. Delegated Entity must reduce the payment amount to Subcontracted Providers by the amount of any applicable copayments. The date of receipt is the date the Delegated Entity receives the claim, as indicated by its date stamp (including electronic date stamp) on the claim, and date of payment is the date of the check release or other form of payment release to the -Subcontracted Provider.

3. Clean Claims. A clean claim is defined as one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a Subcontracted Provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

4. Interest on Claims. To the extent Delegated Entity is required to pay interest and penalties on claims to Subcontracted Providers due to late payment of compensation by Company, Company will reimburse Delegated Entity for such interest and penalties. The Company or Delegated Entity, as applicable, must pay in-network Subcontracted Providers interest at seven percent (7%) per annum, calculated daily for the full period in which the clean claim remains unpaid beyond the thirty (30) day clean claims payment deadline. Interest owed to the Subcontracted Provider must be paid on the same date as the claim. This paragraph does not apply to payments made due to a rate change, as set forth below.

5. Rate Changes. In the case of Subcontracted Provider reimbursement that is tied to the Medicaid fee-for-service rate schedule, Delegated Entity must implement any rate changes adopted by the BMS within thirty (30) calendar days of notification of the rate change. Delegated Entity must pay the new rate for claims not yet paid with a date of service on or after the effective date of change. Delegated Entity must reprocess any claims paid between the notification date and the system load date to the

updated rate. This provision does not apply to payments made to CAHs or FQHCs/RHCs pursuant to the State Contract.

6. Education. Delegated Entity agrees to provide information to Subcontracted Providers regarding the following: (a) Proper billing forms and procedures; (b) Copayment collection; and (c) Balance billing issues.

7. Provider Preventable Conditions and Reporting. Delegated Entity agrees that no payments may be made to Subcontracted Providers for provider-preventable conditions of which Delegated Entity is aware.

8. Appeals. Delegated Entity agrees to comply and cooperate with Company's applicable appeal, grievance, and external review procedures, provide Company with the information necessary to resolve same, and abide by decisions of the applicable appeals, grievance, and review committees. Company will provide to Provider the same information pertaining Company's grievance, appeal, and fair hearing procedures as was provided to Company's Members. Delegated Entity will provide all Subcontracted Providers with such information upon entering into a provider contract with Delegated Entity.

9. Member Letters. Company will delegate the printing and mailing of the Member letters as set forth in writing from Company to Delegated Entity. Letters to Members must meet the instructions received in writing from Company, including, but not limited, the following requirements, as applicable: (1) use the Section 1557 Notice, (2) tagline, and (3) font size. To the extent applicable, Member written material from Provider must meet the requirements under 42 CFR 438.10 and the following requirements:

- a. All Member written material must be readable at the 6th grade level and easily understood, be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- b. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.
- c. The Parties must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, make available written information in each prevalent non-English language, and make oral interpretation services available. These services must be made available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.
- d. Written materials must include taglines in the prevalent non-English languages and large print (in a font size no smaller than eighteen (18) point) explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of the Company.

Exhibit G

DELEGATED CREDENTIALING ADDENDUM

A. Description of Credentialing Services. Provider will provide the credentialing and recredentialing services for Subcontracted Providers as described below. Provider may be referred to as "Delegated Entity" in this Addendum.

1. Written Policies and Procedures. Delegated Entity will establish and maintain written policies and procedures for the credentialing and triennial (as required by applicable state law and/or NCQA standards) recredentialing of Subcontracted Providers. The policies and procedures will also set forth the scope of the Credentialing and Recredentialing Program (i.e. what categories of providers are credentialed). These policies and procedures will be provided to Company on request and will be followed by Delegated Entity in its credentialing services under this Agreement.

2. Credentialing Committee. Delegated Entity agrees to establish or maintain a credentialing review process to make credentialing and recredentialing decisions for Subcontracted Providers, including a credentialing committee review process for those providers not found to be in compliance with Delegated Entity's credentialing and recredentialing criteria. This committee shall include an appropriate number of providers who are optometrists, as required by NCQA and any applicable state law or regulation.

3. Credentialing and Recredentialing Standards. Delegated Entity agrees to adopt credentialing and recredentialing criteria that complies with W. Va. C.S.R. § 114-53-6 and 42 CFR 455, Subpart B. Data supplied to the Company shall include the initial date of the credentialing decision of the Delegated Entity; if different, the initial date of provider participation at the Delegated Entity; and the last date of recredentialing at the Delegated Entity. Delegated Entity's primary verification standards shall be consistent with NCQA standards and regulatory requirements that are not inconsistent with NCQA standards. The credentialing and recredentialing criteria shall include at a minimum primary verification (including, but not limited to, verification in writing, via telephone, microfiche, or online query) of the following:

- a. Current valid license to practice in the state where Subcontracted Provider will provide Covered services to Members.
- b. Valid DEA or state narcotics certification, as applicable.
- c. Graduation from an accredited medical school and completion of an accredited residency or board certification, as applicable, for physicians, or a nationally accredited program and/or completion of appropriate clinical training or education for non-physicians.
- d. Work history.
- e. Current, adequate malpractice insurance in accordance with Delegated Entity's policy.
- f. Professional liability claims history.

4. Application Process. Delegated Entity agrees to establish or maintain a formal application process which requires that each provider complete Delegated Entity's application to become a Subcontracted Provider and/or, where applicable, a state-mandated application. Delegated Entity agrees to include an attestation by the applicant to the accuracy and completeness of the information

on the credentialing and recredentialing applications. The credentialing process must include a statement by the applicant regarding: (a) any physical or mental health problems that may affect current ability to provide health care; (b) any history of chemical dependency/substance abuse; (c) history of loss of license; (d) felony convictions as required by W. Va. C.S.R. § 114-53-6.3 and other criminal convictions as required by 42 C.F.R. 455.106; (e) history of loss or limitation of privileges or disciplinary activity; (f) history of debarment, suspension or exclusion from any federal or state healthcare programs; and (g) an attestation to correctness/completeness of the application.

5. Sanctions, Terminations, and Suspensions. Delegated Entity agrees to adopt policies and procedures, which, at a minimum comply with the applicable requirements of the Health Care Quality Improvement Act of 1986, DHHS Office of Inspector General and Office of Personnel Management standards, and any applicable state peer review law and are acceptable to Company, to reduce, suspend, or terminate the participating provider status of a Subcontracted Provider. Company retains the right to approve, suspend, or terminate providers as to the Plans. Such policies and procedures shall include a mechanism for reporting to appropriate authorities, including but not limited to the National Practitioner Data Bank and applicable state regulatory agency, serious quality deficiencies leading to suspension or termination and an appeal process for adversely affected Participating Providers. Delegated Entity agrees to notify Company within ten (10) calendar days of any report submitted pursuant to this section.

6. Termination Data. Upon termination of this Agreement, Delegated Entity agrees to provide access to applicable credentialing and recredentialing data regarding the services it has performed under this Agreement if needed by Company for a regulatory agency or NCQA audit.

7. Site Visits. Delegated Entity shall have a process to monitor and investigate Member complaints related to the quality of all practitioner office sites, the site's accessibility, or appearance, and adequacy of waiting/exam room space. In addition the following steps must be taken:

a. Delegated Entity sets reasonable thresholds for the number of complaints for physical accessibility, physical appearance, and adequacy of waiting and examining room space that must be received before conducting an office site visit, which meet NCQA standards.

b. Delegated Entity must conduct the site visit within sixty (60) days of the reasonable complaint threshold and must institute actions for improvement with sites that do not meet the thresholds. Delegated Entity will address any deficiencies, via a corrective action plan, with the office to implement such corrective actions.

c. Delegated Entity must evaluate the effectiveness of the actions at least every six months and for every subsequent complaint until sites with deficiencies meet the thresholds.

8. Delegated Entity agrees to monitor applicable state board sanction lists, DHHS Office of Inspector General Sanction Lists and the Excluded Parties List Systems Lists within thirty (30) days of their publication.

9. During the recredentialing process, Provider must consider performance indicators such as those collected through the quality assurance and performance improvement program, the utilization management system, the grievance system, enrollee satisfaction surveys, enrollee complaints, and other activities of Provider.

10. Provider Participation and Enrollment Requirements. West Virginia Medicaid recognizes enrolled ophthalmologists, optometrists, opticians, ocularists, and vision service centers as eligible providers for covered vision services in accordance with their license and scope of practice to enrolled Medicaid members. To be eligible for participation and reimbursement of covered vision services, all providers must: (a) meet all applicable licensing, accreditation and certification requirements; (b) have a valid signed provider enrollment application/agreement on file; (c) meet and maintain all BMS provider enrollment requirements; and (d) independent vision centers must also meet state and local business rules and regulations.

Exhibit H

DELEGATED NETWORK DEVELOPMENT AND MANAGEMENT ADDENDUM

A. Description of Network Development and Management Services. Provider will provide the network development and management services as described below. Provider may be referred to as "Delegated Entity" in this Addendum.

1. Procedures. Delegated Entity agrees to establish procedures to ensure consistent and accurate management of network development and management services and to provide copies to Company upon request. Provider will follow these procedures in its services under this Addendum.

2. Education. Delegated Entity agrees to provide education to network development and management staff regarding provider relations procedures.

3. Network Adequacy. Delegated Entity shall arrange for PVCs to provide Covered Services to Members as necessary to achieve the geographic access standards under the State Contract. Delegated Entity shall ensure that its network of PVCs remains adequate to provide Covered Services to Members. Delegated Entity shall administer such PVC network on an ongoing basis and may modify its arrangements with PVCs in its discretion from time to time.

4. Subcontracted Provider Information. Provider shall provide to Company a complete list of Subcontracted Providers, including any unique names, office addresses, telephone and facsimile numbers. Provider shall notify Company in writing, in accordance with a mutually agreed upon delivery schedule, of any changes to this information including, but not limited to, any additional Subcontracted Providers that joined Provider's provider network.

5. Subcontracted Provider Agreements. Provider agrees to require that Subcontracted Providers comply with the requirements of Exhibit J to this Agreement. Company will obtain all necessary approvals from BMS for Provider's template provider contracts and substantive modifications thereto developed in connection with this Agreement.

6. Selection of Providers. Company shall be entitled to prohibit individual PVCs from providing Covered Services to Members by providing Delegated Entity with written notice, provided, however, that this provision shall not be construed to obligate Delegated Entity to contract with or to make use of any particular vision care professional. Delegated Entity may continue to include such providers in its networks with other health plans.

7. Provider Relations. Delegated Entity's provider relations representatives will serve as liaisons with PVCs to resolve inquiries from PVCs.

8. Participating Vision Care Providers' Compliance. Delegated Entity shall require that all PVCs comply with applicable BMS requirements.

9. Availability of Covered Services. Delegated Entity shall require that PVCPs satisfy the following standards regarding Covered Services:

- a. Waiting time for appointments for Covered Services which are routine vision services shall not exceed two (2) weeks;
- b. Urgent Covered Services, including primary eye care services, shall be made available to a Member within 48 hours of the time such services are requested, or such shorter period of time as PVCP determines is clinically indicated.
- c. Compliance with the above requirements shall be deemed satisfied if an appointment with a geographically appropriate PVCP is offered as available to a Member within the time period specified, regardless of the Member's preference or availability for appointment times.

10. Communications. Delegated Entity shall develop and distribute to PVCPs materials regarding Delegated Entity's administration of Covered Services to be provided to eligible Members, and shall provide copies of same to Company upon request. Delegated Entity shall be responsible for inquiries from PVCPs pertaining to Member eligibility.

Exhibit I

DELEGATED CUSTOMER SERVICE ADDENDUM

A. Description of Call Center Services. Provider will provide the call center services related to its arrangement for the provision of customer services as described below. Provider may be referred to as “Delegated Entity” in this Addendum.

1. Procedures. Delegated Entity agrees to establish procedures to ensure consistent and accurate management of call center services and to provide copies to Company upon request. Provider will follow these procedures in its services under this Addendum.

2. Education. Delegated Entity agrees to provide education to call center staff regarding proper call procedures.

3. Toll Free Number. Delegated Entity shall establish and maintain customer call centers where Members can call a toll-free number with customer service questions between the hours of 8:00 am and 6:00 EST pm Monday through Friday, except holidays.

4. Ability to Observe Service. Delegated Entity will provide the capability to record and monitor live calls to ensure compliance with this Agreement and to identify training opportunities.

5. Performance Requirements. The call center services must meet the following minimum performance requirements:

a. Eighty-three percent (83%) of calls are answered live within thirty (30) seconds during operating hours. Time measured begins when the Member is placed in the call queue to wait to speak to a customer services representative; and

b. The call abandonment rate shall not exceed five percent (5%) of total calls for the monthly reporting period.

6. Provider will notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services, if applicable. The enrollee must be informed that the information is available in paper form without charge upon request and must be provided with the information within five business days. Electronic information must be placed on a website that is prominent and readily accessible. It must be provided in an electronic form which can be electronically retained and printed.

Exhibit J

SUBCONTRACTED PROVIDER AGREEMENT REQUIREMENTS WEST VIRGINIA MEDICAID

In addition to certain terms contained within the Agreement, the following provisions are applicable to Subcontracted Providers that provide services to West Virginia Medicaid recipients and shall appear in the provider agreements between Subcontracted Providers and Provider ("Provider Agreement"). In the event of a conflict between this Exhibit and the Agreement, this Exhibit shall control.

1. The Provider Agreements must abide by all federal regulations.
2. Payment Terms. Provider Agreements must provide a complete description of the payment method or payment amounts applicable to a Subcontracted Provider. The Provider Agreements or provider manual must explain how to submit a clean claim, including a complete listing of all required information, such as claims coding and processing guidelines for the applicable provider type. Provider must pay in-network Subcontracted Providers within thirty (30) days of clean claims receipt. BMS is not liable or responsible for payment for Covered Services rendered pursuant to the Provider Agreement.
3. Termination Rights. The Provider Agreement must contain a clear definition of each party's termination rights.
4. Disclosure of Ownership. Subcontracted Provider must disclose information on ownership and control, and information on interlocking relationships per 42 CFR 104(b)(3). Ownership shall be defined per 42 CFR 455.101. A Subcontracted Provider that is a business entity, corporation, or a partnership must disclose the name, date of birth, Social Security number, and address of each person who is a director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the Subcontracted Provider. The address for corporate entities must include as applicable: primary business address, every business location, P.O. Box address, and tax ID. The Subcontracted Provider must keep information current at all times by informing Provider in writing within thirty-five (35) days of any changes to such ownership and control information.
5. Significant Transactions. Subcontracted Provider must disclose the following information related to business transactions within thirty-five (35) days of request of the Secretary of DHHS or BMS: full and complete information about (1) the ownership of any subcontractor with whom the Subcontracted Provider has had business transactions totaling more than \$25,000 during the previous 12-month period, and (2) any significant business transactions between the Subcontracted Provider and any wholly owned supplier, or between the Subcontracted Provider and any subcontractor, during the previous five years.
6. Healthcare Related Criminal Convictions. Subcontracted Provider, or its director, officer, principal, partner, agent, managing employee, or other person with ownership or control interest of five percent or more in the Subcontracted Provider, must disclose information on criminal convictions

related to Medicare, Medicaid, or Title XX programs. Subcontracted Providers must notify Provider immediately if the Subcontracted Provider receives notice of such conviction. The definition of "convicted" per 42 CFR 1001.2 must be included in the Provider Agreement.

7. Exclusion from Federal Healthcare Programs. Subcontracted Providers shall certify that the provider, provider's director, officer, principal, partner, managing employee, or other person with ownership or control interest of five percent or more in the Subcontracted Provider have not been excluded, suspended, debarred, revoked, or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal agreement, as well as any other state or federal health-care program. Subcontracted Providers shall notify Provider immediately if it receives notice that any action is being taken against a Subcontracted Provider or any person above as defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 USC § 1320a-7), which could result in exclusion from the Medicaid program. Subcontracted Providers must fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.

8. Provider-Preventable Conditions. Subcontracted Providers to report to the Provider provider-preventable conditions associated with claims. No payment will be made by Provider to a Subcontracted Provider for provider-preventable conditions, as identified in the State Contract, if applicable. Subcontracted Providers shall comply with the reporting requirements of 42 CFR § 447.26(d) as a condition of payment from Provider, if applicable.

9. Direct Marketing Prohibited. In accordance with 42 CFR 438.104, Subcontracted Providers shall not engage in direct marketing to enrollees that is designed to increase enrollment in a particular MCO. This prohibition should not constrain Subcontracted Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

10. If a Subcontracted Provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), the Subcontracted Provider must comply with Section 6032 of the Deficit Reduction Act of 2005.

11. Liens Prohibited. Subcontracted Providers may not interfere with or place any liens upon the State's or Provider's or Company's right, acting as the State's agent, to recovery from third party resources.

12. Advance Directives. Subcontracted Providers shall comply with 42 CFR 422.128 and West Virginia Health Care Decisions Act relating to advance directives.

13. Complaints and Appeals. The Provider Agreements shall contain a description of Company's provider complaint and appeal processes.

14. Overpayments. The Provider Agreements will contain requirements for provider reporting and return of overpayments.

15. Certification. Subcontracted Providers shall attest to a certification for claims for Medicaid goods and services, which should include the following information: that all statements are true, accurate, and complete; no material fact has been omitted; all services will be medically necessary to the health of the specific patient; and understanding that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.

Exhibit K

SERVICE LEVEL AGREEMENTS

The responsibilities and requirements in the State Contract are subject to performance evaluation by BMS. Any and all responsibilities or requirements not fulfilled may have remedies, and BMS may assess remedies, including actual or liquidated damages. This Exhibit outlines performance standards that carry liquidated damage values. Provider shall be liable for such damages only to the extent that Provider is solely responsible for the underlying non-compliance. Company shall provide Provider with notice of any such non-compliance and an opportunity to cure such non-compliance, where applicable, before any sanctions are imposed on Provider.

No.	Program Non-Performance	Measurement Period	Liquidated Damages
1	Failure to submit required reports, information requests, documentation, ad hoc reports, data certification forms, or any other data required within the timeframes provided by this Contract or by BMS. The MCO may have a one business day grace period following the due date of the data, report, or form.	Ongoing	\$250 per day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements. After three (3) instances of non-performance during the Contract period, the amount is increased by \$1,000 per day per each item that is overdue.
2	Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner.	Monthly	\$1,000 per single encounter file per reporting period.
3	Failure to meet a 95% encounter acceptance rate as required by the State Contract.	Monthly	\$100 per each rejected encounter below the 95% acceptance rate threshold
4	Failure to resolve at least 98% of member appeals within 45 calendar days from the date the appeal is filed with the Company, unless an enrollee requests an extension or the Company shows that a delay is necessary and in the interest of the enrollee, if applicable.	Quarterly	Not applicable – Provider is not delegated for appeals
5	Failure to notify affected members of program or service site changes, at least 14 calendar days before the	Ongoing	\$250 per each incident per affected member.

No.	Program Non-Performance	Measurement Period	Liquidated Damages
	intended effective date of the change.		
6	Failure to report timely to BMS significant network changes.	Ongoing	\$500 per incident of non-compliance.
7	Failure to meet provider credentialing requirements, including background screening requirements.	Ongoing	\$500 per incident of non-compliance.
8	Failure to comply with the marketing requirements, or engagement in prohibited marketing practices, if applicable. Failure to meet all social media marketing requirements, or engagement in any prohibited social media practices, if applicable.	Ongoing	Not applicable – Provider is not delegated for marketing
9	Failure to pay 7% annual interest on the same date as an in-network clean claim that remained unpaid beyond the 30-day claims payment deadline.	Quarterly	\$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim's payment.
10	Failure to provide timely MCO covered services when, in the determination of BMS, such failure results in actual harm to a member or places a member at risk of imminent harm.	Ongoing	\$7,500 per day for each incident of non-compliance
11	Failure to provide timely service authorization (prior authorization) as described in the State Contract, if applicable. Failure to honor service authorization as described in the State Contract, if applicable.	Ongoing	\$5,000 per incident of non-compliance
12	Failure to administer member copayments, including charging excess copayments for covered services.	Ongoing	\$100 per each copay incident imposed in error.
13	Failure to hold or improperly release funds subject to a credible allegation of fraud payment hold, as applicable.	Ongoing	Amount held or released improperly

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Appendix

GLOSSARY OF TERMS

The Health Plan Glossary of Terms

Acronym	Definition
THP	The Health Plan
COMET	Care Organization Management Evaluation Tool
HEART	Health Plan Enterprise Adjudication Research Tool
Drop Box	THP System repository
CAP	Corrective action plan
APM	Alternative Payment Model
JOC	Joint Operating Committee
MDT	Multidisciplinary Team
CQI	Continuous Quality Improvement Committee
EMT	Executive Management Team
NAS	Neonatal Abstinence Syndrome
DOJ	Department of Justice
MDOC	Medical Director's Oversight Committee
PAC	Clinical Analytics, Population Health, the Physician Advisory Committee
SIU	Special Investigation Unit
P&T	Pharmacy & Therapeutic Committee
QIC	Quality Improvement Committee
QIP	Quality Improvement Programs
QAPI	Quality Assurance and Performance Improvement

6

Appendix

NETWORK ANALYSIS

Foster Care Membership

Managed Care Accessibility Analysis

August 08, 2019

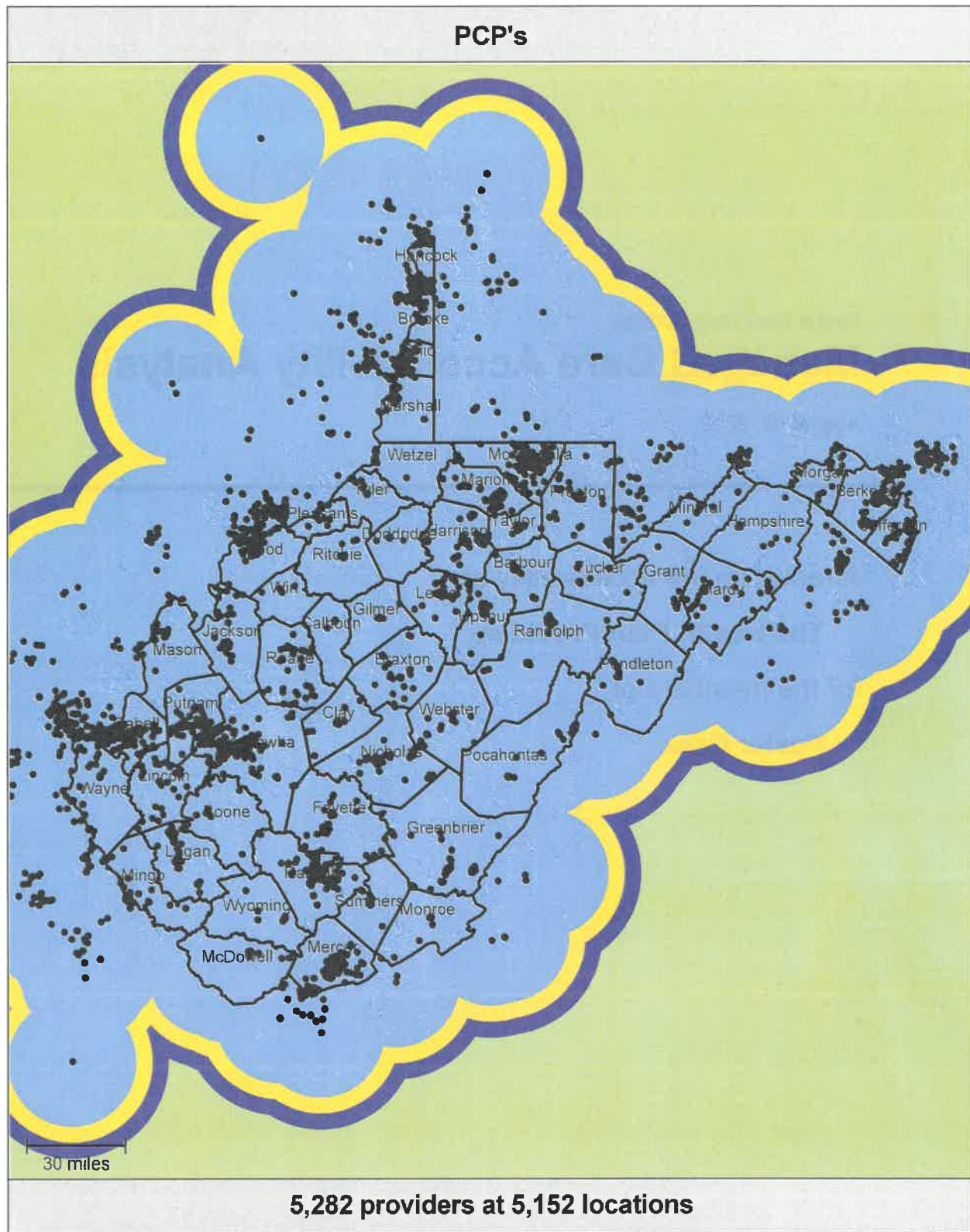
A report on the accessibility of

The Health Plan Providers

for the members of

Foster Care

Provider locations



- Single provider locations (5,138)
- Multiple provider locations (14)

- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	27	0.3	100.0	100.0	100.0
BERKELEY	694	118	2.2	100.0	100.0	100.0
BOONE	300	59	0.0	100.0	100.0	100.0
BRAXTON	201	29	1.1	100.0	100.0	100.0
BROOKE	56	17	1.6	100.0	100.0	100.0
CABELL	1,048	360	0.3	100.0	100.0	100.0
CALHOUN	171	17	0.0	100.0	100.0	100.0
CLAY	241	25	0.0	100.0	100.0	100.0
DODDRIDGE	37	16	1.0	100.0	100.0	100.0
FAYETTE	580	130	0.6	100.0	100.0	100.0
GILMER	70	11	0.0	100.0	100.0	100.0
GRANT	146	20	0.6	100.0	100.0	100.0
GREENBRIER	340	101	0.1	100.0	100.0	100.0
HAMPSHIRE	255	31	0.1	100.0	100.0	100.0
HANCOCK	392	60	2.9	100.0	100.0	100.0
HARDY	101	43	0.7	100.0	100.0	100.0
HARRISON	550	139	0.6	100.0	100.0	100.0
JACKSON	480	99	0.0	100.0	100.0	100.0
JEFFERSON	226	60	1.6	100.0	100.0	100.0
KANAWHA	1,619	500	0.0	100.0	100.0	100.0
LEWIS	126	50	0.8	100.0	100.0	100.0
LINCOLN	348	96	0.0	100.0	100.0	100.0
LOGAN	414	117	0.0	100.0	100.0	100.0
MARION	155	149	0.2	100.0	100.0	100.0
MARSHALL	165	36	0.6	100.0	100.0	100.0
MASON	939	33	0.2	100.0	100.0	100.0
MCDOWELL	507	47	0.3	100.0	100.0	100.0
MERCER	151	114	0.7	100.0	100.0	100.0
MINERAL	421	26	0.5	100.0	100.0	100.0
MINGO	417	72	0.7	100.0	100.0	100.0
MONONGALIA	117	400	0.2	100.0	100.0	100.0
MONROE	68	19	0.5	100.0	100.0	100.0
MORGAN	281	18	1.8	100.0	100.0	100.0
NICHOLAS	447	91	0.0	100.0	100.0	100.0
OHIO	366	103	0.4	100.0	100.0	100.0
PENDLETON	26	29	0.0	100.0	100.0	100.0
PLEASANTS	39	13	1.4	100.0	100.0	100.0
POCAHONTAS	88	18	1.4	100.0	100.0	100.0
PRESTON	342	67	0.2	100.0	100.0	100.0

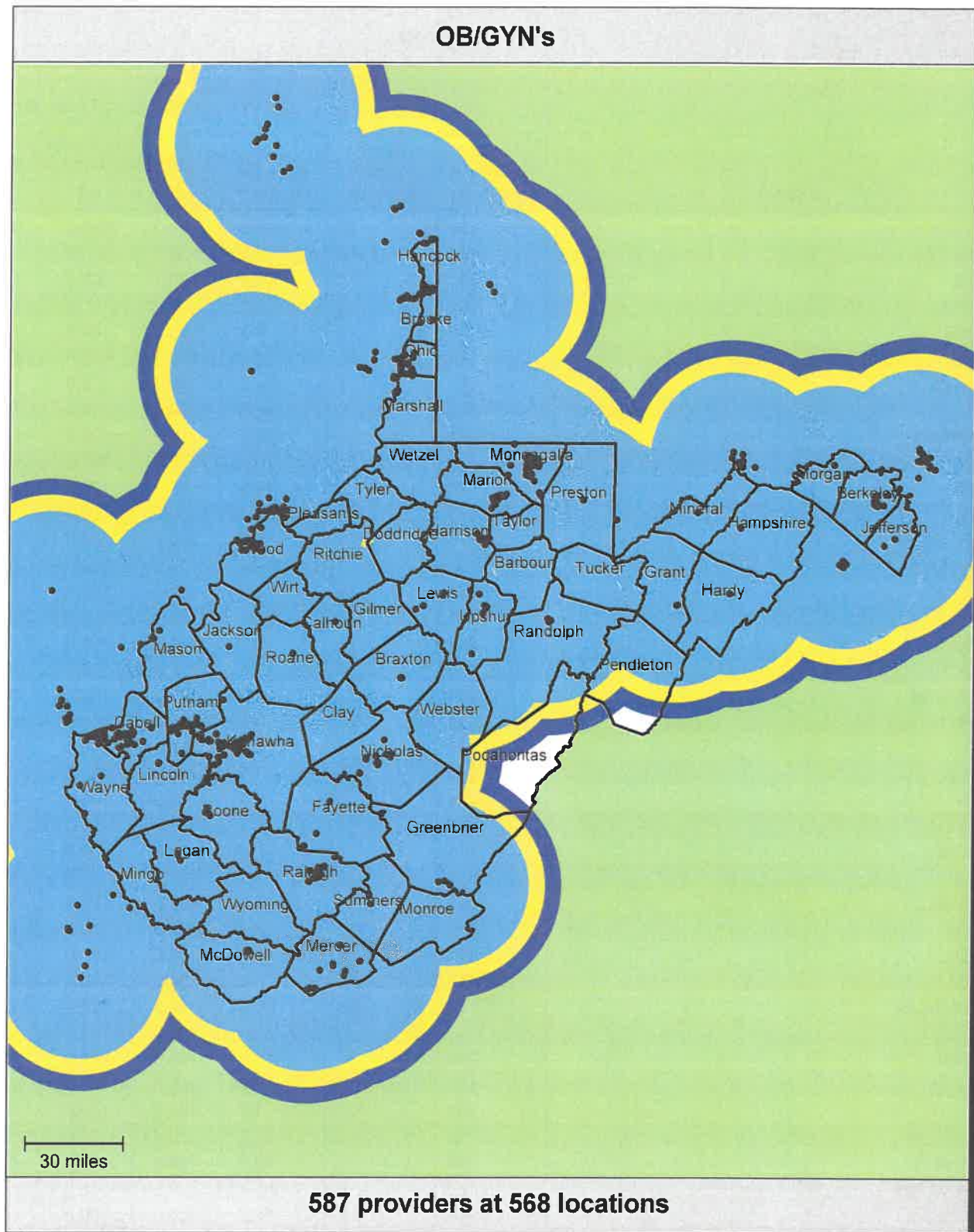
Provider group: PCP's

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	135	1.0	100.0	100.0	100.0
RALEIGH	984	146	0.3	100.0	100.0	100.0
RANDOLPH	412	76	0.3	100.0	100.0	100.0
RITCHIE	151	8	0.6	100.0	100.0	100.0
ROANE	242	36	1.0	100.0	100.0	100.0
SUMMERS	116	27	0.5	100.0	100.0	100.0
TAYLOR	301	25	0.4	100.0	100.0	100.0
TUCKER	52	15	1.3	100.0	100.0	100.0
TYLER	26	14	0.2	100.0	100.0	100.0
UPSHUR	245	62	0.4	100.0	100.0	100.0
WAYNE	522	50	0.1	100.0	100.0	100.0
WEBSTER	168	50	0.3	100.0	100.0	100.0
WETZEL	116	33	0.1	100.0	100.0	100.0
WIRT	63	18	0.0	100.0	100.0	100.0
WOOD	851	108	0.5	100.0	100.0	100.0
WYOMING	403	37	0.0	100.0	100.0	100.0
TOTALS	18,348	4,200	0.5	100.0	100.0	100.0

Provider group: PCP's

Provider locations



- Single provider locations (565)
- Multiple provider locations (3)

- 25 mile radius
- 30 mile radius
- 35 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				25	30	35
BARBOUR	281	0	16.5	100.0	100.0	100.0
BERKELEY	694	28	3.3	100.0	100.0	100.0
BOONE	300	11	0.4	100.0	100.0	100.0
BRAXTON	201	2	4.2	100.0	100.0	100.0
BROOKE	56	2	4.3	100.0	100.0	100.0
CABELL	1,048	59	1.4	100.0	100.0	100.0
CALHOUN	171	1	21.2	100.0	100.0	100.0
CLAY	241	0	18.5	100.0	100.0	100.0
DODDRIDGE	37	0	26.7	18.9	100.0	100.0
FAYETTE	580	3	10.8	100.0	100.0	100.0
GILMER	70	0	14.9	100.0	100.0	100.0
GRANT	146	2	1.3	100.0	100.0	100.0
GREENBRIER	340	3	5.8	100.0	100.0	100.0
HAMPSHIRE	255	2	0.4	100.0	100.0	100.0
HANCOCK	392	15	4.9	100.0	100.0	100.0
HARDY	101	1	10.0	100.0	100.0	100.0
HARRISON	550	11	5.5	100.0	100.0	100.0
JACKSON	480	1	17.6	100.0	100.0	100.0
JEFFERSON	226	2	5.6	100.0	100.0	100.0
KANAWHA	1,619	72	0.0	100.0	100.0	100.0
LEWIS	126	4	2.7	100.0	100.0	100.0
LINCOLN	348	2	1.8	100.0	100.0	100.0
LOGAN	414	3	2.1	100.0	100.0	100.0
MARION	155	15	1.3	100.0	100.0	100.0
MARSHALL	165	3	2.9	100.0	100.0	100.0
MASON	939	3	3.5	100.0	100.0	100.0
MCDOWELL	507	5	0.9	100.0	100.0	100.0
MERCER	151	10	3.4	100.0	100.0	100.0
MINERAL	421	1	17.3	100.0	100.0	100.0
MINGO	417	0	6.6	100.0	100.0	100.0
MONONGALIA	117	58	0.6	100.0	100.0	100.0
MONROE	68	0	15.4	100.0	100.0	100.0
MORGAN	281	1	18.9	100.0	100.0	100.0
NICHOLAS	447	12	1.9	100.0	100.0	100.0
OHIO	366	21	1.2	100.0	100.0	100.0
PENDLETON	26	0	32.2	0.0	0.0	100.0
PLEASANTS	39	0	12.6	100.0	100.0	100.0
POCAHONTAS	88	0	40.4	0.0	0.0	9.1
PRESTON	342	1	12.2	100.0	100.0	100.0

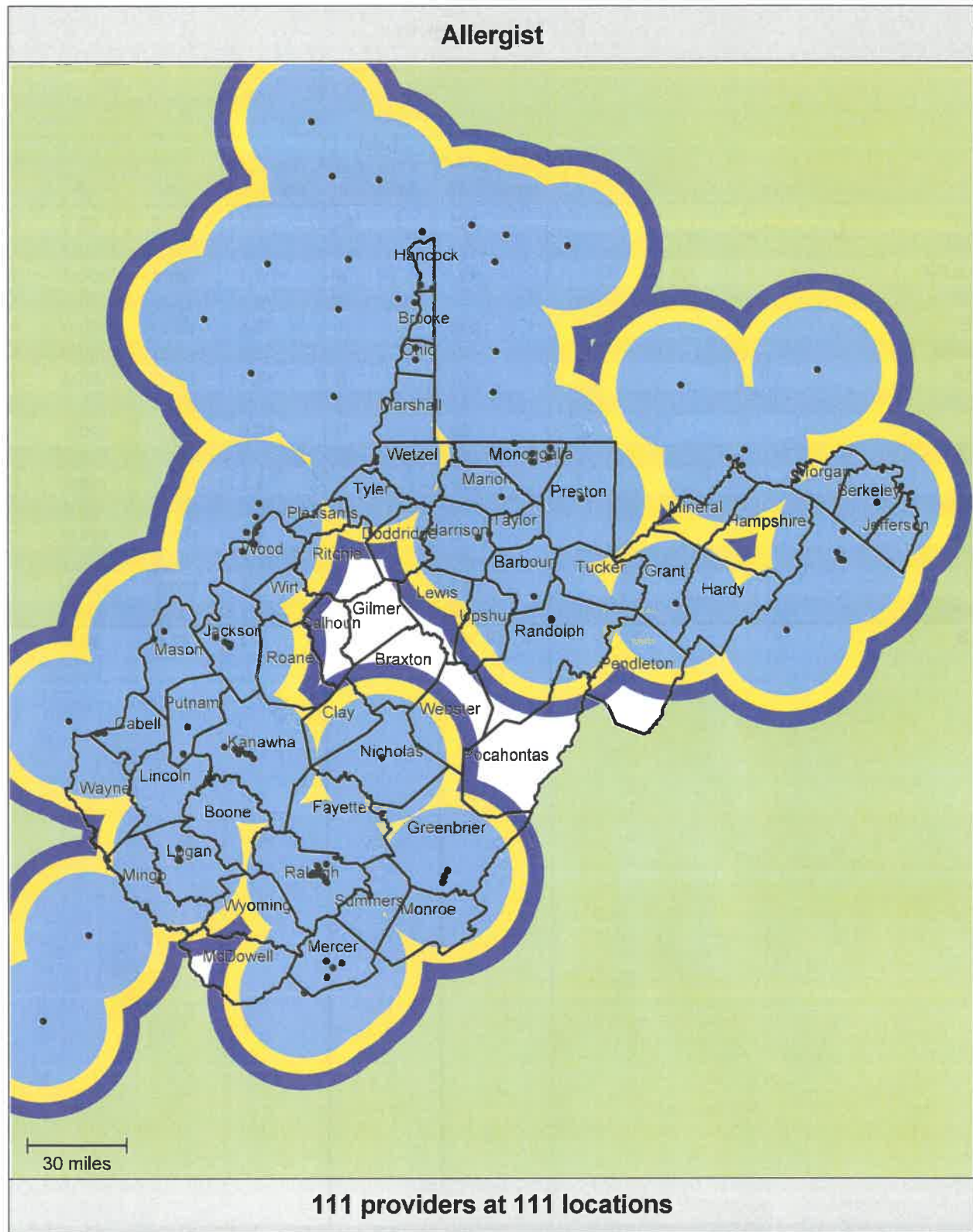
Provider group: OB/GYN's

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				25	30	35
PUTNAM	491	44	3.1	100.0	100.0	100.0
RALEIGH	984	13	1.8	100.0	100.0	100.0
RANDOLPH	412	4	1.1	100.0	100.0	100.0
RITCHIE	151	0	26.3	0.0	100.0	100.0
ROANE	242	1	19.1	100.0	100.0	100.0
SUMMERS	116	1	20.0	100.0	100.0	100.0
TAYLOR	301	0	13.1	100.0	100.0	100.0
TUCKER	52	0	20.2	100.0	100.0	100.0
TYLER	26	0	13.0	100.0	100.0	100.0
UPSHUR	245	10	1.3	100.0	100.0	100.0
WAYNE	522	5	9.1	100.0	100.0	100.0
WEBSTER	168	0	25.8	37.5	87.5	100.0
WETZEL	116	2	1.2	100.0	100.0	100.0
WIRT	63	0	19.0	100.0	100.0	100.0
WOOD	851	12	1.4	100.0	100.0	100.0
WYOMING	403	0	13.1	100.0	100.0	100.0
TOTALS	18,348	446	6.2	97.8	99.3	99.6

Provider group: OB/GYN's

Provider locations



● Provider locations (111)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	1	17.9	92.2	100.0	100.0
BERKELEY	694	1	19.0	55.2	96.8	100.0
BOONE	300	0	21.7	0.0	100.0	100.0
BRAXTON	201	0	55.2	0.0	0.0	0.0
BROOKE	56	0	9.7	100.0	100.0	100.0
CABELL	1,048	2	5.7	100.0	100.0	100.0
CALHOUN	171	0	37.4	0.0	0.0	0.0
CLAY	241	0	33.9	0.0	0.0	0.0
DODDRIDGE	37	0	27.3	0.0	0.0	100.0
FAYETTE	580	0	19.8	71.9	100.0	100.0
GILMER	70	0	47.1	0.0	0.0	0.0
GRANT	146	1	39.1	0.0	0.0	0.0
GREENBRIER	340	4	3.6	100.0	100.0	100.0
HAMPSHIRE	255	0	24.2	0.0	100.0	100.0
HANCOCK	392	2	9.0	100.0	100.0	100.0
HARDY	101	0	33.5	0.0	0.0	0.0
HARRISON	550	2	9.3	100.0	100.0	100.0
JACKSON	480	6	1.9	100.0	100.0	100.0
JEFFERSON	226	0	18.1	92.0	100.0	100.0
KANAWHA	1,619	9	1.5	100.0	100.0	100.0
LEWIS	126	0	28.7	0.0	7.9	84.9
LINCOLN	348	0	18.0	100.0	100.0	100.0
LOGAN	414	5	1.7	100.0	100.0	100.0
MARION	155	1	13.3	100.0	100.0	100.0
MARSHALL	165	0	19.3	95.2	100.0	100.0
MASON	939	2	4.8	100.0	100.0	100.0
MCDOWELL	507	0	26.4	0.0	12.6	100.0
MERCER	151	4	4.5	100.0	100.0	100.0
MINERAL	421	0	27.5	0.0	3.8	92.6
MINGO	417	0	23.9	5.8	88.2	100.0
MONONGALIA	117	6	1.8	100.0	100.0	100.0
MONROE	68	0	14.4	100.0	100.0	100.0
MORGAN	281	0	20.8	40.2	94.3	100.0
NICHOLAS	447	1	39.5	0.0	0.0	0.0
OHIO	366	2	8.4	100.0	100.0	100.0
PENDLETON	26	0	41.1	0.0	0.0	0.0
PLEASANTS	39	0	21.4	15.4	100.0	100.0
POCAHONTAS	88	0	43.3	0.0	0.0	0.0
PRESTON	342	1	19.2	53.8	100.0	100.0

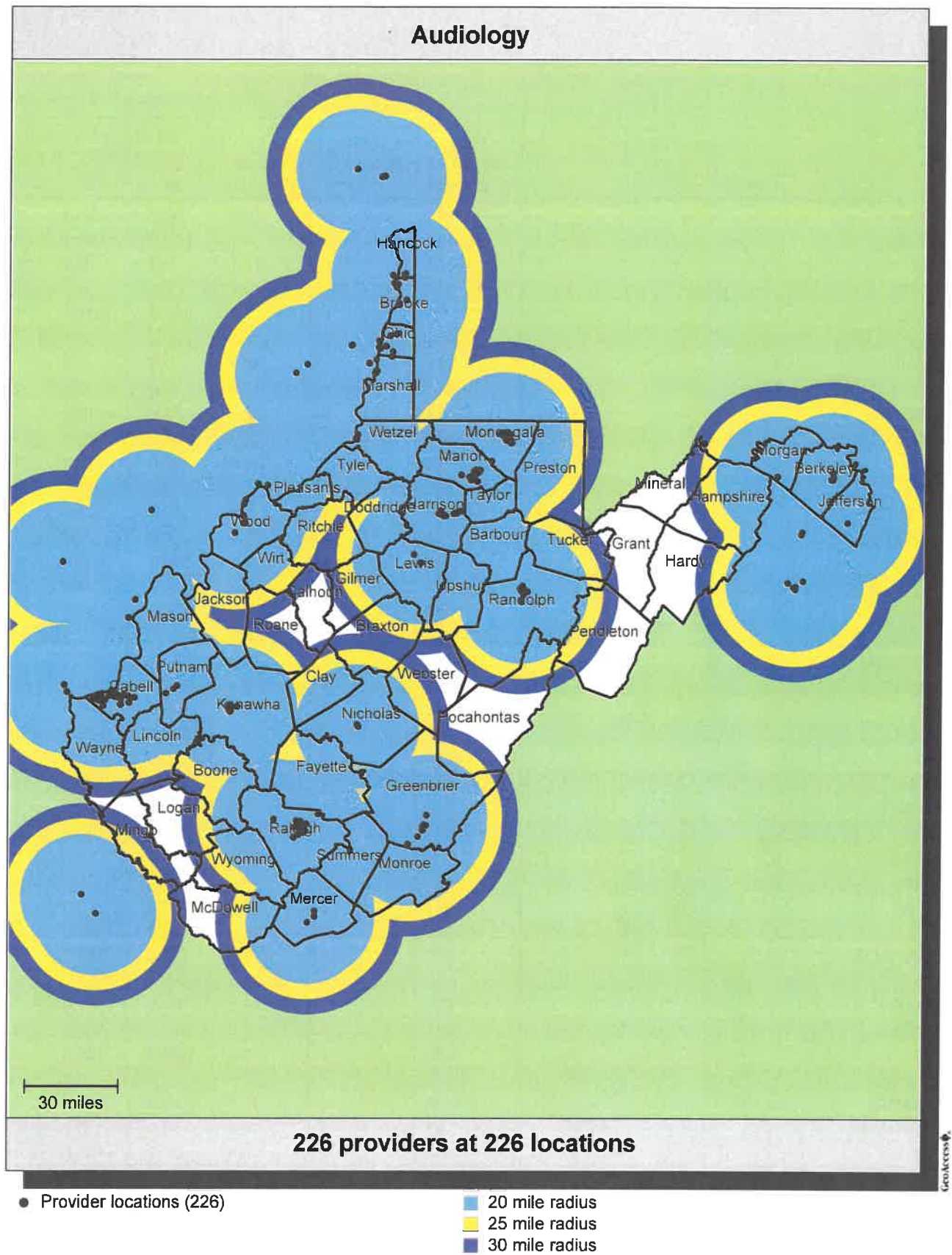
Provider group: Allergist

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	2	15.4	100.0	100.0	100.0
RALEIGH	984	10	2.1	100.0	100.0	100.0
RANDOLPH	412	2	1.2	100.0	100.0	100.0
RITCHIE	151	0	30.6	0.0	0.0	16.6
ROANE	242	0	21.8	39.3	78.1	100.0
SUMMERS	116	0	18.5	67.2	100.0	100.0
TAYLOR	301	0	14.5	100.0	100.0	100.0
TUCKER	52	0	19.8	76.9	100.0	100.0
TYLER	26	0	13.4	100.0	100.0	100.0
UPSHUR	245	0	22.1	5.7	97.1	100.0
WAYNE	522	0	14.1	100.0	100.0	100.0
WEBSTER	168	0	47.8	0.0	0.0	0.0
WETZEL	116	2	2.0	100.0	100.0	100.0
WIRT	63	0	21.4	23.8	100.0	100.0
WOOD	851	5	2.8	100.0	100.0	100.0
WYOMING	403	0	27.6	0.0	0.0	100.0
TOTALS	18,348	71	14.4	69.4	81.7	90.0

Provider group: Allergist

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	18.3	92.2	100.0	100.0
BERKELEY	694	4	4.6	100.0	100.0	100.0
BOONE	300	0	27.1	0.0	0.0	100.0
BRAXTON	201	0	30.1	0.0	8.0	30.8
BROOKE	56	4	1.7	100.0	100.0	100.0
CABELL	1,048	30	1.3	100.0	100.0	100.0
CALHOUN	171	0	38.9	0.0	0.0	0.0
CLAY	241	0	23.2	0.0	100.0	100.0
DODDRIDGE	37	0	22.3	18.9	100.0	100.0
FAYETTE	580	0	19.6	86.6	100.0	100.0
GILMER	70	0	25.3	0.0	40.0	100.0
GRANT	146	0	41.4	0.0	0.0	0.0
GREENBRIER	340	12	0.9	100.0	100.0	100.0
HAMPSHIRE	255	0	38.6	0.0	0.0	0.0
HANCOCK	392	3	8.4	100.0	100.0	100.0
HARDY	101	0	45.0	0.0	0.0	0.0
HARRISON	550	13	1.2	100.0	100.0	100.0
JACKSON	480	0	29.2	0.0	0.0	77.7
JEFFERSON	226	1	15.9	97.8	100.0	100.0
KANAWHA	1,619	10	5.5	100.0	100.0	100.0
LEWIS	126	2	6.3	100.0	100.0	100.0
LINCOLN	348	0	14.0	100.0	100.0	100.0
LOGAN	414	0	40.3	0.0	0.0	0.0
MARION	155	16	1.5	100.0	100.0	100.0
MARSHALL	165	3	3.0	100.0	100.0	100.0
MASON	939	0	12.5	100.0	100.0	100.0
MCDOWELL	507	0	27.3	0.0	12.6	100.0
MERCER	151	3	4.6	100.0	100.0	100.0
MINERAL	421	0	53.5	0.0	0.0	0.0
MINGO	417	0	27.2	0.0	0.0	94.2
MONONGALIA	117	38	0.5	100.0	100.0	100.0
MONROE	68	0	14.1	100.0	100.0	100.0
MORGAN	281	1	19.5	51.6	100.0	100.0
NICHOLAS	447	2	4.2	100.0	100.0	100.0
OHIO	366	7	2.2	100.0	100.0	100.0
PENDLETON	26	0	39.4	0.0	0.0	0.0
PLEASANTS	39	0	17.1	84.6	100.0	100.0
POCAHONTAS	88	0	41.2	0.0	0.0	0.0
PRESTON	342	0	19.9	26.9	100.0	100.0

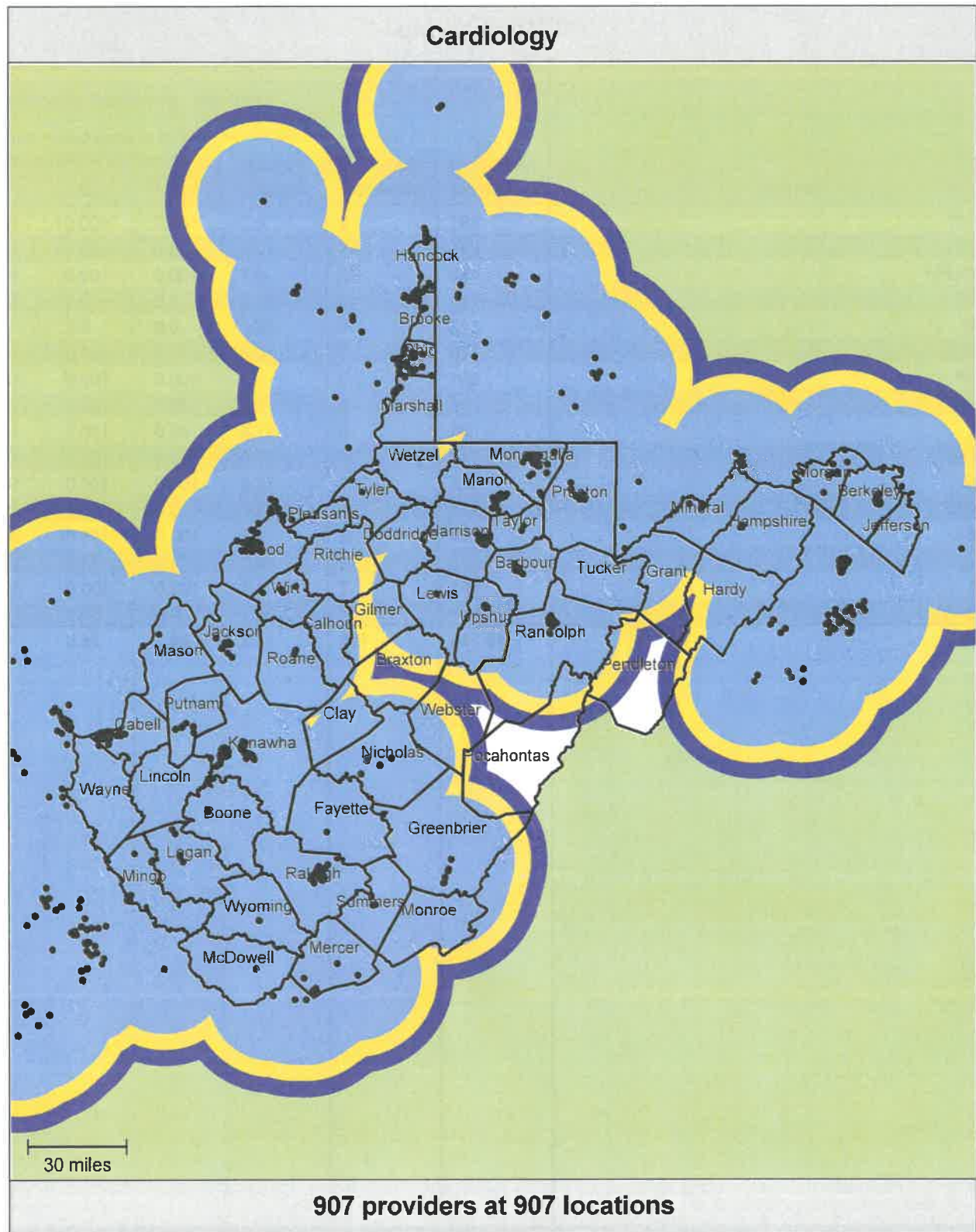
Provider group: Audiology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	3	8.3	100.0	100.0	100.0
RALEIGH	984	17	1.6	100.0	100.0	100.0
RANDOLPH	412	12	0.7	100.0	100.0	100.0
RITCHIE	151	0	28.0	0.0	0.0	100.0
ROANE	242	0	36.7	0.0	0.0	0.0
SUMMERS	116	0	20.8	17.2	100.0	100.0
TAYLOR	301	0	13.1	100.0	100.0	100.0
TUCKER	52	0	19.7	76.9	100.0	100.0
TYLER	26	0	11.8	100.0	100.0	100.0
UPSHUR	245	0	20.0	22.4	100.0	100.0
WAYNE	522	0	12.2	100.0	100.0	100.0
WEBSTER	168	0	34.0	0.0	0.0	12.5
WETZEL	116	3	1.8	100.0	100.0	100.0
WIRT	63	0	18.1	74.6	100.0	100.0
WOOD	851	7	1.6	100.0	100.0	100.0
WYOMING	403	0	24.1	0.0	50.1	100.0
TOTALS	18,348	191	14.3	69.2	76.8	87.6

Provider group: Audiology

Provider locations



● Provider locations (907)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	11	0.6	100.0	100.0	100.0
BERKELEY	694	41	3.3	100.0	100.0	100.0
BOONE	300	1	15.5	100.0	100.0	100.0
BRAXTON	201	0	29.4	0.0	15.4	30.8
BROOKE	56	3	4.7	100.0	100.0	100.0
CABELL	1,048	31	1.2	100.0	100.0	100.0
CALHOUN	171	0	21.1	0.0	100.0	100.0
CLAY	241	0	18.6	100.0	100.0	100.0
DODDRIDGE	37	0	25.6	0.0	18.9	100.0
FAYETTE	580	1	17.0	100.0	100.0	100.0
GILMER	70	0	32.9	0.0	0.0	0.0
GRANT	146	0	32.2	0.0	0.0	6.2
GREENBRIER	340	7	1.3	100.0	100.0	100.0
HAMPSHIRE	255	12	0.2	100.0	100.0	100.0
HANCOCK	392	4	5.2	100.0	100.0	100.0
HARDY	101	0	26.5	0.0	22.8	94.1
HARRISON	550	37	4.5	100.0	100.0	100.0
JACKSON	480	10	1.5	100.0	100.0	100.0
JEFFERSON	226	0	15.3	100.0	100.0	100.0
KANAWHA	1,619	67	0.5	100.0	100.0	100.0
LEWIS	126	1	15.6	96.0	100.0	100.0
LINCOLN	348	0	14.6	100.0	100.0	100.0
LOGAN	414	5	2.1	100.0	100.0	100.0
MARION	155	21	1.2	100.0	100.0	100.0
MARSHALL	165	13	2.5	100.0	100.0	100.0
MASON	939	1	8.4	100.0	100.0	100.0
MCDOWELL	507	1	12.0	100.0	100.0	100.0
MERCER	151	7	8.8	100.0	100.0	100.0
MINERAL	421	10	0.8	100.0	100.0	100.0
MINGO	417	6	2.0	100.0	100.0	100.0
MONONGALIA	117	109	0.4	100.0	100.0	100.0
MONROE	68	0	14.4	100.0	100.0	100.0
MORGAN	281	8	4.5	100.0	100.0	100.0
NICHOLAS	447	5	4.5	100.0	100.0	100.0
OHIO	366	30	1.1	100.0	100.0	100.0
PENDLETON	26	0	37.3	0.0	0.0	0.0
PLEASANTS	39	0	12.5	100.0	100.0	100.0
POCAHONTAS	88	0	40.4	0.0	0.0	0.0
PRESTON	342	8	1.2	100.0	100.0	100.0

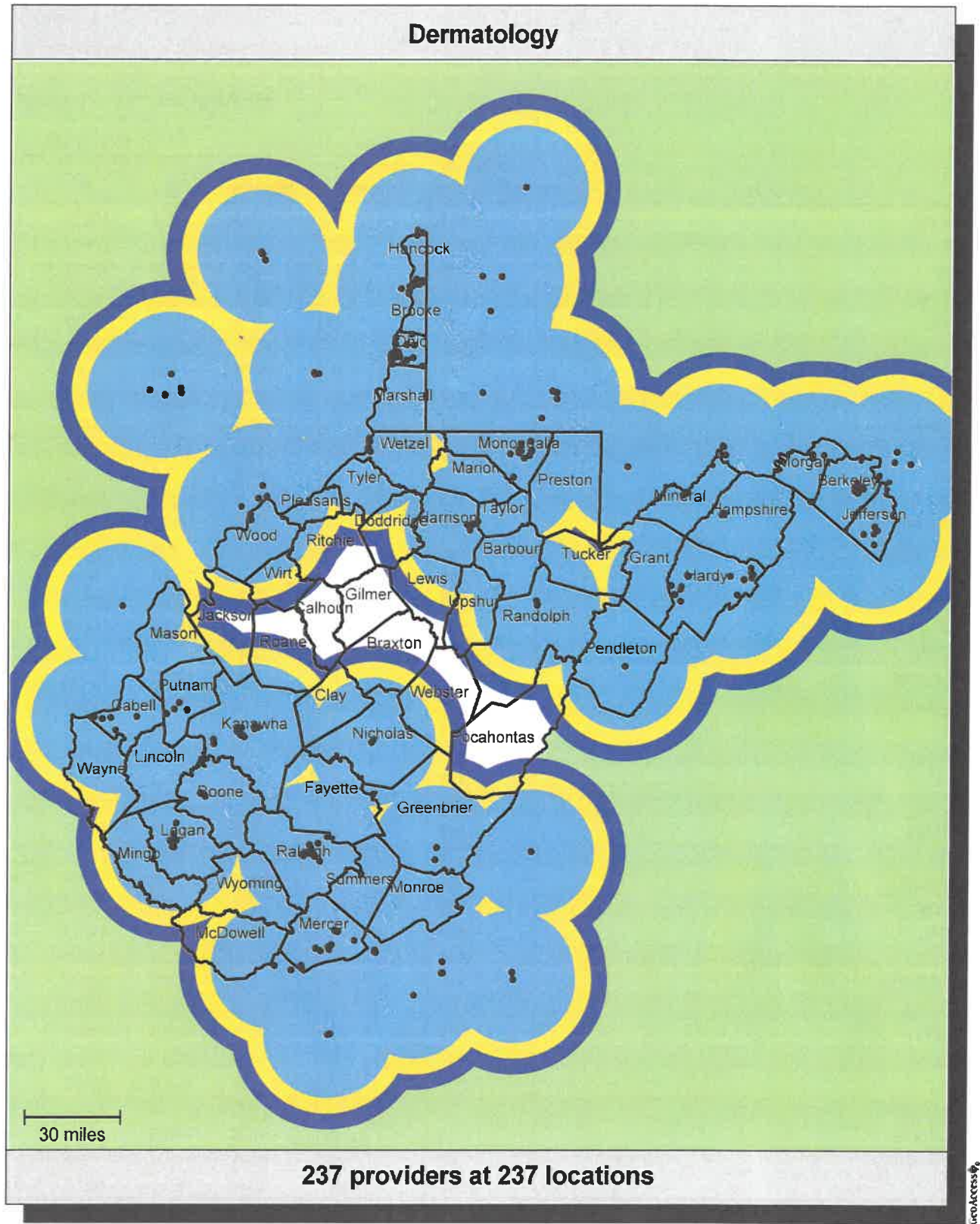
Provider group: Cardiology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	8	5.9	100.0	100.0	100.0
RALEIGH	984	19	1.5	100.0	100.0	100.0
RANDOLPH	412	36	0.3	100.0	100.0	100.0
RITCHIE	151	0	22.1	0.0	100.0	100.0
ROANE	242	2	4.8	100.0	100.0	100.0
SUMMERS	116	2	2.9	100.0	100.0	100.0
TAYLOR	301	2	1.9	100.0	100.0	100.0
TUCKER	52	0	18.1	100.0	100.0	100.0
TYLER	26	2	9.2	100.0	100.0	100.0
UPSHUR	245	5	1.7	100.0	100.0	100.0
WAYNE	522	0	11.7	100.0	100.0	100.0
WEBSTER	168	0	33.1	0.0	0.0	12.5
WETZEL	116	1	11.4	100.0	100.0	100.0
WIRT	63	10	0.0	100.0	100.0	100.0
WOOD	851	24	0.9	100.0	100.0	100.0
WYOMING	403	1	16.8	100.0	100.0	100.0
TOTALS	18,348	562	6.6	93.7	95.8	96.7

Provider group: Cardiology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	17.9	92.2	100.0	100.0
BERKELEY	694	13	3.6	100.0	100.0	100.0
BOONE	300	2	2.4	100.0	100.0	100.0
BRAXTON	201	0	29.2	0.0	22.9	53.7
BROOKE	56	0	7.5	100.0	100.0	100.0
CABELL	1,048	5	3.6	100.0	100.0	100.0
CALHOUN	171	0	44.5	0.0	0.0	0.0
CLAY	241	0	22.7	0.0	100.0	100.0
DODDRIDGE	37	0	26.3	0.0	18.9	100.0
FAYETTE	580	0	19.8	73.1	100.0	100.0
GILMER	70	0	44.6	0.0	0.0	0.0
GRANT	146	0	6.2	100.0	100.0	100.0
GREENBRIER	340	2	4.4	100.0	100.0	100.0
HAMPSHIRE	255	9	0.2	100.0	100.0	100.0
HANCOCK	392	8	6.4	100.0	100.0	100.0
HARDY	101	14	2.6	100.0	100.0	100.0
HARRISON	550	7	5.3	100.0	100.0	100.0
JACKSON	480	0	32.4	0.0	0.0	5.6
JEFFERSON	226	6	2.4	100.0	100.0	100.0
KANAWHA	1,619	13	2.3	100.0	100.0	100.0
LEWIS	126	0	25.8	0.0	45.2	92.1
LINCOLN	348	0	12.5	100.0	100.0	100.0
LOGAN	414	8	1.5	100.0	100.0	100.0
MARION	155	0	13.3	100.0	100.0	100.0
MARSHALL	165	0	8.8	100.0	100.0	100.0
MASON	939	0	31.8	0.0	0.0	16.0
MCDOWELL	507	0	25.5	0.0	24.9	100.0
MERCER	151	11	2.7	100.0	100.0	100.0
MINERAL	421	4	1.1	100.0	100.0	100.0
MINGO	417	0	22.4	11.8	100.0	100.0
MONONGALIA	117	14	1.3	100.0	100.0	100.0
MONROE	68	0	19.4	80.9	100.0	100.0
MORGAN	281	4	5.9	100.0	100.0	100.0
NICHOLAS	447	2	4.4	100.0	100.0	100.0
OHIO	366	27	1.2	100.0	100.0	100.0
PENDLETON	26	6	0.0	100.0	100.0	100.0
PLEASANTS	39	0	18.5	76.9	100.0	100.0
POCAHONTAS	88	0	41.3	0.0	0.0	0.0
PRESTON	342	0	18.4	80.1	100.0	100.0

Provider group: Dermatology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	5	6.5	100.0	100.0	100.0
RALEIGH	984	10	1.9	100.0	100.0	100.0
RANDOLPH	412	3	1.1	100.0	100.0	100.0
RITCHIE	151	0	31.4	0.0	0.0	0.0
ROANE	242	0	34.4	0.0	0.0	11.6
SUMMERS	116	0	19.4	34.5	100.0	100.0
TAYLOR	301	0	13.0	100.0	100.0	100.0
TUCKER	52	0	19.9	76.9	100.0	100.0
TYLER	26	0	12.1	100.0	100.0	100.0
UPSHUR	245	0	21.0	8.6	97.1	100.0
WAYNE	522	0	13.2	100.0	100.0	100.0
WEBSTER	168	0	32.4	0.0	0.0	12.5
WETZEL	116	6	0.9	100.0	100.0	100.0
WIRT	63	0	23.1	23.8	74.6	100.0
WOOD	851	5	5.0	100.0	100.0	100.0
WYOMING	403	0	26.1	0.0	0.0	100.0
TOTALS	18,348	184	11.8	73.7	81.6	88.1

Provider group: Dermatology

Provider locations



664 providers at 662 locations

- Single provider locations (660)
- Multiple provider locations (2)
- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	3	1.2	100.0	100.0	100.0
BERKELEY	694	17	3.5	100.0	100.0	100.0
BOONE	300	0	17.5	100.0	100.0	100.0
BRAXTON	201	3	10.0	100.0	100.0	100.0
BROOKE	56	0	7.3	100.0	100.0	100.0
CABELL	1,048	27	1.7	100.0	100.0	100.0
CALHOUN	171	0	26.5	0.0	0.0	100.0
CLAY	241	0	22.4	0.0	100.0	100.0
DODDRIDGE	37	0	26.4	0.0	18.9	100.0
FAYETTE	580	3	18.4	100.0	100.0	100.0
GILMER	70	0	16.5	100.0	100.0	100.0
GRANT	146	3	2.5	100.0	100.0	100.0
GREENBRIER	340	11	1.4	100.0	100.0	100.0
HAMPSHIRE	255	2	0.6	100.0	100.0	100.0
HANCOCK	392	6	5.7	100.0	100.0	100.0
HARDY	101	0	11.0	100.0	100.0	100.0
HARRISON	550	18	4.8	100.0	100.0	100.0
JACKSON	480	3	2.3	100.0	100.0	100.0
JEFFERSON	226	7	3.0	100.0	100.0	100.0
KANAWHA	1,619	72	0.6	100.0	100.0	100.0
LEWIS	126	2	6.4	100.0	100.0	100.0
LINCOLN	348	0	13.8	100.0	100.0	100.0
LOGAN	414	4	1.9	100.0	100.0	100.0
MARION	155	13	1.4	100.0	100.0	100.0
MARSHALL	165	5	3.1	100.0	100.0	100.0
MASON	939	3	2.8	100.0	100.0	100.0
MCDOWELL	507	1	12.0	100.0	100.0	100.0
MERCER	151	14	2.3	100.0	100.0	100.0
MINERAL	421	3	1.3	100.0	100.0	100.0
MINGO	417	0	2.1	100.0	100.0	100.0
MONONGALIA	117	86	0.7	100.0	100.0	100.0
MONROE	68	0	13.4	100.0	100.0	100.0
MORGAN	281	1	18.9	57.3	100.0	100.0
NICHOLAS	447	3	3.9	100.0	100.0	100.0
OHIO	366	22	1.2	100.0	100.0	100.0
PENDLETON	26	0	32.1	0.0	0.0	0.0
PLEASANTS	39	0	11.6	100.0	100.0	100.0
POCAHONTAS	88	0	37.0	0.0	0.0	0.0
PRESTON	342	4	1.9	100.0	100.0	100.0

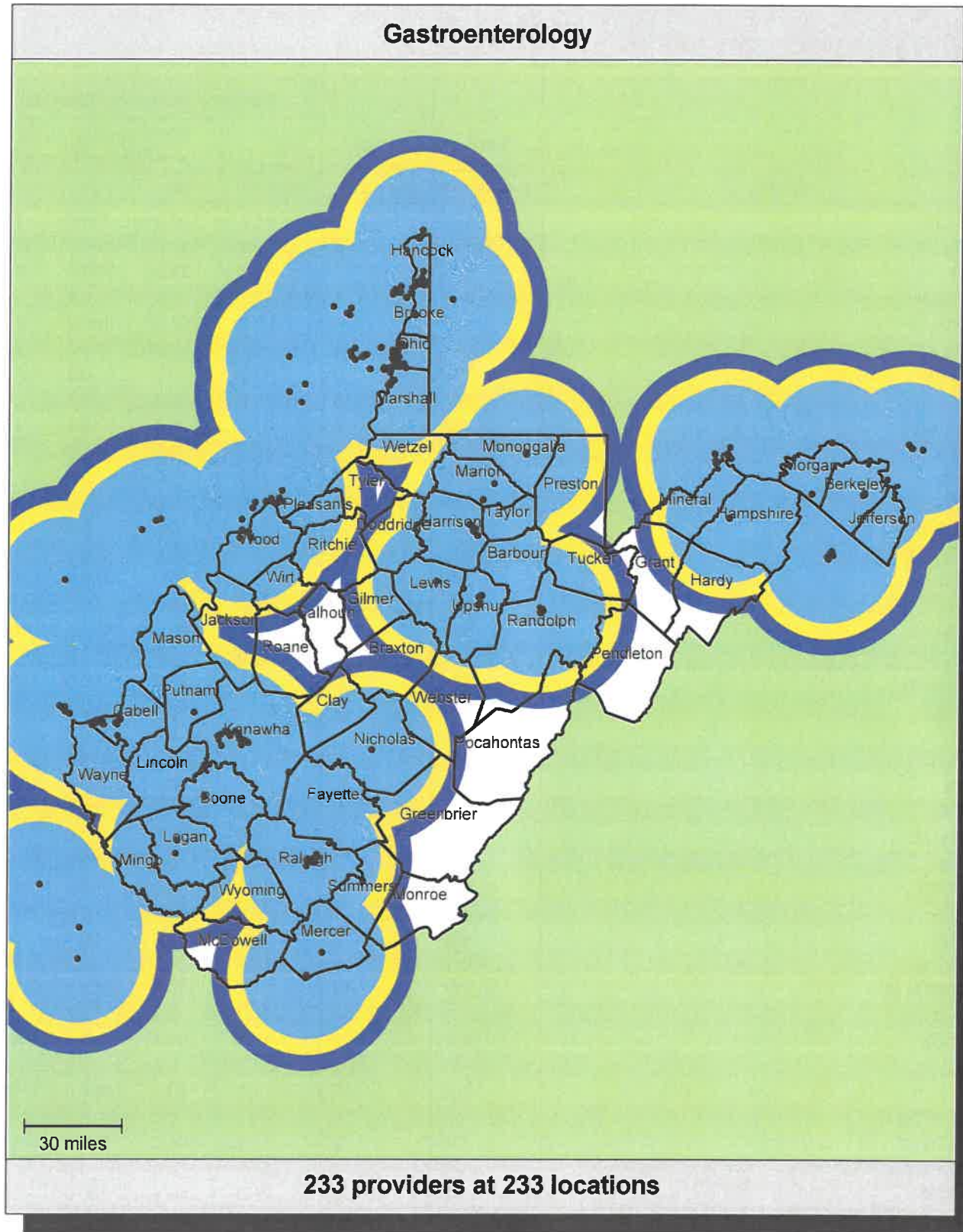
Provider group: General Surgery

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	9	6.7	100.0	100.0	100.0
RALEIGH	984	25	1.4	100.0	100.0	100.0
RANDOLPH	412	8	0.9	100.0	100.0	100.0
RITCHIE	151	0	25.6	0.0	16.6	100.0
ROANE	242	2	8.2	100.0	100.0	100.0
SUMMERS	116	1	19.4	34.5	100.0	100.0
TAYLOR	301	2	1.9	100.0	100.0	100.0
TUCKER	52	1	17.8	100.0	100.0	100.0
TYLER	26	0	22.6	0.0	100.0	100.0
UPSHUR	245	11	1.4	100.0	100.0	100.0
WAYNE	522	0	10.9	100.0	100.0	100.0
WEBSTER	168	0	31.6	0.0	0.0	12.5
WETZEL	116	1	24.0	0.0	71.6	100.0
WIRT	63	0	19.9	49.2	100.0	100.0
WOOD	851	5	2.3	100.0	100.0	100.0
WYOMING	403	3	10.1	100.0	100.0	100.0
TOTALS	18,348	404	6.1	93.2	96.5	98.6

Provider group: General Surgery

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	18.2	100.0	100.0	100.0
BERKELEY	694	3	4.8	100.0	100.0	100.0
BOONE	300	1	20.1	25.3	100.0	100.0
BRAXTON	201	0	37.1	0.0	0.0	0.0
BROOKE	56	1	7.8	100.0	100.0	100.0
CABELL	1,048	14	1.5	100.0	100.0	100.0
CALHOUN	171	0	41.6	0.0	0.0	0.0
CLAY	241	0	29.8	0.0	0.0	71.4
DODDRIDGE	37	0	27.0	0.0	18.9	100.0
FAYETTE	580	1	19.5	93.3	100.0	100.0
GILMER	70	0	31.8	0.0	0.0	0.0
GRANT	146	0	41.8	0.0	0.0	0.0
GREENBRIER	340	0	39.8	0.0	0.0	0.0
HAMPSHIRE	255	1	20.0	40.8	100.0	100.0
HANCOCK	392	10	5.0	100.0	100.0	100.0
HARDY	101	0	42.9	0.0	0.0	0.0
HARRISON	550	7	5.3	100.0	100.0	100.0
JACKSON	480	0	30.0	0.0	0.0	38.5
JEFFERSON	226	0	16.4	97.8	100.0	100.0
KANAWHA	1,619	25	0.9	100.0	100.0	100.0
LEWIS	126	1	10.7	100.0	100.0	100.0
LINCOLN	348	0	19.0	100.0	100.0	100.0
LOGAN	414	2	4.0	100.0	100.0	100.0
MARION	155	2	6.6	100.0	100.0	100.0
MARSHALL	165	8	2.8	100.0	100.0	100.0
MASON	939	0	32.2	0.0	0.0	10.4
MCDOWELL	507	0	28.6	0.0	0.0	100.0
MERCER	151	2	13.9	93.4	100.0	100.0
MINERAL	421	0	17.8	92.6	100.0	100.0
MINGO	417	0	25.2	0.0	29.3	100.0
MONONGALIA	117	15	1.7	100.0	100.0	100.0
MONROE	68	0	42.7	0.0	0.0	0.0
MORGAN	281	2	15.4	94.3	100.0	100.0
NICHOLAS	447	1	31.2	0.0	5.6	27.7
OHIO	366	17	1.5	100.0	100.0	100.0
PENDLETON	26	0	41.1	0.0	0.0	0.0
PLEASANTS	39	0	13.2	100.0	100.0	100.0
POCAHONTAS	88	0	52.7	0.0	0.0	0.0
PRESTON	342	0	21.9	13.5	100.0	100.0

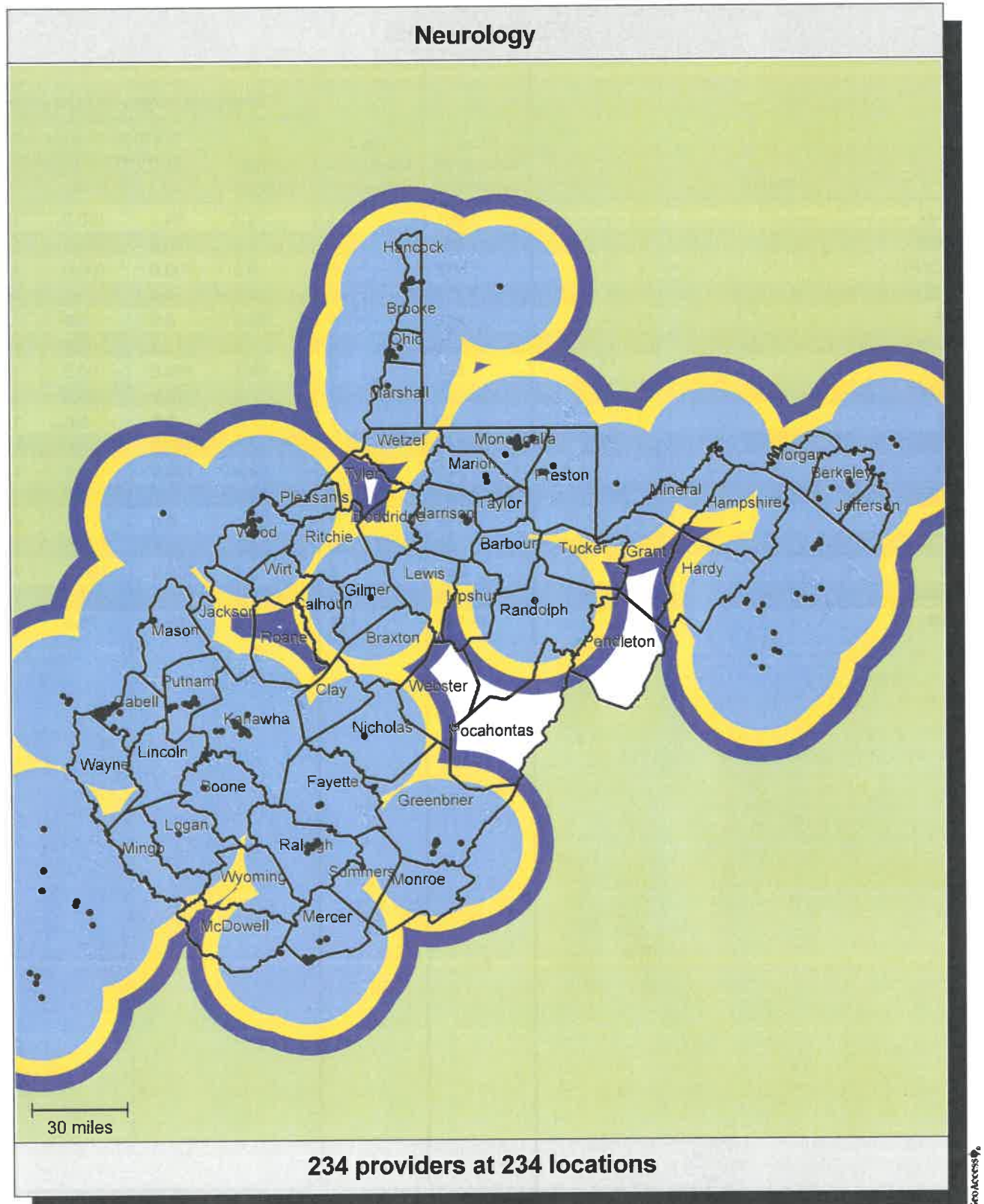
Provider group: Gastroenterology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	1	17.3	84.5	100.0	100.0
RALEIGH	984	9	2.1	100.0	100.0	100.0
RANDOLPH	412	6	0.9	100.0	100.0	100.0
RITCHIE	151	0	29.2	0.0	0.0	100.0
ROANE	242	0	38.9	0.0	0.0	0.0
SUMMERS	116	0	21.1	17.2	100.0	100.0
TAYLOR	301	0	14.7	100.0	100.0	100.0
TUCKER	52	0	20.4	76.9	100.0	100.0
TYLER	26	0	28.2	0.0	0.0	100.0
UPSHUR	245	4	2.3	100.0	100.0	100.0
WAYNE	522	0	12.9	100.0	100.0	100.0
WEBSTER	168	0	38.6	0.0	0.0	0.0
WETZEL	116	0	24.1	0.0	71.6	100.0
WIRT	63	0	21.9	23.8	100.0	100.0
WOOD	851	2	3.1	100.0	100.0	100.0
WYOMING	403	0	27.4	0.0	0.0	100.0
TOTALS	18,348	135	15.4	65.2	71.9	82.8

Provider group: Gastroenterology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	18.8	92.2	100.0	100.0
BERKELEY	694	5	4.6	100.0	100.0	100.0
BOONE	300	1	20.4	25.0	100.0	100.0
BRAXTON	201	0	31.5	0.0	0.0	23.4
BROOKE	56	0	8.2	100.0	100.0	100.0
CABELL	1,048	21	2.1	100.0	100.0	100.0
CALHOUN	171	0	38.9	0.0	0.0	0.0
CLAY	241	0	29.7	0.0	0.0	85.5
DODDRIDGE	37	0	26.9	0.0	18.9	100.0
FAYETTE	580	2	8.1	100.0	100.0	100.0
GILMER	70	1	45.2	0.0	0.0	0.0
GRANT	146	0	32.6	0.0	0.0	0.0
GREENBRIER	340	7	1.4	100.0	100.0	100.0
HAMPSHIRE	255	0	33.8	0.0	0.0	0.0
HANCOCK	392	3	8.9	100.0	100.0	100.0
HARDY	101	0	27.2	0.0	10.9	88.1
HARRISON	550	5	5.4	100.0	100.0	100.0
JACKSON	480	0	24.0	5.6	77.9	100.0
JEFFERSON	226	0	16.7	97.8	100.0	100.0
KANAWHA	1,619	21	0.8	100.0	100.0	100.0
LEWIS	126	0	25.8	0.0	41.3	92.1
LINCOLN	348	0	13.8	100.0	100.0	100.0
LOGAN	414	1	20.8	26.6	100.0	100.0
MARION	155	2	3.4	100.0	100.0	100.0
MARSHALL	165	1	9.4	100.0	100.0	100.0
MASON	939	2	3.7	100.0	100.0	100.0
MCDOWELL	507	0	27.1	0.0	12.6	100.0
MERCER	151	6	6.1	100.0	100.0	100.0
MINERAL	421	0	21.7	0.0	96.2	100.0
MINGO	417	0	23.3	0.0	100.0	100.0
MONONGALIA	117	66	0.6	100.0	100.0	100.0
MONROE	68	0	14.7	100.0	100.0	100.0
MORGAN	281	0	16.9	86.1	100.0	100.0
NICHOLAS	447	1	33.3	0.0	0.0	11.0
OHIO	366	6	2.8	100.0	100.0	100.0
PENDLETON	26	0	42.6	0.0	0.0	0.0
PLEASANTS	39	0	17.2	84.6	100.0	100.0
POCAHONTAS	88	0	41.8	0.0	0.0	0.0
PRESTON	342	3	7.1	100.0	100.0	100.0

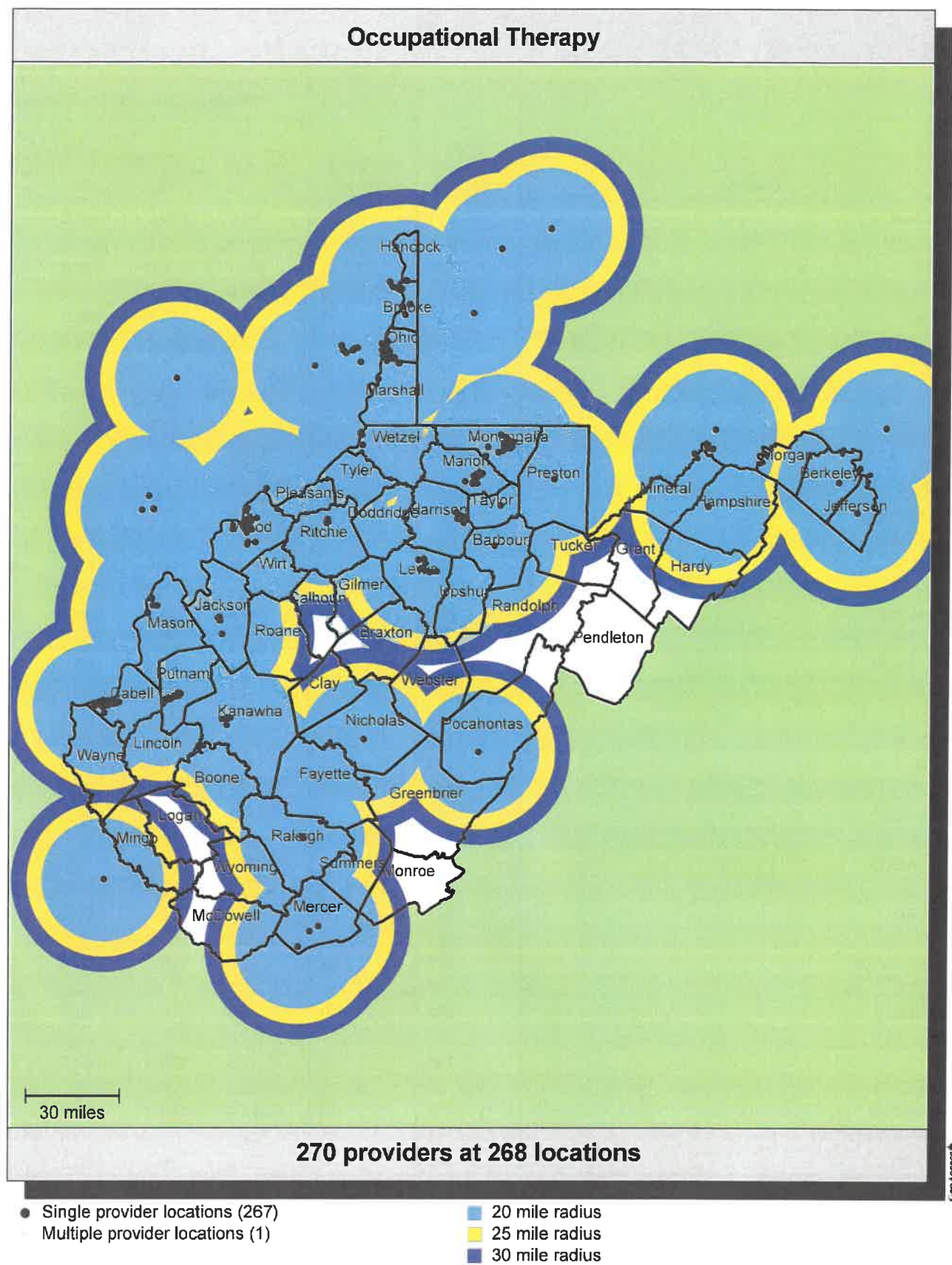
Provider group: Neurology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	12	4.6	100.0	100.0	100.0
RALEIGH	984	7	2.3	100.0	100.0	100.0
RANDOLPH	412	1	40.6	0.0	0.0	0.0
RITCHIE	151	0	26.4	0.0	0.0	100.0
ROANE	242	0	35.3	0.0	0.0	0.0
SUMMERS	116	0	21.5	17.2	100.0	100.0
TAYLOR	301	0	14.7	100.0	100.0	100.0
TUCKER	52	0	30.1	0.0	11.5	34.6
TYLER	26	0	33.7	0.0	0.0	0.0
UPSHUR	245	0	21.9	5.7	94.3	100.0
WAYNE	522	0	11.6	100.0	100.0	100.0
WEBSTER	168	0	46.3	0.0	0.0	0.0
WETZEL	116	0	31.7	0.0	0.0	18.1
WIRT	63	0	17.0	100.0	100.0	100.0
WOOD	851	9	2.0	100.0	100.0	100.0
WYOMING	403	0	26.4	0.0	0.0	100.0
TOTALS	18,348	183	13.7	66.2	78.3	87.2

Provider group: Neurology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	1	14.8	100.0	100.0	100.0
BERKELEY	694	1	18.3	93.2	100.0	100.0
BOONE	300	0	24.1	0.0	100.0	100.0
BRAXTON	201	0	34.9	0.0	0.0	3.5
BROOKE	56	4	1.9	100.0	100.0	100.0
CABELL	1,048	23	0.7	100.0	100.0	100.0
CALHOUN	171	0	24.7	0.0	100.0	100.0
CLAY	241	0	35.3	0.0	0.0	0.0
DODDRIDGE	37	0	17.0	100.0	100.0	100.0
FAYETTE	580	0	21.9	13.4	100.0	100.0
GILMER	70	0	24.2	0.0	91.4	100.0
GRANT	146	0	49.5	0.0	0.0	0.0
GREENBRIER	340	0	41.9	0.0	0.0	0.0
HAMPSHIRE	255	1	19.6	94.1	100.0	100.0
HANCOCK	392	1	11.8	100.0	100.0	100.0
HARDY	101	0	44.3	0.0	0.0	0.0
HARRISON	550	25	4.5	100.0	100.0	100.0
JACKSON	480	5	2.0	100.0	100.0	100.0
JEFFERSON	226	1	16.7	88.5	100.0	100.0
KANAWHA	1,619	10	6.1	100.0	100.0	100.0
LEWIS	126	9	2.6	100.0	100.0	100.0
LINCOLN	348	0	12.4	100.0	100.0	100.0
LOGAN	414	0	39.9	0.0	0.0	0.0
MARION	155	13	1.5	100.0	100.0	100.0
MARSHALL	165	1	9.1	100.0	100.0	100.0
MASON	939	5	2.1	100.0	100.0	100.0
MCDOWELL	507	0	27.5	0.0	0.0	100.0
MERCER	151	3	6.4	100.0	100.0	100.0
MINERAL	421	0	17.7	92.6	100.0	100.0
MINGO	417	0	50.3	0.0	0.0	0.0
MONONGALIA	117	49	0.8	100.0	100.0	100.0
MONROE	68	0	43.7	0.0	0.0	0.0
MORGAN	281	0	28.2	0.0	0.0	85.8
NICHOLAS	447	1	38.6	0.0	0.0	0.0
OHIO	366	16	1.5	100.0	100.0	100.0
PENDLETON	26	0	62.8	0.0	0.0	0.0
PLEASANTS	39	0	13.9	100.0	100.0	100.0
POCAHONTAS	88	1	41.4	0.0	0.0	0.0
PRESTON	342	1	20.9	20.2	100.0	100.0

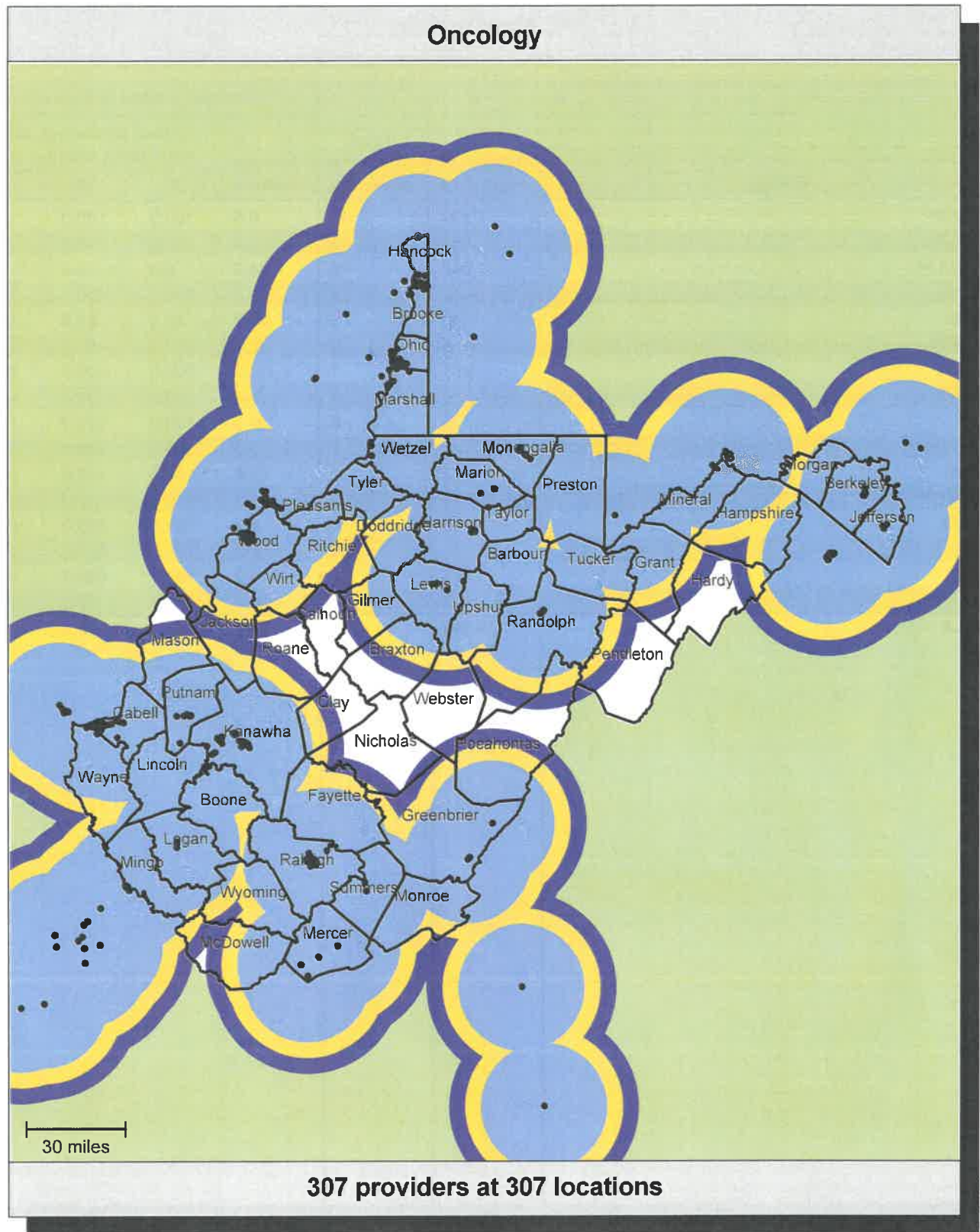
Provider group: Occupational Therapy

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	18	6.5	100.0	100.0	100.0
RALEIGH	984	2	2.9	100.0	100.0	100.0
RANDOLPH	412	0	34.2	0.0	0.0	0.0
RITCHIE	151	4	4.3	100.0	100.0	100.0
ROANE	242	0	21.9	39.3	83.9	100.0
SUMMERS	116	0	22.9	17.2	92.2	100.0
TAYLOR	301	1	13.0	100.0	100.0	100.0
TUCKER	52	0	24.4	0.0	34.6	100.0
TYLER	26	0	15.0	100.0	100.0	100.0
UPSHUR	245	0	13.7	100.0	100.0	100.0
WAYNE	522	0	12.6	100.0	100.0	100.0
WEBSTER	168	0	35.3	0.0	0.0	0.0
WETZEL	116	4	2.2	100.0	100.0	100.0
WIRT	63	0	13.2	100.0	100.0	100.0
WOOD	851	34	0.9	100.0	100.0	100.0
WYOMING	403	0	28.2	0.0	0.0	100.0
TOTALS	18,348	234	15.6	67.4	76.3	83.1

Provider group: Occupational Therapy

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	18.8	92.2	100.0	100.0
BERKELEY	694	6	4.3	100.0	100.0	100.0
BOONE	300	0	17.4	100.0	100.0	100.0
BRAXTON	201	0	36.1	0.0	0.0	0.0
BROOKE	56	0	9.8	100.0	100.0	100.0
CABELL	1,048	26	1.4	100.0	100.0	100.0
CALHOUN	171	0	38.9	0.0	0.0	0.0
CLAY	241	0	33.6	0.0	0.0	0.0
DODDRIDGE	37	0	25.2	0.0	18.9	100.0
FAYETTE	580	0	20.7	20.0	100.0	100.0
GILMER	70	0	25.3	0.0	40.0	100.0
GRANT	146	0	36.1	0.0	0.0	0.0
GREENBRIER	340	3	9.6	100.0	100.0	100.0
HAMPSHIRE	255	0	20.5	5.9	100.0	100.0
HANCOCK	392	11	6.3	100.0	100.0	100.0
HARDY	101	0	40.3	0.0	0.0	0.0
HARRISON	550	7	4.6	100.0	100.0	100.0
JACKSON	480	0	31.3	0.0	0.0	22.1
JEFFERSON	226	3	3.8	100.0	100.0	100.0
KANAWHA	1,619	40	0.6	100.0	100.0	100.0
LEWIS	126	3	3.8	100.0	100.0	100.0
LINCOLN	348	0	9.3	100.0	100.0	100.0
LOGAN	414	3	2.1	100.0	100.0	100.0
MARION	155	4	2.5	100.0	100.0	100.0
MARSHALL	165	6	2.8	100.0	100.0	100.0
MASON	939	0	32.7	0.0	0.0	0.0
MCDOWELL	507	0	26.7	0.0	12.6	100.0
MERCER	151	5	7.6	100.0	100.0	100.0
MINERAL	421	0	23.1	0.0	100.0	100.0
MINGO	417	0	2.1	100.0	100.0	100.0
MONONGALIA	117	43	1.0	100.0	100.0	100.0
MONROE	68	0	25.3	0.0	39.7	100.0
MORGAN	281	0	20.5	48.8	100.0	100.0
NICHOLAS	447	0	40.0	0.0	0.0	0.0
OHIO	366	14	1.8	100.0	100.0	100.0
PENDLETON	26	0	41.1	0.0	0.0	0.0
PLEASANTS	39	0	13.1	100.0	100.0	100.0
POCAHONTAS	88	0	36.1	0.0	0.0	0.0
PRESTON	342	0	20.4	13.5	100.0	100.0

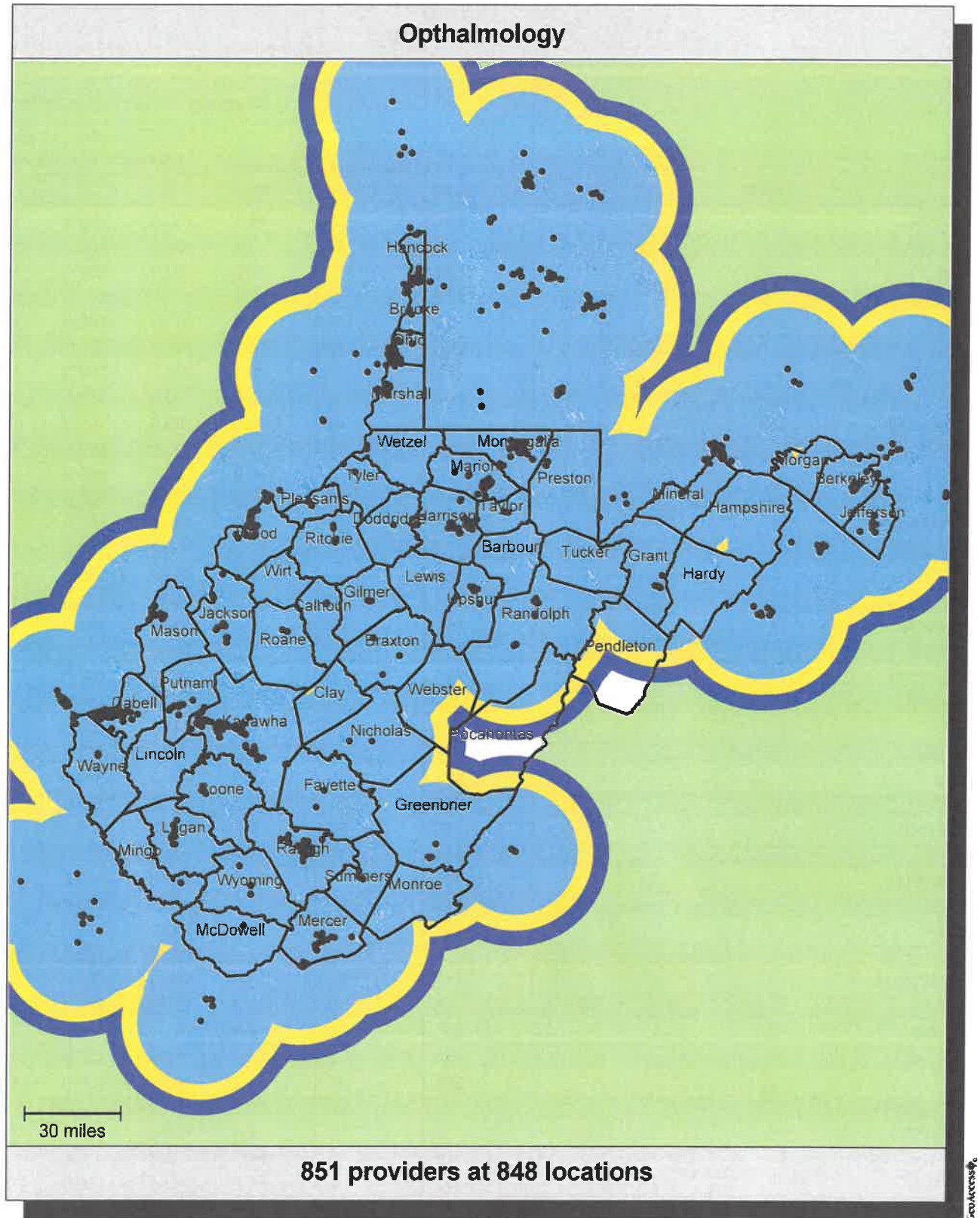
Provider group: Oncology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	10	5.8	100.0	100.0	100.0
RALEIGH	984	11	1.9	100.0	100.0	100.0
RANDOLPH	412	5	1.0	100.0	100.0	100.0
RITCHIE	151	0	27.7	0.0	0.0	100.0
ROANE	242	0	37.7	0.0	0.0	0.0
SUMMERS	116	1	20.4	17.2	100.0	100.0
TAYLOR	301	0	14.4	100.0	100.0	100.0
TUCKER	52	0	20.1	76.9	100.0	100.0
TYLER	26	0	12.1	100.0	100.0	100.0
UPSHUR	245	1	11.6	100.0	100.0	100.0
WAYNE	522	0	10.9	100.0	100.0	100.0
WEBSTER	168	0	40.7	0.0	0.0	0.0
WETZEL	116	5	1.2	100.0	100.0	100.0
WIRT	63	0	19.0	49.2	100.0	100.0
WOOD	851	6	1.7	100.0	100.0	100.0
WYOMING	403	0	26.7	0.0	0.0	100.0
TOTALS	18,348	213	13.4	66.1	76.2	82.9

Provider group: Oncology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	14.1	100.0	100.0	100.0
BERKELEY	694	14	3.4	100.0	100.0	100.0
BOONE	300	8	0.5	100.0	100.0	100.0
BRAXTON	201	3	9.0	100.0	100.0	100.0
BROOKE	56	4	1.9	100.0	100.0	100.0
CABELL	1,048	46	0.7	100.0	100.0	100.0
CALHOUN	171	2	0.4	100.0	100.0	100.0
CLAY	241	0	23.6	0.0	100.0	100.0
DODDRIDGE	37	4	10.9	100.0	100.0	100.0
FAYETTE	580	4	7.3	100.0	100.0	100.0
GILMER	70	3	0.8	100.0	100.0	100.0
GRANT	146	7	1.0	100.0	100.0	100.0
GREENBRIER	340	4	4.9	100.0	100.0	100.0
HAMPSHIRE	255	0	17.2	100.0	100.0	100.0
HANCOCK	392	21	4.7	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	43	1.1	100.0	100.0	100.0
JACKSON	480	17	1.0	100.0	100.0	100.0
JEFFERSON	226	8	2.4	100.0	100.0	100.0
KANAWHA	1,619	88	1.1	100.0	100.0	100.0
LEWIS	126	0	14.3	100.0	100.0	100.0
LINCOLN	348	0	13.1	100.0	100.0	100.0
LOGAN	414	15	1.0	100.0	100.0	100.0
MARION	155	23	1.2	100.0	100.0	100.0
MARSHALL	165	21	0.4	100.0	100.0	100.0
MASON	939	12	1.0	100.0	100.0	100.0
MCDOWELL	507	1	12.0	100.0	100.0	100.0
MERCER	151	22	2.1	100.0	100.0	100.0
MINERAL	421	5	1.0	100.0	100.0	100.0
MINGO	417	3	2.6	100.0	100.0	100.0
MONONGALIA	117	79	0.4	100.0	100.0	100.0
MONROE	68	0	14.1	100.0	100.0	100.0
MORGAN	281	0	19.4	51.6	100.0	100.0
NICHOLAS	447	2	8.0	100.0	100.0	100.0
OHIO	366	25	1.2	100.0	100.0	100.0
PENDLETON	26	0	32.1	0.0	0.0	0.0
PLEASANTS	39	2	4.0	100.0	100.0	100.0
POCAHONTAS	88	0	34.7	0.0	0.0	0.0
PRESTON	342	3	11.0	100.0	100.0	100.0

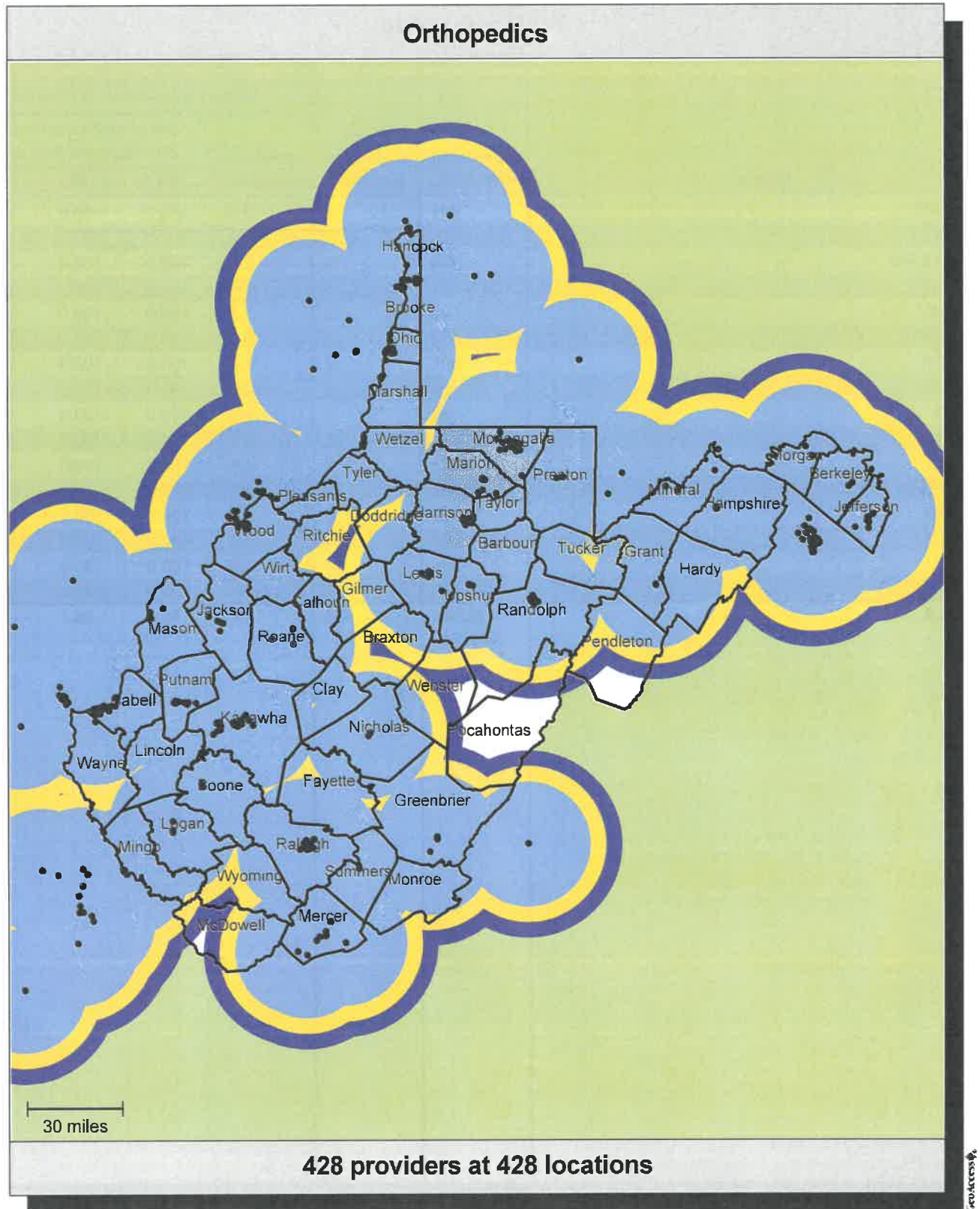
Provider group: Ophthalmology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	14	3.4	100.0	100.0	100.0
RALEIGH	984	37	0.9	100.0	100.0	100.0
RANDOLPH	412	14	0.8	100.0	100.0	100.0
RITCHIE	151	5	0.6	100.0	100.0	100.0
ROANE	242	2	5.2	100.0	100.0	100.0
SUMMERS	116	2	3.2	100.0	100.0	100.0
TAYLOR	301	2	1.6	100.0	100.0	100.0
TUCKER	52	0	19.5	76.9	100.0	100.0
TYLER	26	2	9.3	100.0	100.0	100.0
UPSHUR	245	13	1.4	100.0	100.0	100.0
WAYNE	522	7	1.4	100.0	100.0	100.0
WEBSTER	168	0	24.8	0.0	75.0	100.0
WETZEL	116	2	1.9	100.0	100.0	100.0
WIRT	63	0	16.2	100.0	100.0	100.0
WOOD	851	39	1.3	100.0	100.0	100.0
WYOMING	403	6	1.4	100.0	100.0	100.0
TOTALS	18,348	634	4.4	96.3	99.1	99.4

Provider group: Ophthalmology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	17.1	100.0	100.0	100.0
BERKELEY	694	2	5.6	100.0	100.0	100.0
BOONE	300	2	1.2	100.0	100.0	100.0
BRAXTON	201	0	28.1	0.0	22.9	69.7
BROOKE	56	0	7.5	100.0	100.0	100.0
CABELL	1,048	45	1.9	100.0	100.0	100.0
CALHOUN	171	0	22.1	0.0	100.0	100.0
CLAY	241	0	22.7	0.0	100.0	100.0
DODDRIDGE	37	0	26.0	0.0	18.9	100.0
FAYETTE	580	0	21.1	0.0	100.0	100.0
GILMER	70	0	23.8	0.0	100.0	100.0
GRANT	146	3	1.4	100.0	100.0	100.0
GREENBRIER	340	3	2.6	100.0	100.0	100.0
HAMPSHIRE	255	3	0.5	100.0	100.0	100.0
HANCOCK	392	4	5.9	100.0	100.0	100.0
HARDY	101	0	10.2	100.0	100.0	100.0
HARRISON	550	12	5.1	100.0	100.0	100.0
JACKSON	480	5	2.2	100.0	100.0	100.0
JEFFERSON	226	8	2.5	100.0	100.0	100.0
KANAWHA	1,619	43	4.0	100.0	100.0	100.0
LEWIS	126	7	2.8	100.0	100.0	100.0
LINCOLN	348	0	16.4	100.0	100.0	100.0
LOGAN	414	3	2.0	100.0	100.0	100.0
MARION	155	8	1.8	100.0	100.0	100.0
MARSHALL	165	4	3.1	100.0	100.0	100.0
MASON	939	4	2.8	100.0	100.0	100.0
MCDOWELL	507	0	27.8	0.0	0.0	100.0
MERCER	151	9	3.0	100.0	100.0	100.0
MINERAL	421	4	1.6	100.0	100.0	100.0
MINGO	417	0	2.6	100.0	100.0	100.0
MONONGALIA	117	70	0.7	100.0	100.0	100.0
MONROE	68	0	20.7	0.0	100.0	100.0
MORGAN	281	2	7.2	100.0	100.0	100.0
NICHOLAS	447	2	4.4	100.0	100.0	100.0
OHIO	366	9	2.4	100.0	100.0	100.0
PENDLETON	26	0	31.8	0.0	0.0	0.0
PLEASANTS	39	0	14.0	100.0	100.0	100.0
POCAHONTAS	88	0	39.8	0.0	0.0	0.0
PRESTON	342	2	3.0	100.0	100.0	100.0

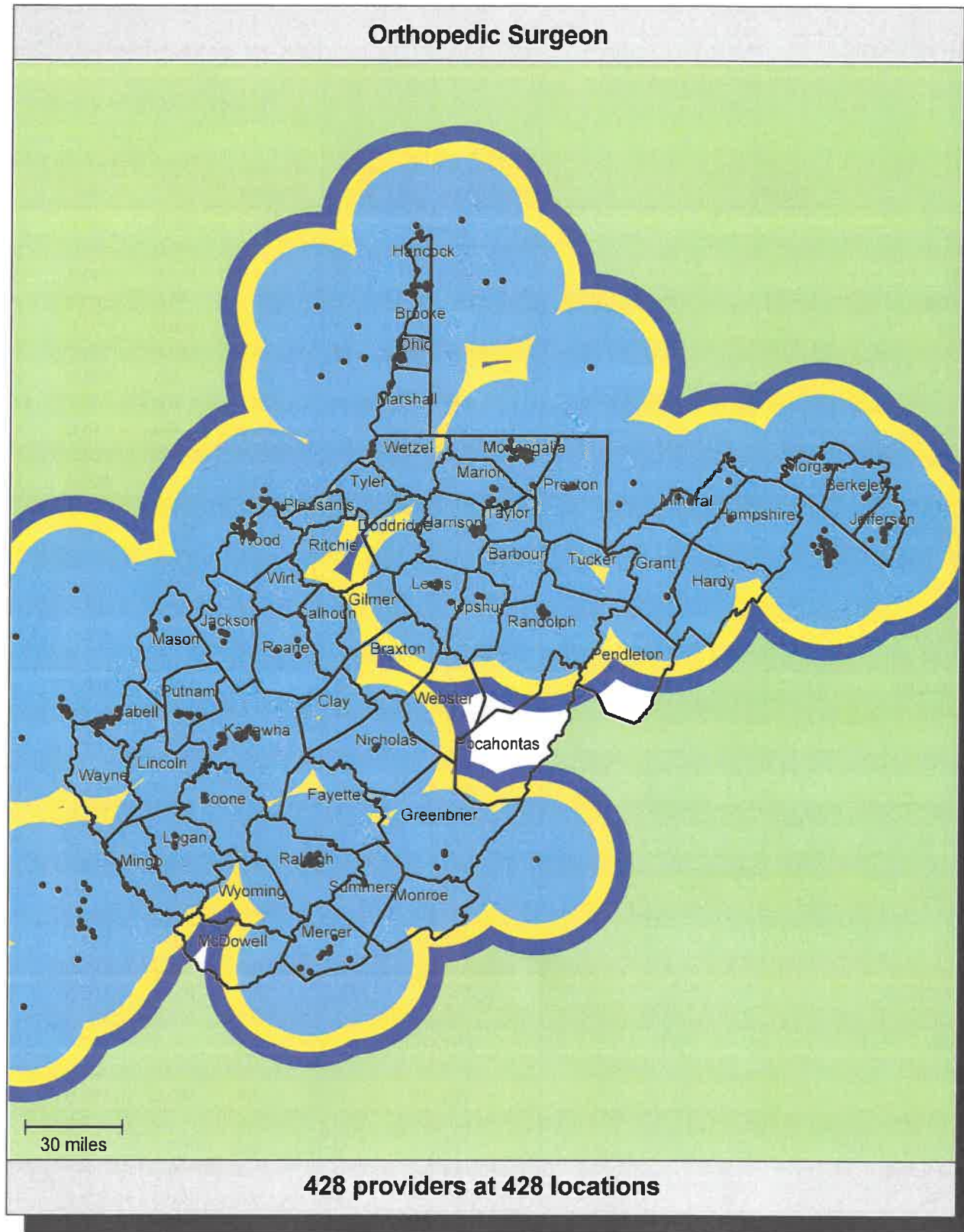
Provider group: Orthopedics

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	11	5.7	100.0	100.0	100.0
RALEIGH	984	13	1.8	100.0	100.0	100.0
RANDOLPH	412	8	1.0	100.0	100.0	100.0
RITCHIE	151	0	28.9	0.0	0.0	100.0
ROANE	242	3	6.4	100.0	100.0	100.0
SUMMERS	116	1	20.3	17.2	100.0	100.0
TAYLOR	301	0	11.7	100.0	100.0	100.0
TUCKER	52	0	19.6	76.9	100.0	100.0
TYLER	26	0	11.8	100.0	100.0	100.0
UPSHUR	245	3	1.9	100.0	100.0	100.0
WAYNE	522	0	12.0	100.0	100.0	100.0
WEBSTER	168	0	32.1	0.0	0.0	12.5
WETZEL	116	9	0.5	100.0	100.0	100.0
WIRT	63	0	19.9	49.2	100.0	100.0
WOOD	851	8	1.9	100.0	100.0	100.0
WYOMING	403	0	26.9	0.0	0.0	100.0
TOTALS	18,348	310	7.6	84.5	91.7	98.2

Provider group: Orthopedics

Provider locations



● Provider locations (428)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	17.1	100.0	100.0	100.0
BERKELEY	694	2	5.6	100.0	100.0	100.0
BOONE	300	2	1.2	100.0	100.0	100.0
BRAXTON	201	0	28.1	0.0	22.9	69.7
BROOKE	56	0	7.5	100.0	100.0	100.0
CABELL	1,048	45	1.9	100.0	100.0	100.0
CALHOUN	171	0	22.1	0.0	100.0	100.0
CLAY	241	0	22.7	0.0	100.0	100.0
DODDRIDGE	37	0	26.0	0.0	18.9	100.0
FAYETTE	580	0	21.1	0.0	100.0	100.0
GILMER	70	0	23.8	0.0	100.0	100.0
GRANT	146	3	1.4	100.0	100.0	100.0
GREENBRIER	340	3	2.6	100.0	100.0	100.0
HAMPSHIRE	255	3	0.5	100.0	100.0	100.0
HANCOCK	392	4	5.9	100.0	100.0	100.0
HARDY	101	0	10.2	100.0	100.0	100.0
HARRISON	550	12	5.1	100.0	100.0	100.0
JACKSON	480	5	2.2	100.0	100.0	100.0
JEFFERSON	226	8	2.5	100.0	100.0	100.0
KANAWHA	1,619	43	4.0	100.0	100.0	100.0
LEWIS	126	7	2.8	100.0	100.0	100.0
LINCOLN	348	0	16.4	100.0	100.0	100.0
LOGAN	414	3	2.0	100.0	100.0	100.0
MARION	155	8	1.8	100.0	100.0	100.0
MARSHALL	165	4	3.1	100.0	100.0	100.0
MASON	939	4	2.8	100.0	100.0	100.0
MCDOWELL	507	0	27.8	0.0	0.0	100.0
MERCER	151	9	3.0	100.0	100.0	100.0
MINERAL	421	4	1.6	100.0	100.0	100.0
MINGO	417	0	2.6	100.0	100.0	100.0
MONONGALIA	117	70	0.7	100.0	100.0	100.0
MONROE	68	0	20.7	0.0	100.0	100.0
MORGAN	281	2	7.2	100.0	100.0	100.0
NICHOLAS	447	2	4.4	100.0	100.0	100.0
OHIO	366	9	2.4	100.0	100.0	100.0
PENDLETON	26	0	31.8	0.0	0.0	0.0
PLEASANTS	39	0	14.0	100.0	100.0	100.0
POCAHONTAS	88	0	39.8	0.0	0.0	0.0
PRESTON	342	2	3.0	100.0	100.0	100.0

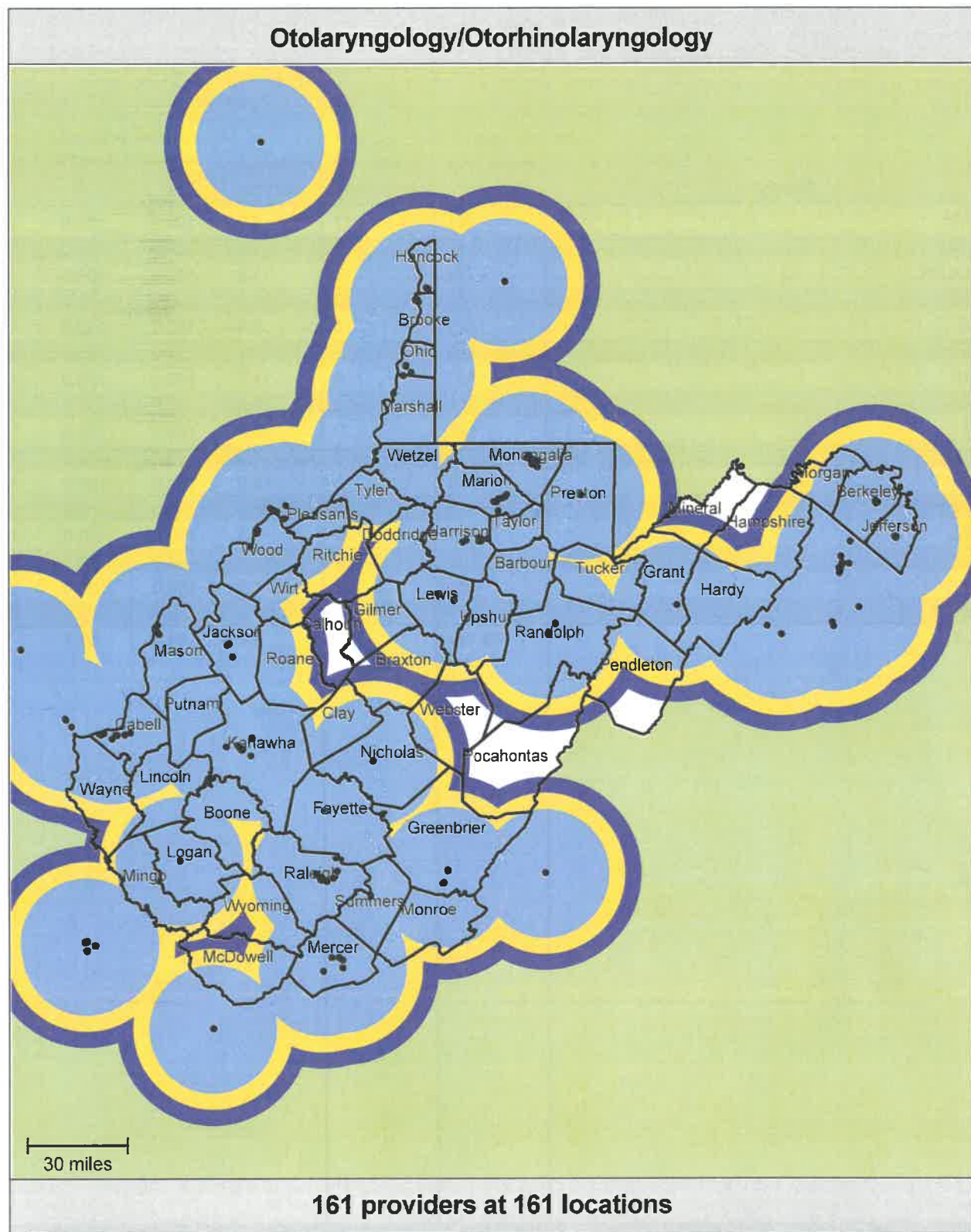
Provider group: Orthopedic Surgeon

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	11	5.7	100.0	100.0	100.0
RALEIGH	984	13	1.8	100.0	100.0	100.0
RANDOLPH	412	8	1.0	100.0	100.0	100.0
RITCHIE	151	0	28.9	0.0	0.0	100.0
ROANE	242	3	6.4	100.0	100.0	100.0
SUMMERS	116	1	20.3	17.2	100.0	100.0
TAYLOR	301	0	11.7	100.0	100.0	100.0
TUCKER	52	0	19.6	76.9	100.0	100.0
TYLER	26	0	11.8	100.0	100.0	100.0
UPSHUR	245	3	1.9	100.0	100.0	100.0
WAYNE	522	0	12.0	100.0	100.0	100.0
WEBSTER	168	0	32.1	0.0	0.0	12.5
WETZEL	116	9	0.5	100.0	100.0	100.0
WIRT	63	0	19.9	49.2	100.0	100.0
WOOD	851	8	1.9	100.0	100.0	100.0
WYOMING	403	0	26.9	0.0	0.0	100.0
TOTALS	18,348	310	7.6	84.5	91.7	98.2

Provider group: Orthopedic Surgeon

Provider locations



● Provider locations (161)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	18.8	92.2	100.0	100.0
BERKELEY	694	4	4.3	100.0	100.0	100.0
BOONE	300	0	24.4	0.0	97.7	100.0
BRAXTON	201	0	35.1	0.0	0.0	0.0
BROOKE	56	0	8.2	100.0	100.0	100.0
CABELL	1,048	9	1.7	100.0	100.0	100.0
CALHOUN	171	0	37.3	0.0	0.0	0.0
CLAY	241	0	29.7	0.0	0.0	85.5
DODDRIDGE	37	0	22.8	18.9	100.0	100.0
FAYETTE	580	1	19.0	86.6	100.0	100.0
GILMER	70	0	26.5	0.0	0.0	100.0
GRANT	146	1	32.6	0.0	0.0	0.0
GREENBRIER	340	5	1.4	100.0	100.0	100.0
HAMPSHIRE	255	0	36.4	0.0	0.0	0.0
HANCOCK	392	2	8.6	100.0	100.0	100.0
HARDY	101	0	27.1	0.0	15.8	88.1
HARRISON	550	7	2.2	100.0	100.0	100.0
JACKSON	480	3	2.4	100.0	100.0	100.0
JEFFERSON	226	3	3.4	100.0	100.0	100.0
KANAWHA	1,619	9	5.5	100.0	100.0	100.0
LEWIS	126	2	6.6	100.0	100.0	100.0
LINCOLN	348	0	19.0	71.3	100.0	100.0
LOGAN	414	1	43.3	0.0	0.0	0.0
MARION	155	7	1.9	100.0	100.0	100.0
MARSHALL	165	1	9.1	100.0	100.0	100.0
MASON	939	3	2.9	100.0	100.0	100.0
MCDOWELL	507	0	26.7	0.0	12.6	100.0
MERCER	151	5	4.7	100.0	100.0	100.0
MINERAL	421	0	38.8	0.0	0.0	0.0
MINGO	417	0	24.7	0.0	70.7	100.0
MONONGALIA	117	41	0.7	100.0	100.0	100.0
MONROE	68	0	14.2	100.0	100.0	100.0
MORGAN	281	0	20.0	48.8	100.0	100.0
NICHOLAS	447	1	28.6	0.0	11.0	72.3
OHIO	366	4	3.1	100.0	100.0	100.0
PENDLETON	26	0	38.8	0.0	0.0	0.0
PLEASANTS	39	0	14.0	100.0	100.0	100.0
POCAHONTAS	88	0	42.5	0.0	0.0	0.0
PRESTON	342	1	19.9	26.9	100.0	100.0

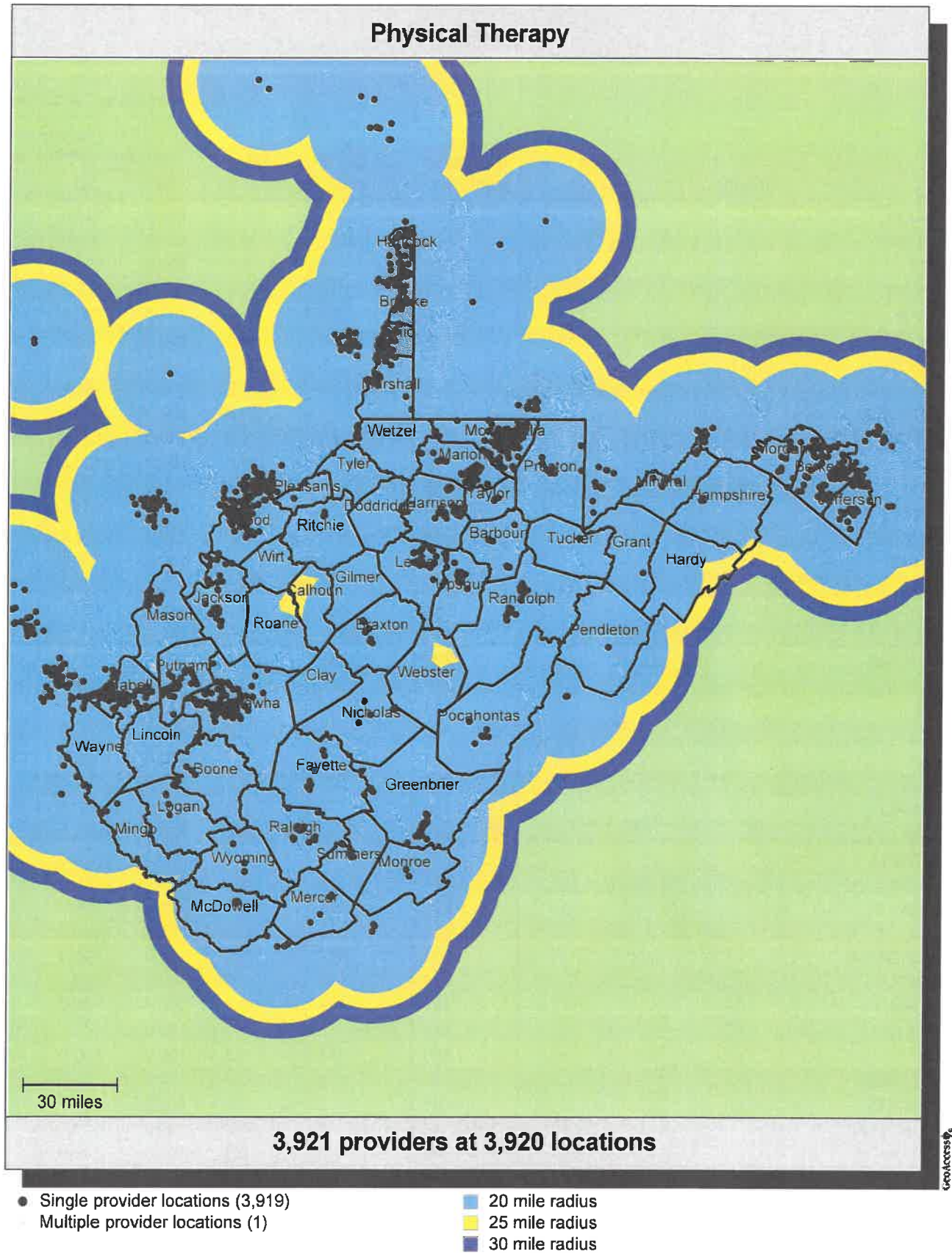
Provider group: Otolaryngology/Otorhinolaryngology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	0	20.3	38.3	100.0	100.0
RALEIGH	984	8	2.9	100.0	100.0	100.0
RANDOLPH	412	2	4.7	100.0	100.0	100.0
RITCHIE	151	0	30.0	0.0	0.0	49.7
ROANE	242	0	22.5	28.1	72.7	100.0
SUMMERS	116	0	17.7	92.2	100.0	100.0
TAYLOR	301	0	13.2	100.0	100.0	100.0
TUCKER	52	0	23.5	0.0	100.0	100.0
TYLER	26	0	15.0	100.0	100.0	100.0
UPSHUR	245	0	17.3	97.1	100.0	100.0
WAYNE	522	0	13.4	100.0	100.0	100.0
WEBSTER	168	0	37.8	0.0	0.0	0.0
WETZEL	116	2	2.8	100.0	100.0	100.0
WIRT	63	0	22.5	23.8	100.0	100.0
WOOD	851	5	5.3	100.0	100.0	100.0
WYOMING	403	0	28.0	0.0	0.0	100.0
TOTALS	18,348	127	13.9	68.7	78.9	88.4

Provider group: Otolaryngology/Otorhinolaryngology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	20	1.3	100.0	100.0	100.0
BERKELEY	694	96	2.3	100.0	100.0	100.0
BOONE	300	3	2.7	100.0	100.0	100.0
BRAXTON	201	32	5.6	100.0	100.0	100.0
BROOKE	56	61	0.0	100.0	100.0	100.0
CABELL	1,048	105	0.5	100.0	100.0	100.0
CALHOUN	171	0	23.0	0.0	100.0	100.0
CLAY	241	0	20.7	0.0	100.0	100.0
DODDRIDGE	37	4	10.8	100.0	100.0	100.0
FAYETTE	580	29	4.9	100.0	100.0	100.0
GILMER	70	0	12.0	100.0	100.0	100.0
GRANT	146	1	28.5	0.0	0.0	100.0
GREENBRIER	340	101	0.0	100.0	100.0	100.0
HAMPSHIRE	255	23	0.1	100.0	100.0	100.0
HANCOCK	392	41	1.6	100.0	100.0	100.0
HARDY	101	0	27.0	0.0	22.8	83.2
HARRISON	550	161	0.7	100.0	100.0	100.0
JACKSON	480	120	0.0	100.0	100.0	100.0
JEFFERSON	226	45	1.7	100.0	100.0	100.0
KANAWHA	1,619	298	0.6	100.0	100.0	100.0
LEWIS	126	57	1.5	100.0	100.0	100.0
LINCOLN	348	0	8.5	100.0	100.0	100.0
LOGAN	414	6	3.9	100.0	100.0	100.0
MARION	155	237	0.0	100.0	100.0	100.0
MARSHALL	165	79	0.1	100.0	100.0	100.0
MASON	939	49	0.0	100.0	100.0	100.0
MCDOWELL	507	5	0.9	100.0	100.0	100.0
MERCER	151	4	5.6	100.0	100.0	100.0
MINERAL	421	27	0.5	100.0	100.0	100.0
MINGO	417	2	16.2	100.0	100.0	100.0
MONONGALIA	117	457	0.2	100.0	100.0	100.0
MONROE	68	2	2.9	100.0	100.0	100.0
MORGAN	281	14	2.2	100.0	100.0	100.0
NICHOLAS	447	5	7.0	100.0	100.0	100.0
OHIO	366	171	0.3	100.0	100.0	100.0
PENDLETON	26	14	0.0	100.0	100.0	100.0
PLEASANTS	39	2	7.5	100.0	100.0	100.0
POCAHONTAS	88	35	0.0	100.0	100.0	100.0
PRESTON	342	23	0.3	100.0	100.0	100.0

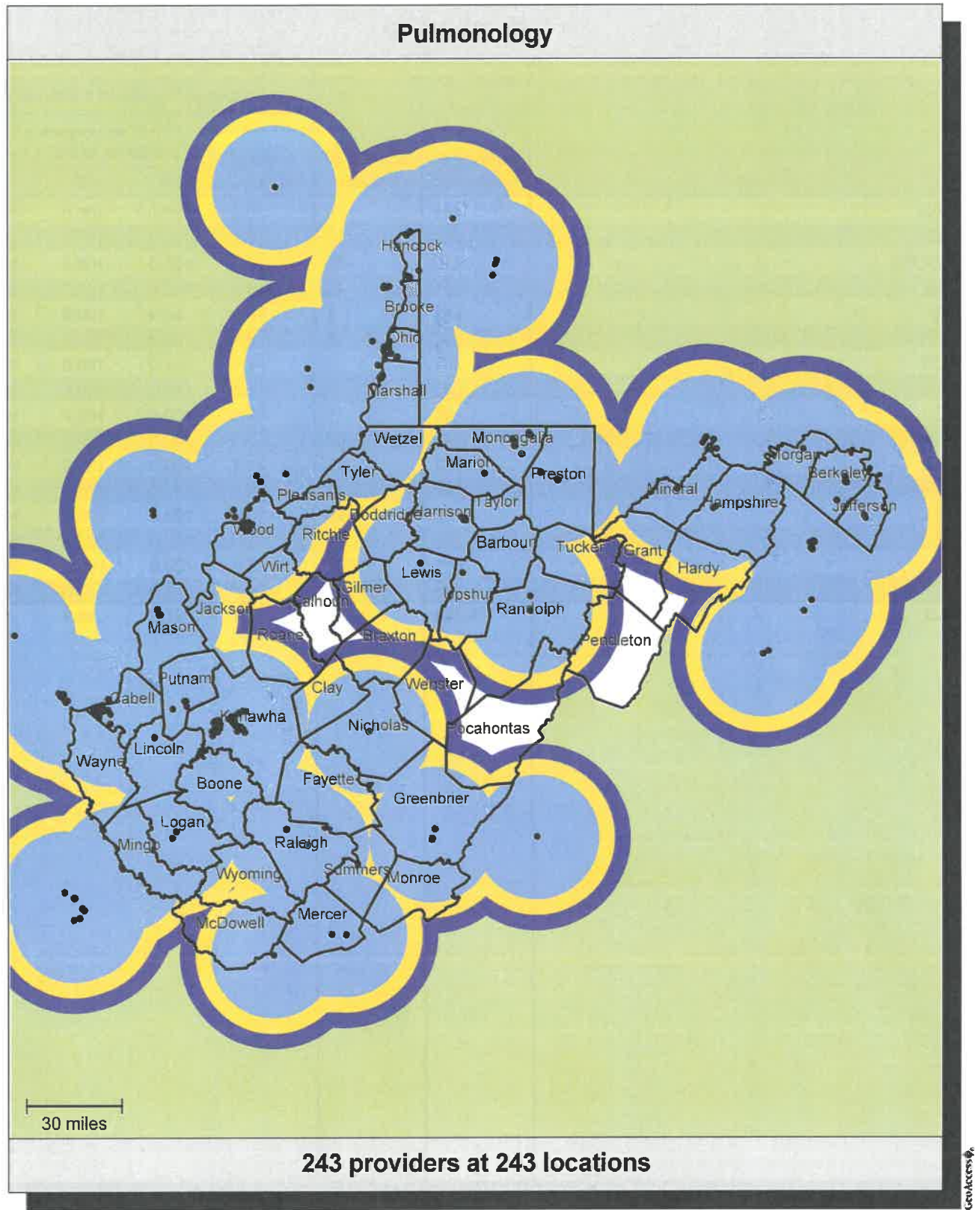
Provider group: Physical Therapy

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	70	0.8	100.0	100.0	100.0
RALEIGH	984	19	2.0	100.0	100.0	100.0
RANDOLPH	412	35	0.5	100.0	100.0	100.0
RITCHIE	151	46	4.1	100.0	100.0	100.0
ROANE	242	0	19.8	50.4	100.0	100.0
SUMMERS	116	30	0.0	100.0	100.0	100.0
TAYLOR	301	3	1.0	100.0	100.0	100.0
TUCKER	52	6	11.8	100.0	100.0	100.0
TYLER	26	1	11.6	100.0	100.0	100.0
UPSHUR	245	98	0.0	100.0	100.0	100.0
WAYNE	522	13	11.2	100.0	100.0	100.0
WEBSTER	168	0	19.0	87.5	100.0	100.0
WETZEL	116	48	0.0	100.0	100.0	100.0
WIRT	63	0	11.0	100.0	100.0	100.0
WOOD	851	606	0.0	100.0	100.0	100.0
WYOMING	403	10	0.0	100.0	100.0	100.0
TOTALS	18,348	3,314	3.4	95.6	98.8	99.9

Provider group: Physical Therapy

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	18.4	92.2	100.0	100.0
BERKELEY	694	6	4.1	100.0	100.0	100.0
BOONE	300	0	19.3	100.0	100.0	100.0
BRAXTON	201	0	37.1	0.0	0.0	0.0
BROOKE	56	0	11.1	100.0	100.0	100.0
CABELL	1,048	18	2.2	100.0	100.0	100.0
CALHOUN	171	0	40.2	0.0	0.0	0.0
CLAY	241	0	29.0	0.0	0.0	85.5
DODDRIDGE	37	0	26.7	0.0	18.9	100.0
FAYETTE	580	0	23.2	0.0	93.3	100.0
GILMER	70	0	35.1	0.0	0.0	0.0
GRANT	146	0	37.3	0.0	0.0	0.0
GREENBRIER	340	3	1.6	100.0	100.0	100.0
HAMPSHIRE	255	2	1.1	100.0	100.0	100.0
HANCOCK	392	5	5.5	100.0	100.0	100.0
HARDY	101	0	31.2	0.0	5.9	44.6
HARRISON	550	4	5.5	100.0	100.0	100.0
JACKSON	480	0	21.4	22.1	94.4	100.0
JEFFERSON	226	2	4.0	100.0	100.0	100.0
KANAWHA	1,619	53	0.8	100.0	100.0	100.0
LEWIS	126	1	12.8	92.1	100.0	100.0
LINCOLN	348	1	13.6	100.0	100.0	100.0
LOGAN	414	2	3.8	100.0	100.0	100.0
MARION	155	1	15.7	100.0	100.0	100.0
MARSHALL	165	6	2.9	100.0	100.0	100.0
MASON	939	4	3.3	100.0	100.0	100.0
MCDOWELL	507	0	31.7	0.0	0.0	12.6
MERCER	151	2	8.5	100.0	100.0	100.0
MINERAL	421	1	17.0	96.4	100.0	100.0
MINGO	417	0	2.8	100.0	100.0	100.0
MONONGALIA	117	29	1.0	100.0	100.0	100.0
MONROE	68	0	19.4	80.9	100.0	100.0
MORGAN	281	1	18.9	57.3	100.0	100.0
NICHOLAS	447	1	39.5	0.0	0.0	0.0
OHIO	366	10	1.9	100.0	100.0	100.0
PENDLETON	26	0	42.2	0.0	0.0	0.0
PLEASANTS	39	0	16.1	100.0	100.0	100.0
POCAHONTAS	88	0	38.8	0.0	0.0	0.0
PRESTON	342	3	2.0	100.0	100.0	100.0

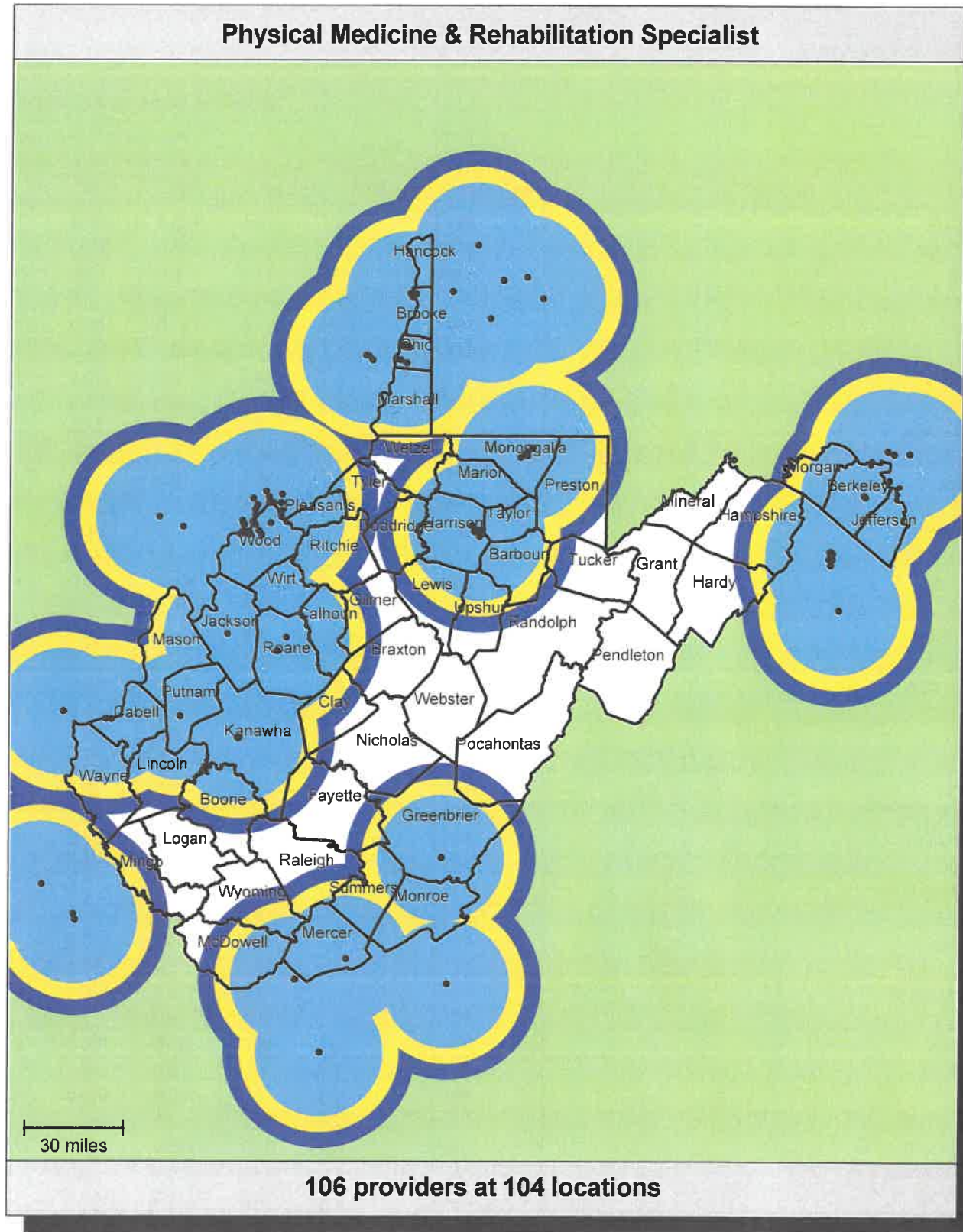
Provider group: Pulmonology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	4	6.8	100.0	100.0	100.0
RALEIGH	984	2	10.6	100.0	100.0	100.0
RANDOLPH	412	2	4.6	100.0	100.0	100.0
RITCHIE	151	0	27.8	0.0	0.0	100.0
ROANE	242	0	34.4	0.0	0.0	11.6
SUMMERS	116	0	24.2	0.0	100.0	100.0
TAYLOR	301	0	15.1	100.0	100.0	100.0
TUCKER	52	0	22.9	0.0	100.0	100.0
TYLER	26	0	22.6	0.0	100.0	100.0
UPSHUR	245	1	20.0	20.0	100.0	100.0
WAYNE	522	0	11.4	100.0	100.0	100.0
WEBSTER	168	0	42.3	0.0	0.0	0.0
WETZEL	116	1	24.0	0.0	71.6	100.0
WIRT	63	0	18.2	74.6	100.0	100.0
WOOD	851	7	1.7	100.0	100.0	100.0
WYOMING	403	0	27.4	0.0	0.0	100.0
TOTALS	18,348	172	12.2	74.6	83.2	88.7

Provider group: Pulmonology

Provider locations



- Single provider locations (103)
- Multiple provider locations (1)

- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	0	16.5	100.0	100.0	100.0
BERKELEY	694	2	4.9	100.0	100.0	100.0
BOONE	300	0	27.1	0.0	0.0	100.0
BRAXTON	201	0	42.3	0.0	0.0	0.0
BROOKE	56	0	7.4	100.0	100.0	100.0
CABELL	1,048	2	4.2	100.0	100.0	100.0
CALHOUN	171	0	26.5	0.0	0.0	100.0
CLAY	241	0	34.2	0.0	0.0	0.0
DODDRIDGE	37	0	27.0	0.0	18.9	100.0
FAYETTE	580	0	41.7	0.0	0.0	0.0
GILMER	70	0	39.6	0.0	0.0	0.0
GRANT	146	0	55.5	0.0	0.0	0.0
GREENBRIER	340	1	40.7	0.0	0.0	0.0
HAMPSHIRE	255	0	37.3	0.0	0.0	0.0
HANCOCK	392	0	12.8	100.0	100.0	100.0
HARDY	101	0	48.6	0.0	0.0	0.0
HARRISON	550	9	5.5	100.0	100.0	100.0
JACKSON	480	1	19.5	55.8	94.4	100.0
JEFFERSON	226	0	16.9	95.6	100.0	100.0
KANAWHA	1,619	3	5.5	100.0	100.0	100.0
LEWIS	126	0	25.7	0.0	54.0	92.1
LINCOLN	348	0	23.3	0.0	85.6	100.0
LOGAN	414	0	45.5	0.0	0.0	0.0
MARION	155	0	15.3	100.0	100.0	100.0
MARSHALL	165	0	12.0	100.0	100.0	100.0
MASON	939	0	32.6	0.0	0.0	0.0
MCDOWELL	507	0	35.4	0.0	0.0	0.0
MERCER	151	1	18.4	72.8	94.7	100.0
MINERAL	421	0	52.3	0.0	0.0	0.0
MINGO	417	0	26.1	0.0	16.8	94.2
MONONGALIA	117	12	1.1	100.0	100.0	100.0
MONROE	68	0	29.3	0.0	0.0	100.0
MORGAN	281	0	20.1	51.6	100.0	100.0
NICHOLAS	447	0	44.3	0.0	0.0	0.0
OHIO	366	5	2.8	100.0	100.0	100.0
PENDLETON	26	0	75.0	0.0	0.0	0.0
PLEASANTS	39	0	12.7	100.0	100.0	100.0
POCAHONTAS	88	0	74.3	0.0	0.0	0.0
PRESTON	342	0	22.0	13.5	100.0	100.0

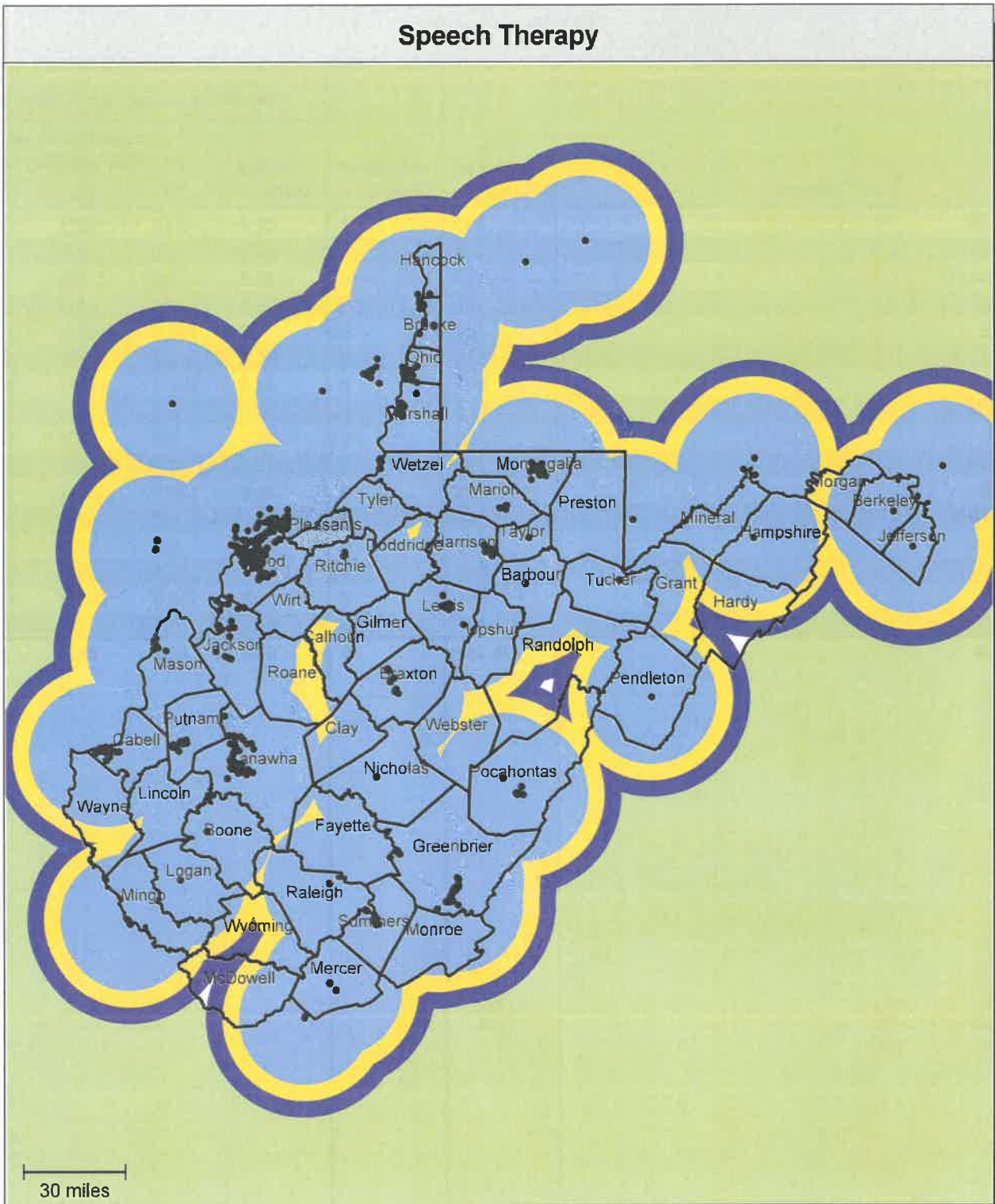
Provider group: Physical Medicine & Rehabilitation Specialist

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	1	22.4	23.0	92.3	100.0
RALEIGH	984	0	40.1	0.0	0.0	0.0
RANDOLPH	412	0	38.6	0.0	0.0	0.0
RITCHIE	151	0	26.8	0.0	0.0	100.0
ROANE	242	2	7.7	100.0	100.0	100.0
SUMMERS	116	0	30.6	0.0	0.0	10.3
TAYLOR	301	0	14.1	100.0	100.0	100.0
TUCKER	52	0	35.1	0.0	0.0	11.5
TYLER	26	0	29.0	0.0	0.0	100.0
UPSHUR	245	0	20.6	15.1	97.1	100.0
WAYNE	522	0	16.6	100.0	100.0	100.0
WEBSTER	168	0	58.2	0.0	0.0	0.0
WETZEL	116	0	30.7	0.0	0.0	26.7
WIRT	63	0	19.1	74.6	100.0	100.0
WOOD	851	6	2.9	100.0	100.0	100.0
WYOMING	403	0	41.3	0.0	0.0	0.0
TOTALS	18,348	45	23.5	45.7	54.7	61.8

Provider group: Physical Medicine & Rehabilitation Specialist

Provider locations



- Provider locations (726)
- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR	281	1	14.2	100.0	100.0	100.0
BERKELEY	694	1	18.4	87.3	100.0	100.0
BOONE	300	1	20.0	46.0	100.0	100.0
BRAXTON	201	16	5.6	100.0	100.0	100.0
BROOKE	56	4	2.4	100.0	100.0	100.0
CABELL	1,048	47	1.1	100.0	100.0	100.0
CALHOUN	171	0	23.0	0.0	100.0	100.0
CLAY	241	0	27.2	0.0	0.0	100.0
DODDRIDGE	37	0	17.0	100.0	100.0	100.0
FAYETTE	580	0	22.7	0.0	93.3	100.0
GILMER	70	0	12.1	100.0	100.0	100.0
GRANT	146	0	28.5	0.0	0.0	100.0
GREENBRIER	340	44	0.5	100.0	100.0	100.0
HAMPSHIRE	255	1	22.5	0.0	100.0	100.0
HANCOCK	392	1	10.4	100.0	100.0	100.0
HARDY	101	0	32.9	0.0	0.0	10.9
HARRISON	550	23	4.5	100.0	100.0	100.0
JACKSON	480	35	2.3	100.0	100.0	100.0
JEFFERSON	226	1	17.1	88.5	100.0	100.0
KANAWHA	1,619	108	1.8	100.0	100.0	100.0
LEWIS	126	11	2.4	100.0	100.0	100.0
LINCOLN	348	0	13.6	100.0	100.0	100.0
LOGAN	414	1	20.8	26.6	100.0	100.0
MARION	155	4	2.3	100.0	100.0	100.0
MARSHALL	165	30	0.4	100.0	100.0	100.0
MASON	939	5	2.5	100.0	100.0	100.0
MCDOWELL	507	0	26.1	0.0	12.6	100.0
MERCER	151	2	5.7	100.0	100.0	100.0
MINERAL	421	0	21.4	3.8	100.0	100.0
MINGO	417	0	2.2	100.0	100.0	100.0
MONONGALIA	117	23	0.7	100.0	100.0	100.0
MONROE	68	0	13.4	100.0	100.0	100.0
MORGAN	281	0	29.4	0.0	0.0	51.6
NICHOLAS	447	1	25.0	0.0	61.1	100.0
OHIO	366	14	1.7	100.0	100.0	100.0
PENDLETON	26	4	0.0	100.0	100.0	100.0
PLEASANTS	39	0	11.2	100.0	100.0	100.0
POCAHONTAS	88	12	1.0	100.0	100.0	100.0
PRESTON	342	0	20.1	26.9	100.0	100.0

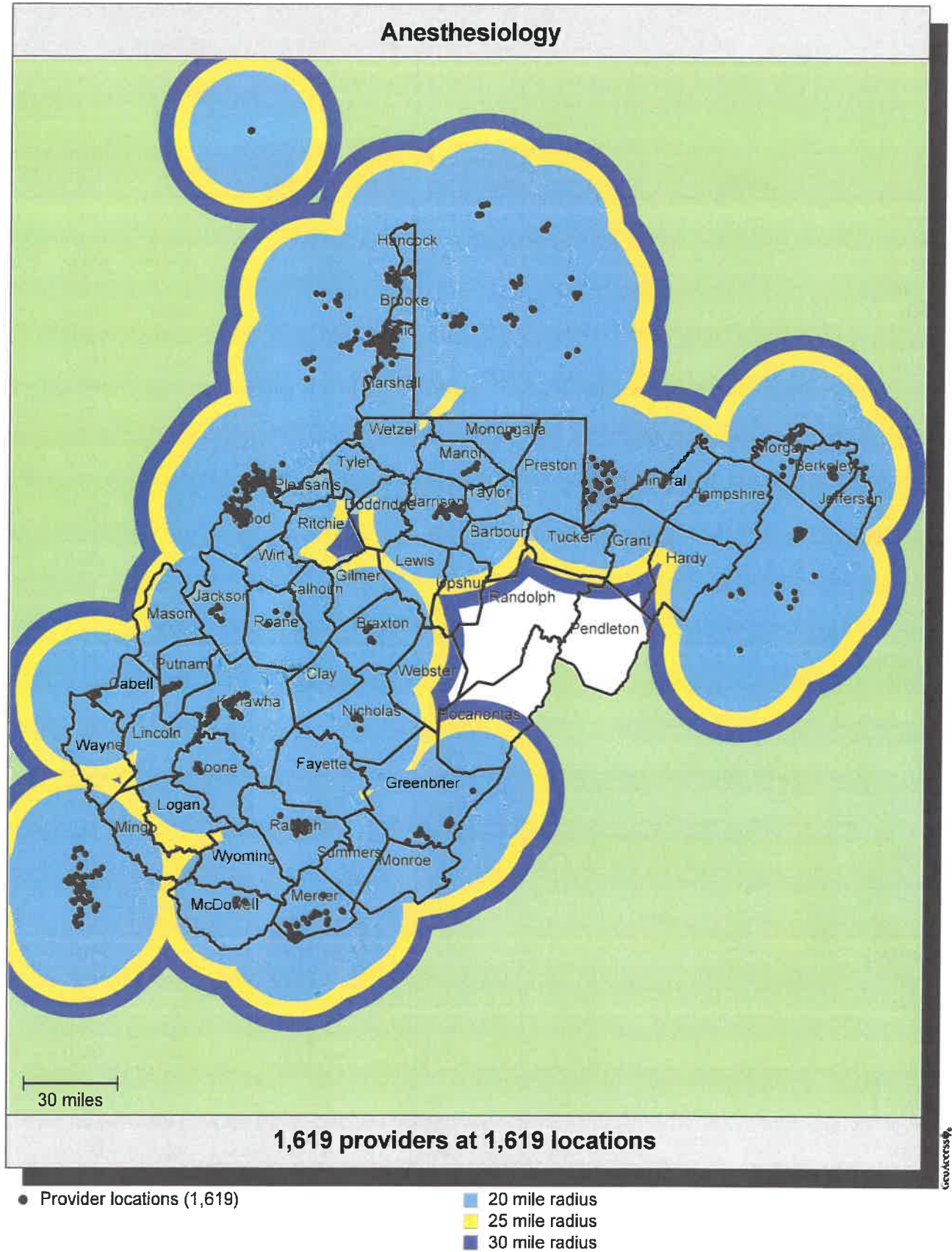
Provider group: Speech Therapy

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
PUTNAM	491	16	7.0	100.0	100.0	100.0
RALEIGH	984	1	18.2	88.6	94.3	100.0
RANDOLPH	412	0	30.5	0.0	0.0	20.9
RITCHIE	151	4	4.4	100.0	100.0	100.0
ROANE	242	0	22.2	27.7	83.5	100.0
SUMMERS	116	17	0.3	100.0	100.0	100.0
TAYLOR	301	1	13.2	100.0	100.0	100.0
TUCKER	52	3	12.6	100.0	100.0	100.0
TYLER	26	0	13.0	100.0	100.0	100.0
UPSHUR	245	0	15.2	97.1	100.0	100.0
WAYNE	522	0	12.7	100.0	100.0	100.0
WEBSTER	168	0	27.5	0.0	0.0	100.0
WETZEL	116	5	0.9	100.0	100.0	100.0
WIRT	63	0	11.0	100.0	100.0	100.0
WOOD	851	162	0.6	100.0	100.0	100.0
WYOMING	403	0	32.9	0.0	0.0	0.0
TOTALS	18,348	599	12.1	71.4	86.4	94.8

Provider group: Speech Therapy

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	16.5	100.0	100.0	100.0
BERKELEY	694	29	3.0	100.0	100.0	100.0
BOONE	300	8	0.0	100.0	100.0	100.0
BRAXTON	201	5	5.7	100.0	100.0	100.0
BROOKE	56	0	6.4	100.0	100.0	100.0
CABELL	1,048	15	3.7	100.0	100.0	100.0
CALHOUN	171	0	18.0	100.0	100.0	100.0
CLAY	241	0	20.5	28.6	100.0	100.0
DODDRIDGE	37	0	21.7	18.9	100.0	100.0
FAYETTE	580	4	18.4	100.0	100.0	100.0
GILMER	70	0	16.2	100.0	100.0	100.0
GRANT	146	0	29.5	0.0	0.0	64.4
GREENBRIER	340	39	3.6	100.0	100.0	100.0
HAMPSHIRE	255	11	0.1	100.0	100.0	100.0
HANCOCK	392	4	5.8	100.0	100.0	100.0
HARDY	101	0	26.0	0.0	22.8	100.0
HARRISON	550	53	0.3	100.0	100.0	100.0
JACKSON	480	11	0.6	100.0	100.0	100.0
JEFFERSON	226	0	15.2	100.0	100.0	100.0
KANAWHA	1,619	447	0.5	100.0	100.0	100.0
LEWIS	126	0	18.1	88.1	96.0	100.0
LINCOLN	348	0	11.6	100.0	100.0	100.0
LOGAN	414	0	20.9	26.6	100.0	100.0
MARION	155	7	1.3	100.0	100.0	100.0
MARSHALL	165	13	2.5	100.0	100.0	100.0
MASON	939	0	22.2	21.3	94.8	100.0
MCDOWELL	507	4	0.3	100.0	100.0	100.0
MERCER	151	74	1.1	100.0	100.0	100.0
MINERAL	421	11	0.4	100.0	100.0	100.0
MINGO	417	0	12.9	100.0	100.0	100.0
MONONGALIA	117	64	1.0	100.0	100.0	100.0
MONROE	68	0	9.4	100.0	100.0	100.0
MORGAN	281	15	1.2	100.0	100.0	100.0
NICHOLAS	447	4	2.6	100.0	100.0	100.0
OHIO	366	133	0.0	100.0	100.0	100.0
PENDLETON	26	0	44.1	0.0	0.0	0.0
PLEASANTS	39	0	10.3	100.0	100.0	100.0
POCAHONTAS	88	0	21.2	0.0	100.0	100.0
PRESTON	342	0	14.5	100.0	100.0	100.0

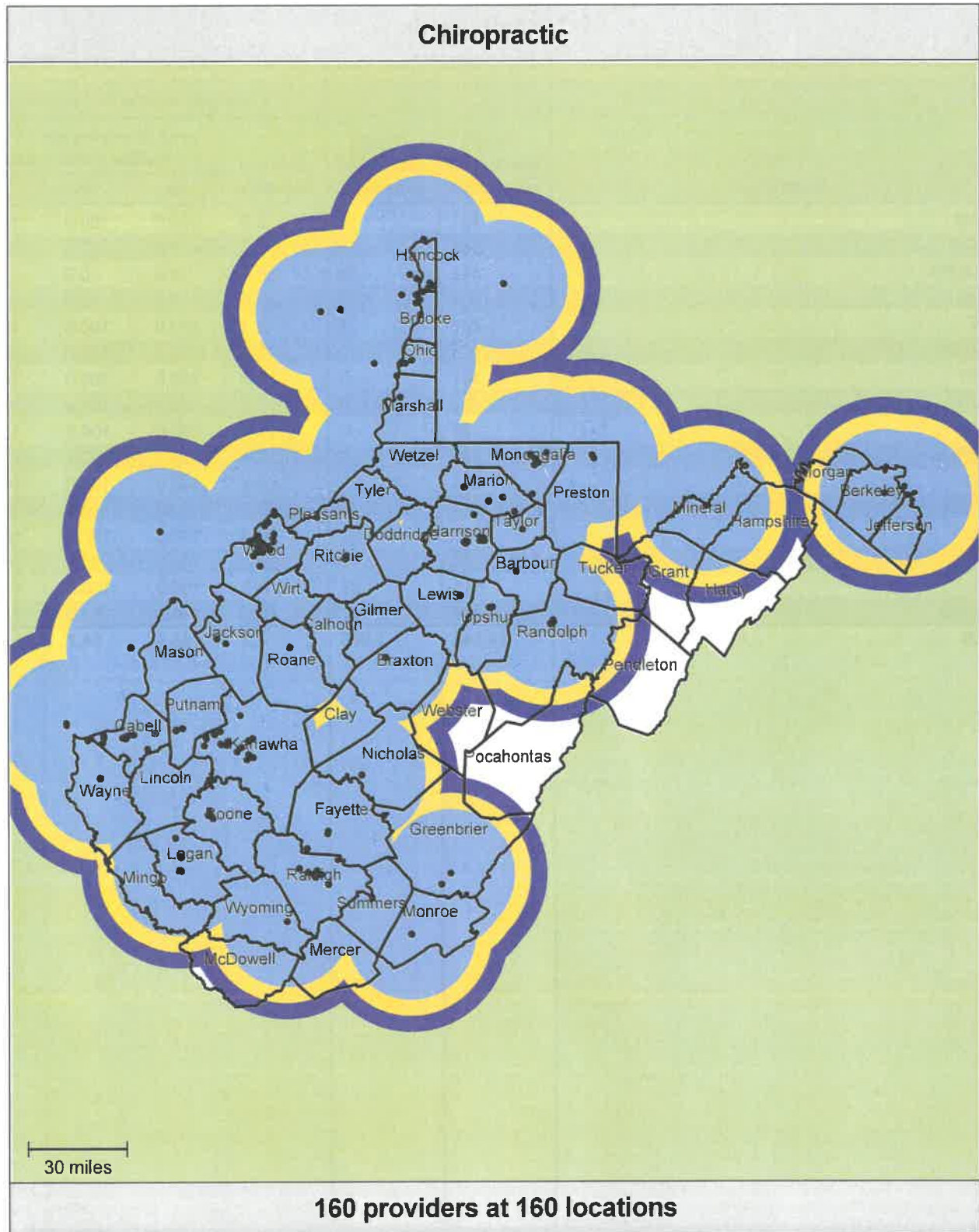
Provider group: Anesthesiology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	30	5.9	100.0	100.0	100.0
RALEIGH	984	28	0.6	100.0	100.0	100.0
RANDOLPH	412	0	38.4	0.0	0.0	0.0
RITCHIE	151	0	25.0	0.0	49.0	100.0
ROANE	242	3	2.3	100.0	100.0	100.0
SUMMERS	116	0	19.3	50.9	100.0	100.0
TAYLOR	301	0	11.0	100.0	100.0	100.0
TUCKER	52	0	23.1	11.5	100.0	100.0
TYLER	26	0	11.6	100.0	100.0	100.0
UPSHUR	245	0	19.4	84.1	97.1	100.0
WAYNE	522	0	9.8	100.0	100.0	100.0
WEBSTER	168	0	28.3	0.0	0.0	87.5
WETZEL	116	53	0.0	100.0	100.0	100.0
WIRT	63	0	16.8	100.0	100.0	100.0
WOOD	851	31	0.5	100.0	100.0	100.0
WYOMING	403	0	11.9	100.0	100.0	100.0
TOTALS	18,348	1,096	8.3	86.4	94.7	97.2

Provider group: Anesthesiology

Provider locations



● Provider locations (160)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	1	1.3	100.0	100.0	100.0
BERKELEY	694	1	5.0	100.0	100.0	100.0
BOONE	300	3	0.3	100.0	100.0	100.0
BRAXTON	201	1	13.6	100.0	100.0	100.0
BROOKE	56	1	2.6	100.0	100.0	100.0
CABELL	1,048	16	1.8	100.0	100.0	100.0
CALHOUN	171	0	20.7	0.0	100.0	100.0
CLAY	241	0	20.8	14.5	100.0	100.0
DODDRIDGE	37	0	18.6	100.0	100.0	100.0
FAYETTE	580	3	6.8	100.0	100.0	100.0
GILMER	70	0	12.7	100.0	100.0	100.0
GRANT	146	0	35.2	0.0	0.0	0.0
GREENBRIER	340	2	1.5	100.0	100.0	100.0
HAMPSHIRE	255	0	16.9	100.0	100.0	100.0
HANCOCK	392	4	4.6	100.0	100.0	100.0
HARDY	101	0	30.3	0.0	5.9	49.5
HARRISON	550	13	1.2	100.0	100.0	100.0
JACKSON	480	3	2.6	100.0	100.0	100.0
JEFFERSON	226	1	15.7	95.1	100.0	100.0
KANAWHA	1,619	18	0.6	100.0	100.0	100.0
LEWIS	126	1	6.1	100.0	100.0	100.0
LINCOLN	348	0	9.1	100.0	100.0	100.0
LOGAN	414	4	1.6	100.0	100.0	100.0
MARION	155	4	1.9	100.0	100.0	100.0
MARSHALL	165	1	1.3	100.0	100.0	100.0
MASON	939	1	11.2	100.0	100.0	100.0
MCDOWELL	507	0	19.4	87.6	100.0	100.0
MERCER	151	0	26.8	0.0	12.6	97.4
MINERAL	421	1	1.3	100.0	100.0	100.0
MINGO	417	0	22.0	11.8	100.0	100.0
MONONGALIA	117	6	0.9	100.0	100.0	100.0
MONROE	68	2	10.5	100.0	100.0	100.0
MORGAN	281	0	20.2	43.1	100.0	100.0
NICHOLAS	447	1	9.1	100.0	100.0	100.0
OHIO	366	3	2.3	100.0	100.0	100.0
PENDLETON	26	0	41.0	0.0	0.0	0.0
PLEASANTS	39	1	3.5	100.0	100.0	100.0
POCAHONTAS	88	0	42.5	0.0	0.0	0.0
PRESTON	342	2	14.6	100.0	100.0	100.0

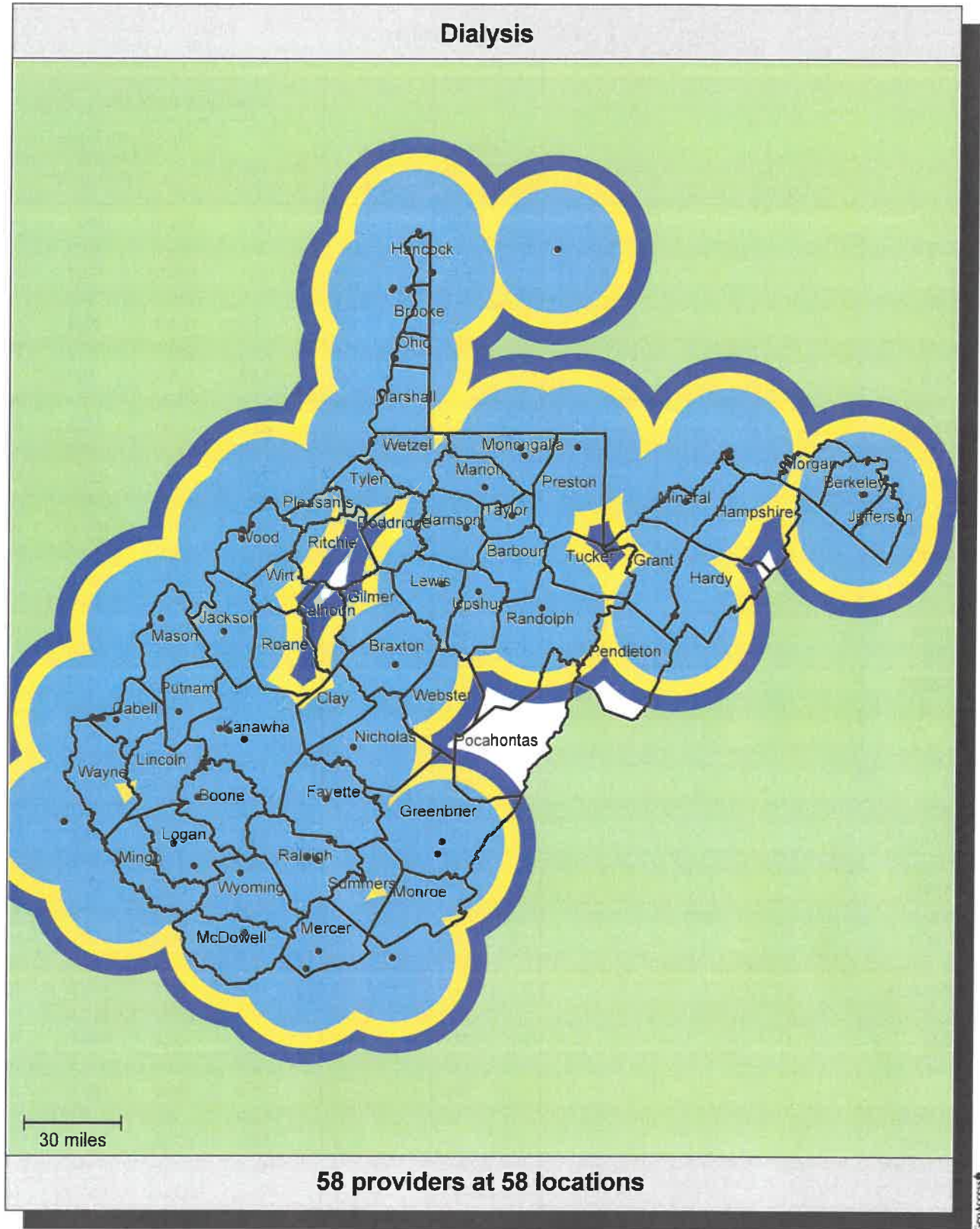
Provider group: Chiropractic

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	3	7.0	100.0	100.0	100.0
RALEIGH	984	7	1.5	100.0	100.0	100.0
RANDOLPH	412	4	0.7	100.0	100.0	100.0
RITCHIE	151	2	0.4	100.0	100.0	100.0
ROANE	242	1	5.1	100.0	100.0	100.0
SUMMERS	116	0	17.4	100.0	100.0	100.0
TAYLOR	301	1	1.1	100.0	100.0	100.0
TUCKER	52	0	19.0	78.8	100.0	100.0
TYLER	26	0	12.4	100.0	100.0	100.0
UPSHUR	245	2	1.7	100.0	100.0	100.0
WAYNE	522	2	1.4	100.0	100.0	100.0
WEBSTER	168	0	35.9	0.0	0.0	0.0
WETZEL	116	1	1.4	100.0	100.0	100.0
WIRT	63	0	13.6	100.0	100.0	100.0
WOOD	851	22	1.0	100.0	100.0	100.0
WYOMING	403	1	9.6	100.0	100.0	100.0
TOTALS	18,348	140	7.0	90.9	96.4	97.4

Provider group: Chiropractic

Provider locations



● Provider locations (58)

20 mile radius

25 mile radius

30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	14.1	100.0	100.0	100.0
BERKELEY	694	2	4.7	100.0	100.0	100.0
BOONE	300	1	2.4	100.0	100.0	100.0
BRAXTON	201	1	3.9	100.0	100.0	100.0
BROOKE	56	0	9.5	100.0	100.0	100.0
CABELL	1,048	3	1.6	100.0	100.0	100.0
CALHOUN	171	0	33.8	0.0	0.0	0.0
CLAY	241	0	17.6	100.0	100.0	100.0
DODDRIDGE	37	0	25.1	0.0	18.9	100.0
FAYETTE	580	2	1.1	100.0	100.0	100.0
GILMER	70	0	23.4	0.0	100.0	100.0
GRANT	146	0	10.7	100.0	100.0	100.0
GREENBRIER	340	2	1.1	100.0	100.0	100.0
HAMPSHIRE	255	0	16.7	100.0	100.0	100.0
HANCOCK	392	0	6.2	100.0	100.0	100.0
HARDY	101	1	11.7	100.0	100.0	100.0
HARRISON	550	2	3.4	100.0	100.0	100.0
JACKSON	480	1	2.1	100.0	100.0	100.0
JEFFERSON	226	1	9.3	100.0	100.0	100.0
KANAWHA	1,619	3	1.5	100.0	100.0	100.0
LEWIS	126	1	4.2	100.0	100.0	100.0
LINCOLN	348	0	16.9	100.0	100.0	100.0
LOGAN	414	2	1.8	100.0	100.0	100.0
MARION	155	1	3.3	100.0	100.0	100.0
MARSHALL	165	0	10.8	100.0	100.0	100.0
MASON	939	1	1.9	100.0	100.0	100.0
MCDOWELL	507	1	1.0	100.0	100.0	100.0
MERCER	151	2	5.0	100.0	100.0	100.0
MINERAL	421	1	3.1	100.0	100.0	100.0
MINGO	417	0	2.5	100.0	100.0	100.0
MONONGALIA	117	2	1.5	100.0	100.0	100.0
MONROE	68	0	18.3	100.0	100.0	100.0
MORGAN	281	0	20.8	40.2	100.0	100.0
NICHOLAS	447	1	6.9	100.0	100.0	100.0
OHIO	366	1	3.4	100.0	100.0	100.0
PENDLETON	26	0	28.2	0.0	0.0	100.0
PLEASANTS	39	0	15.8	100.0	100.0	100.0
POCAHONTAS	88	0	38.8	0.0	0.0	0.0
PRESTON	342	1	14.3	100.0	100.0	100.0

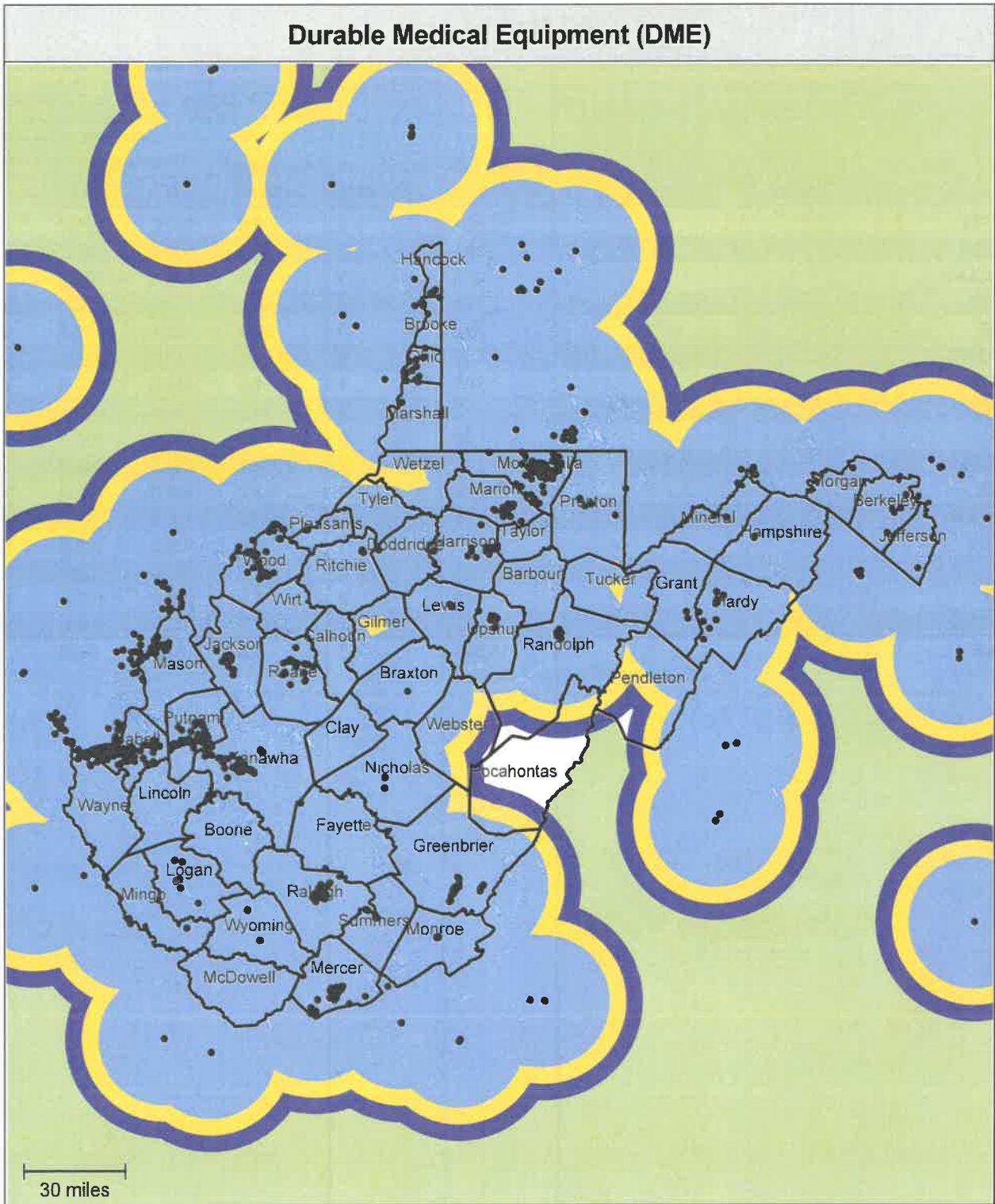
Provider group: Dialysis

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	1	8.3	100.0	100.0	100.0
RALEIGH	984	2	2.2	100.0	100.0	100.0
RANDOLPH	412	1	1.1	100.0	100.0	100.0
RITCHIE	151	0	31.0	0.0	0.0	0.0
ROANE	242	0	22.4	33.9	72.7	100.0
SUMMERS	116	0	20.2	17.2	100.0	100.0
TAYLOR	301	1	1.0	100.0	100.0	100.0
TUCKER	52	0	20.0	76.9	100.0	100.0
TYLER	26	0	14.7	100.0	100.0	100.0
UPSHUR	245	1	2.1	100.0	100.0	100.0
WAYNE	522	0	13.2	100.0	100.0	100.0
WEBSTER	168	0	26.2	0.0	37.5	87.5
WETZEL	116	1	1.9	100.0	100.0	100.0
WIRT	63	0	20.9	23.8	100.0	100.0
WOOD	851	2	2.9	100.0	100.0	100.0
WYOMING	403	1	10.7	100.0	100.0	100.0
TOTALS	18,348	43	6.5	93.5	96.5	97.7

Provider group: Dialysis

Provider locations



1,072 providers at 1,049 locations

- Single provider locations (1,048)
- Multiple provider locations (1)
- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	17.1	100.0	100.0	100.0
BERKELEY	694	5	3.4	100.0	100.0	100.0
BOONE	300	0	16.8	100.0	100.0	100.0
BRAXTON	201	1	4.0	100.0	100.0	100.0
BROOKE	56	1	4.5	100.0	100.0	100.0
CABELL	1,048	136	0.2	100.0	100.0	100.0
CALHOUN	171	0	16.3	100.0	100.0	100.0
CLAY	241	0	22.7	0.0	100.0	100.0
DODDRIDGE	37	1	5.7	100.0	100.0	100.0
FAYETTE	580	2	13.9	100.0	100.0	100.0
GILMER	70	0	23.2	0.0	100.0	100.0
GRANT	146	2	1.1	100.0	100.0	100.0
GREENBRIER	340	27	0.0	100.0	100.0	100.0
HAMPSHIRE	255	2	0.3	100.0	100.0	100.0
HANCOCK	392	5	6.4	100.0	100.0	100.0
HARDY	101	11	0.8	100.0	100.0	100.0
HARRISON	550	24	0.9	100.0	100.0	100.0
JACKSON	480	25	0.0	100.0	100.0	100.0
JEFFERSON	226	1	6.3	100.0	100.0	100.0
KANAWHA	1,619	134	0.0	100.0	100.0	100.0
LEWIS	126	2	2.7	100.0	100.0	100.0
LINCOLN	348	0	7.4	100.0	100.0	100.0
LOGAN	414	6	0.8	100.0	100.0	100.0
MARION	155	23	0.5	100.0	100.0	100.0
MARSHALL	165	1	1.6	100.0	100.0	100.0
MASON	939	25	0.0	100.0	100.0	100.0
MCDOWELL	507	0	12.0	100.0	100.0	100.0
MERCER	151	25	1.4	100.0	100.0	100.0
MINERAL	421	2	1.0	100.0	100.0	100.0
MINGO	417	2	2.0	100.0	100.0	100.0
MONONGALIA	117	123	0.2	100.0	100.0	100.0
MONROE	68	4	0.5	100.0	100.0	100.0
MORGAN	281	1	7.0	100.0	100.0	100.0
NICHOLAS	447	2	3.3	100.0	100.0	100.0
OHIO	366	17	0.7	100.0	100.0	100.0
PENDLETON	26	0	29.5	0.0	0.0	100.0
PLEASANTS	39	3	6.6	100.0	100.0	100.0
POCAHONTAS	88	0	35.1	0.0	0.0	0.0
PRESTON	342	5	1.1	100.0	100.0	100.0

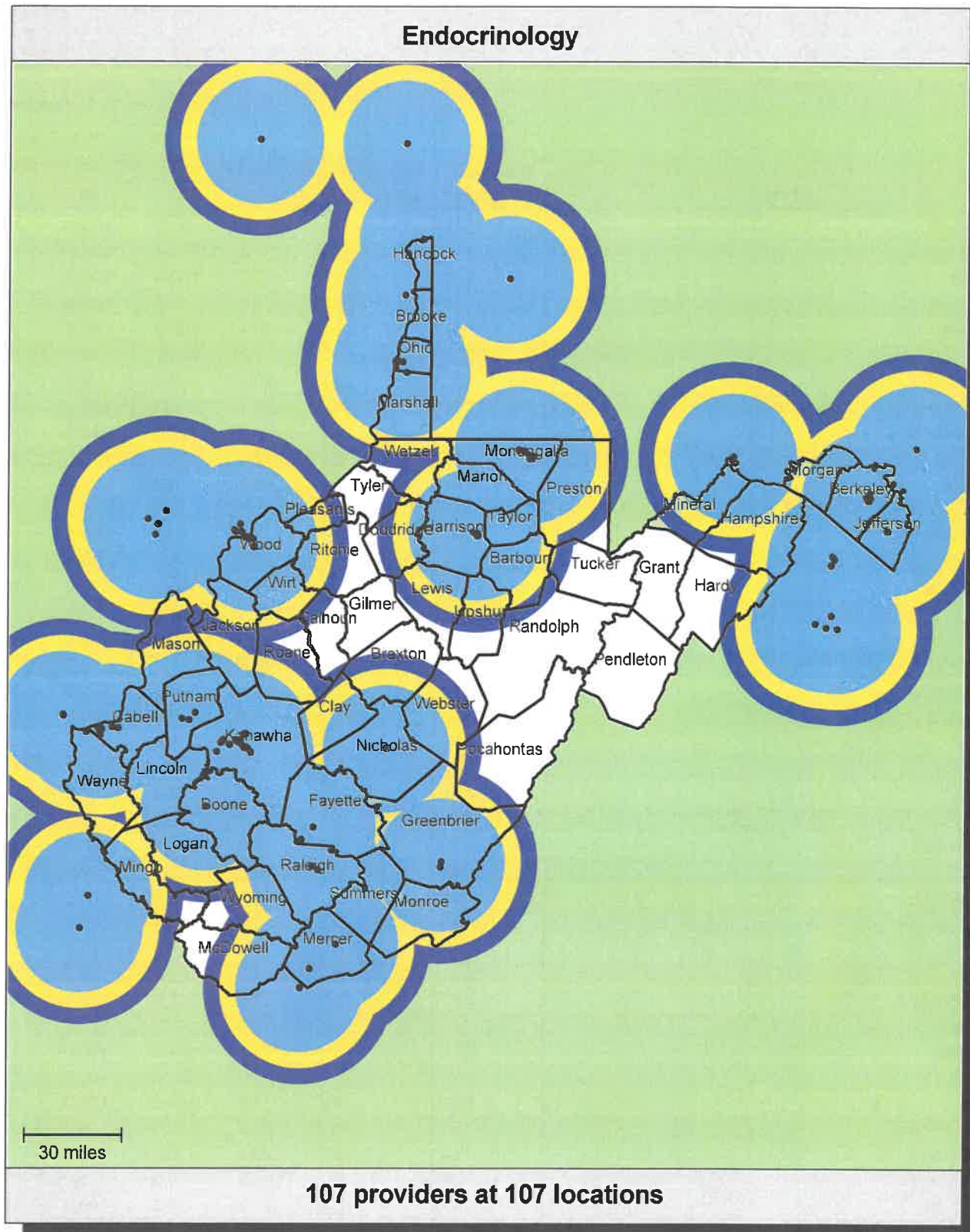
Provider group: Durable Medical Equipment (DME)

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	98	0.0	100.0	100.0	100.0
RALEIGH	984	26	0.8	100.0	100.0	100.0
RANDOLPH	412	9	0.4	100.0	100.0	100.0
RITCHIE	151	4	8.9	100.0	100.0	100.0
ROANE	242	29	0.0	100.0	100.0	100.0
SUMMERS	116	4	0.9	100.0	100.0	100.0
TAYLOR	301	0	7.4	100.0	100.0	100.0
TUCKER	52	0	19.2	76.9	100.0	100.0
TYLER	26	0	15.5	100.0	100.0	100.0
UPSHUR	245	22	0.6	100.0	100.0	100.0
WAYNE	522	24	9.4	100.0	100.0	100.0
WEBSTER	168	0	26.4	0.0	37.5	87.5
WETZEL	116	0	23.6	0.0	100.0	100.0
WIRT	63	0	11.5	100.0	100.0	100.0
WOOD	851	46	1.0	100.0	100.0	100.0
WYOMING	403	3	1.4	100.0	100.0	100.0
TOTALS	18,348	883	4.2	96.1	98.8	99.4

Provider group: Durable Medical Equipment (DME)

Provider locations



● Provider locations (107)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	18.3	92.2	100.0	100.0
BERKELEY	694	6	3.3	100.0	100.0	100.0
BOONE	300	1	0.7	100.0	100.0	100.0
BRAXTON	201	0	24.9	15.4	30.8	92.0
BROOKE	56	0	10.4	100.0	100.0	100.0
CABELL	1,048	9	1.2	100.0	100.0	100.0
CALHOUN	171	0	40.0	0.0	0.0	0.0
CLAY	241	0	24.1	0.0	100.0	100.0
DODDRIDGE	37	0	26.6	0.0	18.9	100.0
FAYETTE	580	2	10.8	100.0	100.0	100.0
GILMER	70	0	44.0	0.0	0.0	0.0
GRANT	146	0	49.5	0.0	0.0	0.0
GREENBRIER	340	2	1.1	100.0	100.0	100.0
HAMPSHIRE	255	0	20.8	0.0	100.0	100.0
HANCOCK	392	0	8.5	100.0	100.0	100.0
HARDY	101	0	43.4	0.0	0.0	0.0
HARRISON	550	5	5.4	100.0	100.0	100.0
JACKSON	480	0	28.8	0.0	0.0	83.3
JEFFERSON	226	2	3.8	100.0	100.0	100.0
KANAWHA	1,619	17	0.8	100.0	100.0	100.0
LEWIS	126	0	26.1	0.0	26.2	92.1
LINCOLN	348	0	17.7	100.0	100.0	100.0
LOGAN	414	0	21.3	13.3	100.0	100.0
MARION	155	0	15.8	100.0	100.0	100.0
MARSHALL	165	0	9.2	100.0	100.0	100.0
MASON	939	0	30.0	0.0	0.0	47.2
MCDOWELL	507	0	25.3	0.0	25.0	100.0
MERCER	151	2	5.8	100.0	100.0	100.0
MINERAL	421	0	24.1	0.0	88.8	100.0
MINGO	417	0	14.3	100.0	100.0	100.0
MONONGALIA	117	13	0.7	100.0	100.0	100.0
MONROE	68	0	17.4	100.0	100.0	100.0
MORGAN	281	0	19.4	51.6	100.0	100.0
NICHOLAS	447	1	6.5	100.0	100.0	100.0
OHIO	366	5	1.8	100.0	100.0	100.0
PENDLETON	26	0	65.2	0.0	0.0	0.0
PLEASANTS	39	0	26.4	0.0	30.8	92.3
POCAHONTAS	88	0	40.3	0.0	0.0	0.0
PRESTON	342	0	21.3	13.5	100.0	100.0

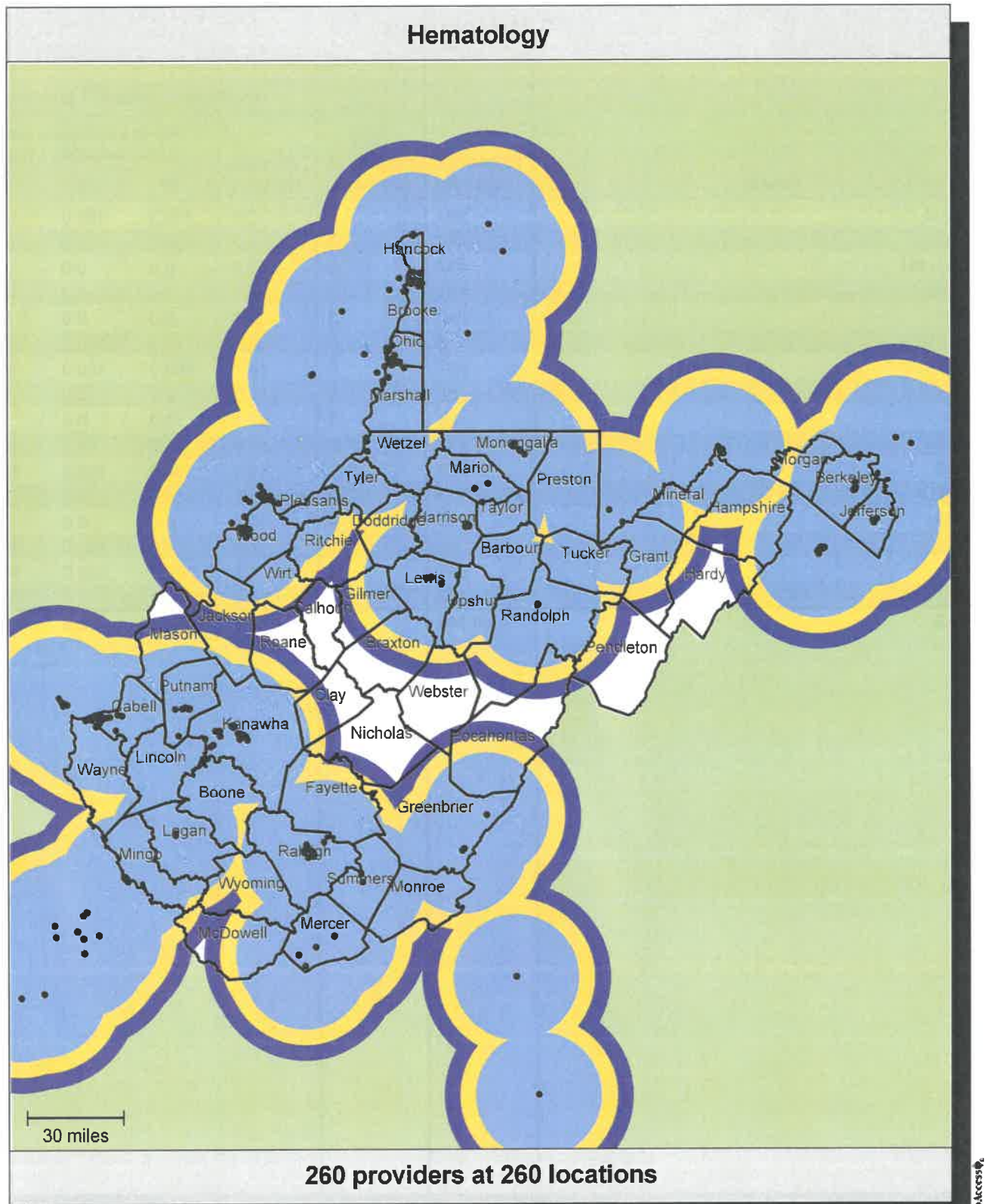
Provider group: Endocrinology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	3	3.7	100.0	100.0	100.0
RALEIGH	984	2	2.0	100.0	100.0	100.0
RANDOLPH	412	0	40.2	0.0	0.0	0.0
RITCHIE	151	0	27.7	0.0	0.0	100.0
ROANE	242	0	35.6	0.0	0.0	0.0
SUMMERS	116	0	20.4	17.2	100.0	100.0
TAYLOR	301	0	14.7	100.0	100.0	100.0
TUCKER	52	0	36.8	0.0	0.0	11.5
TYLER	26	0	42.1	0.0	0.0	0.0
UPSHUR	245	0	21.4	8.6	94.3	100.0
WAYNE	522	0	10.9	100.0	100.0	100.0
WEBSTER	168	0	27.8	0.0	12.5	87.5
WETZEL	116	0	31.5	0.0	0.0	20.7
WIRT	63	0	17.9	74.6	100.0	100.0
WOOD	851	3	1.3	100.0	100.0	100.0
WYOMING	403	0	28.0	0.0	0.0	100.0
TOTALS	18,348	73	14.0	64.4	76.6	88.8

Provider group: Endocrinology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	18.5	92.2	100.0	100.0
BERKELEY	694	6	3.5	100.0	100.0	100.0
BOONE	300	0	16.2	100.0	100.0	100.0
BRAXTON	201	0	34.7	0.0	0.0	15.9
BROOKE	56	0	7.8	100.0	100.0	100.0
CABELL	1,048	22	0.8	100.0	100.0	100.0
CALHOUN	171	0	37.2	0.0	0.0	0.0
CLAY	241	0	33.6	0.0	0.0	0.0
DODDRIDGE	37	0	25.1	0.0	18.9	100.0
FAYETTE	580	0	16.0	100.0	100.0	100.0
GILMER	70	0	23.6	0.0	100.0	100.0
GRANT	146	0	29.5	0.0	0.0	65.8
GREENBRIER	340	3	9.2	100.0	100.0	100.0
HAMPSHIRE	255	0	20.2	29.4	100.0	100.0
HANCOCK	392	11	4.3	100.0	100.0	100.0
HARDY	101	0	34.2	0.0	0.0	0.0
HARRISON	550	6	4.5	100.0	100.0	100.0
JACKSON	480	0	31.1	0.0	0.0	27.5
JEFFERSON	226	3	3.0	100.0	100.0	100.0
KANAWHA	1,619	33	0.5	100.0	100.0	100.0
LEWIS	126	3	2.1	100.0	100.0	100.0
LINCOLN	348	0	9.3	100.0	100.0	100.0
LOGAN	414	2	1.9	100.0	100.0	100.0
MARION	155	3	1.8	100.0	100.0	100.0
MARSHALL	165	4	2.5	100.0	100.0	100.0
MASON	939	0	32.7	0.0	0.0	0.0
MCDOWELL	507	0	23.2	0.0	100.0	100.0
MERCER	151	4	3.6	100.0	100.0	100.0
MINERAL	421	0	23.1	0.0	100.0	100.0
MINGO	417	0	2.0	100.0	100.0	100.0
MONONGALIA	117	35	0.8	100.0	100.0	100.0
MONROE	68	0	21.9	0.0	100.0	100.0
MORGAN	281	0	19.4	51.6	100.0	100.0
NICHOLAS	447	0	39.3	0.0	0.0	0.0
OHIO	366	11	1.2	100.0	100.0	100.0
PENDLETON	26	0	41.1	0.0	0.0	0.0
PLEASANTS	39	0	12.1	100.0	100.0	100.0
POCAHONTAS	88	0	21.2	0.0	100.0	100.0
PRESTON	342	0	19.1	53.5	100.0	100.0

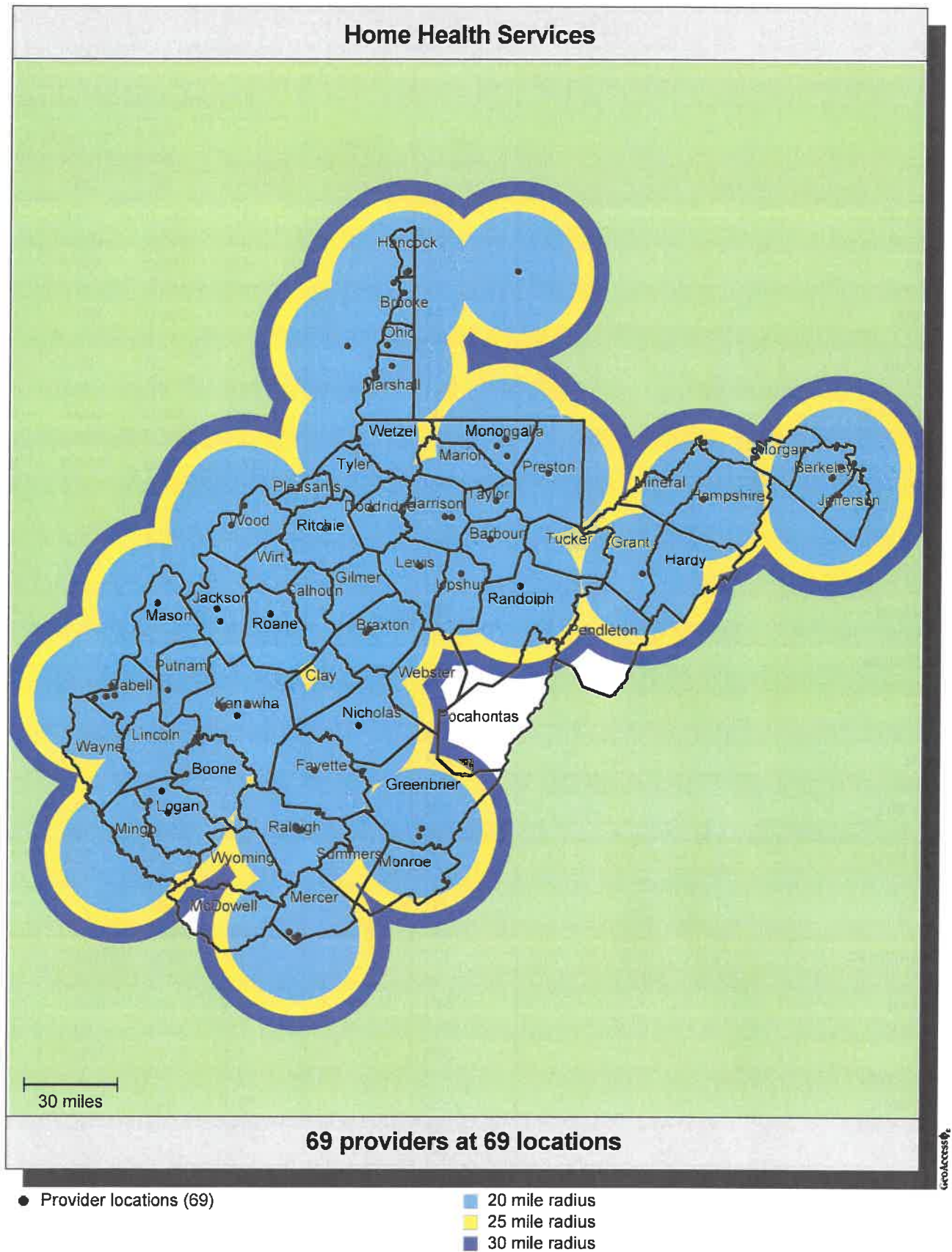
Provider group: Hematology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	7	5.4	100.0	100.0	100.0
RALEIGH	984	10	1.2	100.0	100.0	100.0
RANDOLPH	412	2	1.1	100.0	100.0	100.0
RITCHIE	151	0	27.2	0.0	0.0	100.0
ROANE	242	0	37.7	0.0	0.0	0.0
SUMMERS	116	1	2.4	100.0	100.0	100.0
TAYLOR	301	0	11.2	100.0	100.0	100.0
TUCKER	52	0	19.8	76.9	100.0	100.0
TYLER	26	0	12.1	100.0	100.0	100.0
UPSHUR	245	1	9.0	100.0	100.0	100.0
WAYNE	522	0	10.1	100.0	100.0	100.0
WEBSTER	168	0	37.8	0.0	0.0	0.0
WETZEL	116	4	1.1	100.0	100.0	100.0
WIRT	63	0	19.0	49.2	100.0	100.0
WOOD	851	4	1.2	100.0	100.0	100.0
WYOMING	403	0	26.4	0.0	0.0	100.0
TOTALS	18,348	175	12.4	70.3	79.6	84.2

Provider group: Hematology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	1	1.1	100.0	100.0	100.0
BERKELEY	694	3	3.9	100.0	100.0	100.0
BOONE	300	1	4.9	100.0	100.0	100.0
BRAXTON	201	2	10.0	100.0	100.0	100.0
BROOKE	56	1	4.9	100.0	100.0	100.0
CABELL	1,048	3	1.2	100.0	100.0	100.0
CALHOUN	171	0	21.5	0.0	100.0	100.0
CLAY	241	0	23.2	0.0	100.0	100.0
DODDRIDGE	37	1	1.3	100.0	100.0	100.0
FAYETTE	580	1	1.0	100.0	100.0	100.0
GILMER	70	0	16.2	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	2	2.4	100.0	100.0	100.0
HAMPSHIRE	255	1	0.6	100.0	100.0	100.0
HANCOCK	392	2	7.8	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	2	2.2	100.0	100.0	100.0
JACKSON	480	2	1.5	100.0	100.0	100.0
JEFFERSON	226	2	9.5	100.0	100.0	100.0
KANAWHA	1,619	5	0.9	100.0	100.0	100.0
LEWIS	126	1	3.5	100.0	100.0	100.0
LINCOLN	348	0	15.0	100.0	100.0	100.0
LOGAN	414	3	1.9	100.0	100.0	100.0
MARION	155	0	14.1	100.0	100.0	100.0
MARSHALL	165	3	1.1	100.0	100.0	100.0
MASON	939	1	3.5	100.0	100.0	100.0
MCDOWELL	507	0	24.8	0.0	37.5	100.0
MERCER	151	4	11.8	96.0	100.0	100.0
MINERAL	421	0	17.3	96.4	100.0	100.0
MINGO	417	0	2.2	100.0	100.0	100.0
MONONGALIA	117	4	1.7	100.0	100.0	100.0
MONROE	68	0	14.2	100.0	100.0	100.0
MORGAN	281	0	20.5	48.8	100.0	100.0
NICHOLAS	447	1	4.1	100.0	100.0	100.0
OHIO	366	2	3.2	100.0	100.0	100.0
PENDLETON	26	0	32.2	0.0	0.0	0.0
PLEASANTS	39	0	18.4	69.2	100.0	100.0
POCAHONTAS	88	0	42.6	0.0	0.0	0.0
PRESTON	342	1	1.8	100.0	100.0	100.0

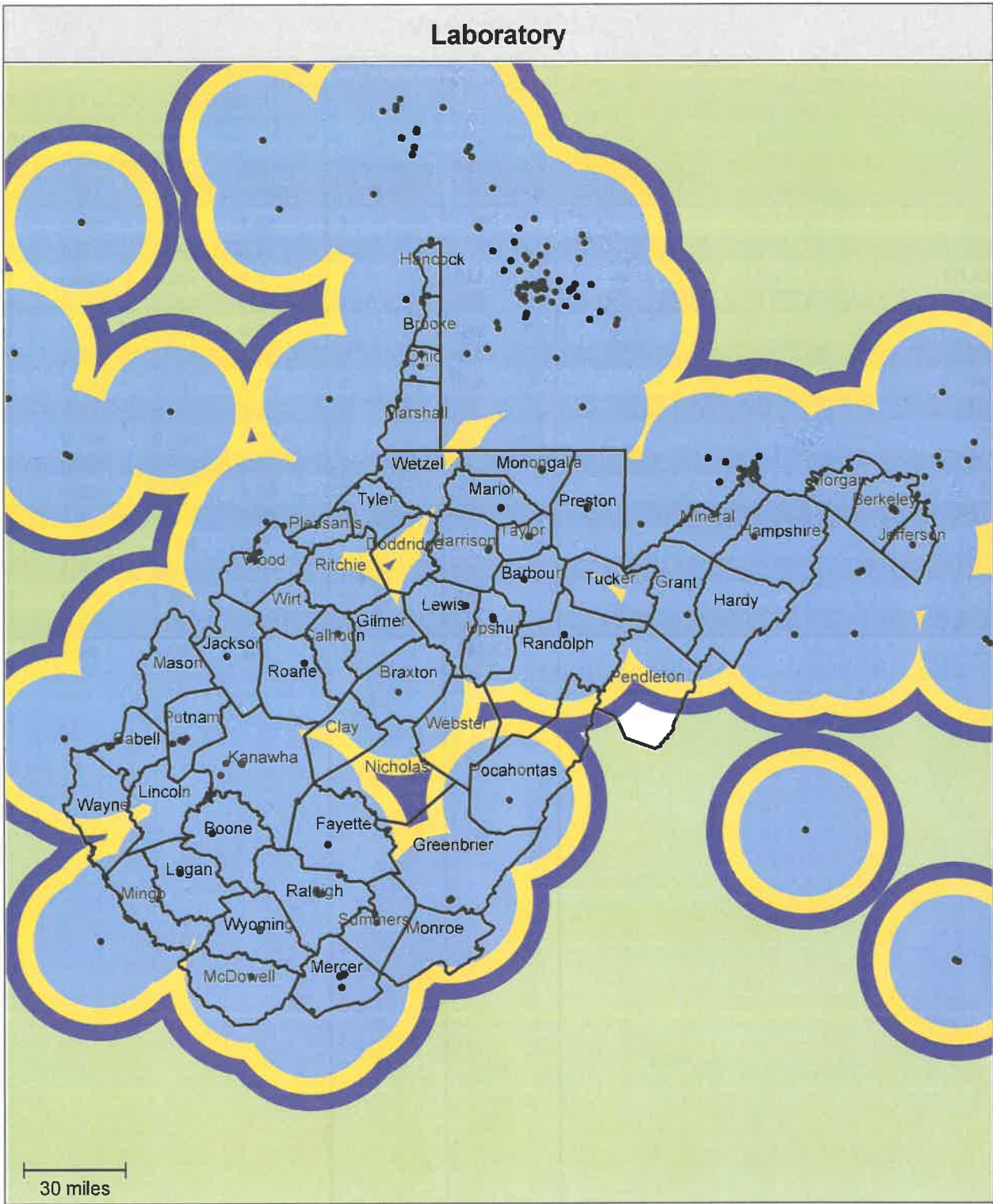
Provider group: Home Health Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	1	10.1	100.0	100.0	100.0
RALEIGH	984	4	1.9	100.0	100.0	100.0
RANDOLPH	412	1	1.4	100.0	100.0	100.0
RITCHIE	151	1	0.6	100.0	100.0	100.0
ROANE	242	1	5.0	100.0	100.0	100.0
SUMMERS	116	0	21.4	17.2	100.0	100.0
TAYLOR	301	1	1.1	100.0	100.0	100.0
TUCKER	52	0	18.8	88.5	100.0	100.0
TYLER	26	0	12.0	100.0	100.0	100.0
UPSHUR	245	1	1.9	100.0	100.0	100.0
WAYNE	522	0	12.4	100.0	100.0	100.0
WEBSTER	168	0	32.7	0.0	0.0	12.5
WETZEL	116	1	1.6	100.0	100.0	100.0
WIRT	63	0	18.8	74.6	100.0	100.0
WOOD	851	3	3.8	100.0	100.0	100.0
WYOMING	403	0	27.3	0.0	0.0	100.0
TOTALS	18,348	64	6.6	89.7	94.5	98.6

Provider group: Home Health Services

Provider locations



255 providers at 255 locations

- Provider locations (255)
- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	1	1.1	100.0	100.0	100.0
BERKELEY	694	3	4.2	100.0	100.0	100.0
BOONE	300	1	2.1	100.0	100.0	100.0
BRAXTON	201	1	5.7	100.0	100.0	100.0
BROOKE	56	0	8.1	100.0	100.0	100.0
CABELL	1,048	3	2.3	100.0	100.0	100.0
CALHOUN	171	1	0.3	100.0	100.0	100.0
CLAY	241	0	27.7	0.0	0.0	100.0
DODDRIDGE	37	0	26.5	0.0	18.9	100.0
FAYETTE	580	2	6.7	100.0	100.0	100.0
GILMER	70	0	15.0	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	4	4.8	100.0	100.0	100.0
HAMPSHIRE	255	1	0.5	100.0	100.0	100.0
HANCOCK	392	1	6.8	100.0	100.0	100.0
HARDY	101	0	10.4	100.0	100.0	100.0
HARRISON	550	2	5.2	100.0	100.0	100.0
JACKSON	480	1	2.3	100.0	100.0	100.0
JEFFERSON	226	1	3.6	100.0	100.0	100.0
KANAWHA	1,619	6	6.0	100.0	100.0	100.0
LEWIS	126	1	6.1	100.0	100.0	100.0
LINCOLN	348	0	13.8	100.0	100.0	100.0
LOGAN	414	1	2.2	100.0	100.0	100.0
MARION	155	1	3.0	100.0	100.0	100.0
MARSHALL	165	1	2.8	100.0	100.0	100.0
MASON	939	1	2.9	100.0	100.0	100.0
MCDOWELL	507	1	1.8	100.0	100.0	100.0
MERCER	151	4	3.4	100.0	100.0	100.0
MINERAL	421	1	1.3	100.0	100.0	100.0
MINGO	417	1	1.9	100.0	100.0	100.0
MONONGALIA	117	6	1.3	100.0	100.0	100.0
MONROE	68	0	14.1	100.0	100.0	100.0
MORGAN	281	1	6.6	100.0	100.0	100.0
NICHOLAS	447	0	26.9	0.0	27.7	100.0
OHIO	366	3	2.5	100.0	100.0	100.0
PENDLETON	26	0	31.8	0.0	0.0	0.0
PLEASANTS	39	0	13.1	100.0	100.0	100.0
POCAHONTAS	88	1	5.6	100.0	100.0	100.0
PRESTON	342	2	1.7	100.0	100.0	100.0

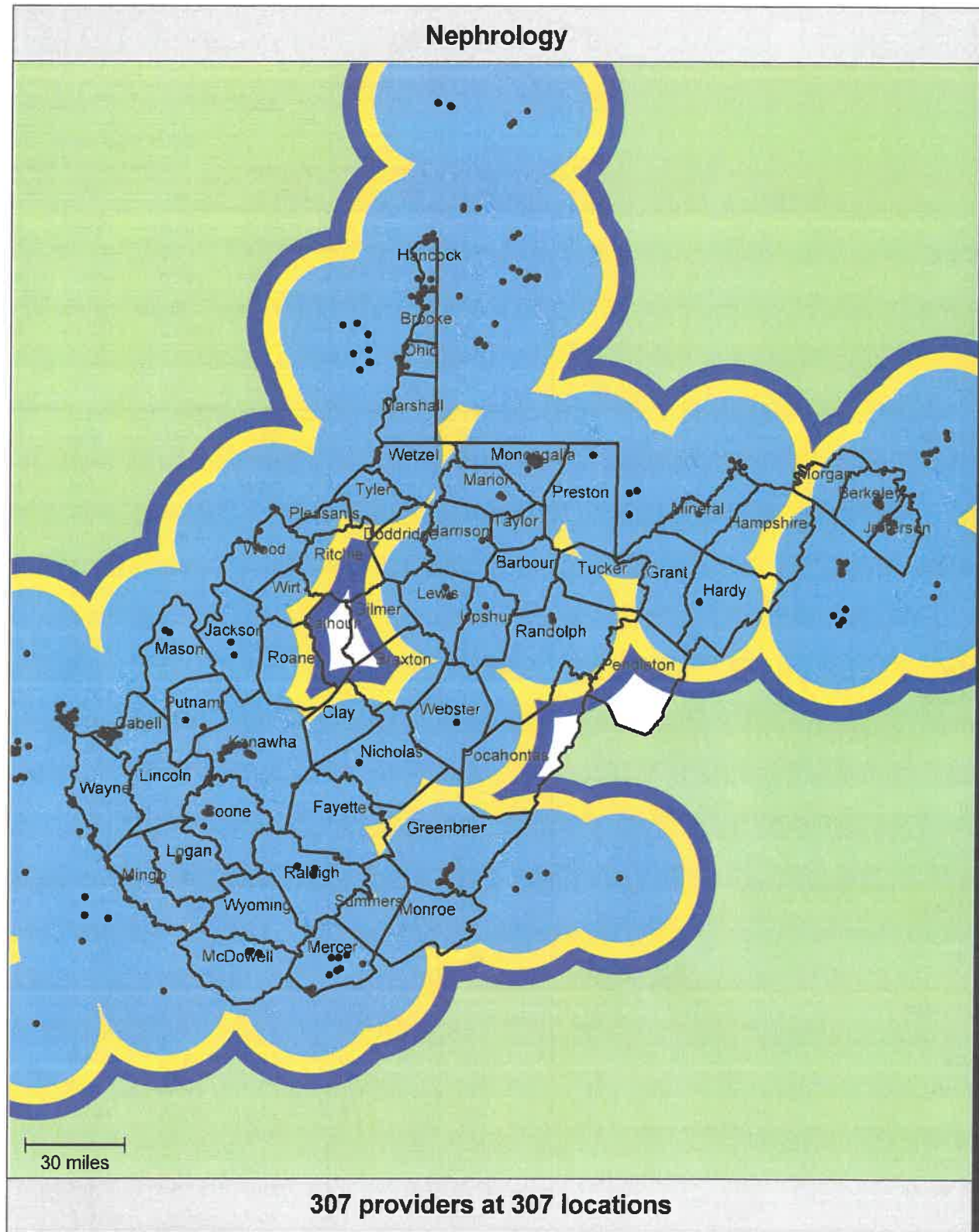
Provider group: Laboratory

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	4	6.6	100.0	100.0	100.0
RALEIGH	984	4	1.9	100.0	100.0	100.0
RANDOLPH	412	1	2.6	100.0	100.0	100.0
RITCHIE	151	0	21.9	0.0	100.0	100.0
ROANE	242	1	5.0	100.0	100.0	100.0
SUMMERS	116	1	2.3	100.0	100.0	100.0
TAYLOR	301	2	0.8	100.0	100.0	100.0
TUCKER	52	0	18.5	88.5	100.0	100.0
TYLER	26	1	9.2	100.0	100.0	100.0
UPSHUR	245	2	1.5	100.0	100.0	100.0
WAYNE	522	1	13.6	100.0	100.0	100.0
WEBSTER	168	0	27.7	0.0	0.0	100.0
WETZEL	116	1	1.2	100.0	100.0	100.0
WIRT	63	0	18.7	74.6	100.0	100.0
WOOD	851	6	1.2	100.0	100.0	100.0
WYOMING	403	1	1.4	100.0	100.0	100.0
TOTALS	18,348	79	5.4	94.0	95.7	99.9

Provider group: Laboratory

Provider locations



● Provider locations (307)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	17.5	100.0	100.0	100.0
BERKELEY	694	8	3.4	100.0	100.0	100.0
BOONE	300	4	0.5	100.0	100.0	100.0
BRAXTON	201	0	25.8	0.0	31.3	100.0
BROOKE	56	2	4.7	100.0	100.0	100.0
CABELL	1,048	13	0.8	100.0	100.0	100.0
CALHOUN	171	0	36.9	0.0	0.0	0.0
CLAY	241	0	17.6	100.0	100.0	100.0
DODDRIDGE	37	0	26.3	0.0	18.9	100.0
FAYETTE	580	2	18.6	100.0	100.0	100.0
GILMER	70	0	25.8	0.0	0.0	100.0
GRANT	146	0	7.6	100.0	100.0	100.0
GREENBRIER	340	11	0.5	100.0	100.0	100.0
HAMPSHIRE	255	0	16.6	100.0	100.0	100.0
HANCOCK	392	4	4.0	100.0	100.0	100.0
HARDY	101	1	5.1	100.0	100.0	100.0
HARRISON	550	2	5.4	100.0	100.0	100.0
JACKSON	480	2	1.5	100.0	100.0	100.0
JEFFERSON	226	6	5.9	100.0	100.0	100.0
KANAWHA	1,619	16	0.5	100.0	100.0	100.0
LEWIS	126	2	3.2	100.0	100.0	100.0
LINCOLN	348	0	18.7	100.0	100.0	100.0
LOGAN	414	2	1.5	100.0	100.0	100.0
MARION	155	4	2.0	100.0	100.0	100.0
MARSHALL	165	0	8.6	100.0	100.0	100.0
MASON	939	2	2.8	100.0	100.0	100.0
MCDOWELL	507	3	0.5	100.0	100.0	100.0
MERCER	151	14	1.9	100.0	100.0	100.0
MINERAL	421	1	3.6	100.0	100.0	100.0
MINGO	417	1	1.4	100.0	100.0	100.0
MONONGALIA	117	30	0.4	100.0	100.0	100.0
MONROE	68	0	13.4	100.0	100.0	100.0
MORGAN	281	0	19.2	51.6	100.0	100.0
NICHOLAS	447	1	6.9	100.0	100.0	100.0
OHIO	366	5	1.9	100.0	100.0	100.0
PENDLETON	26	0	37.8	0.0	0.0	0.0
PLEASANTS	39	0	15.9	92.3	100.0	100.0
POCAHONTAS	88	0	29.3	0.0	9.1	54.5
PRESTON	342	1	15.7	100.0	100.0	100.0

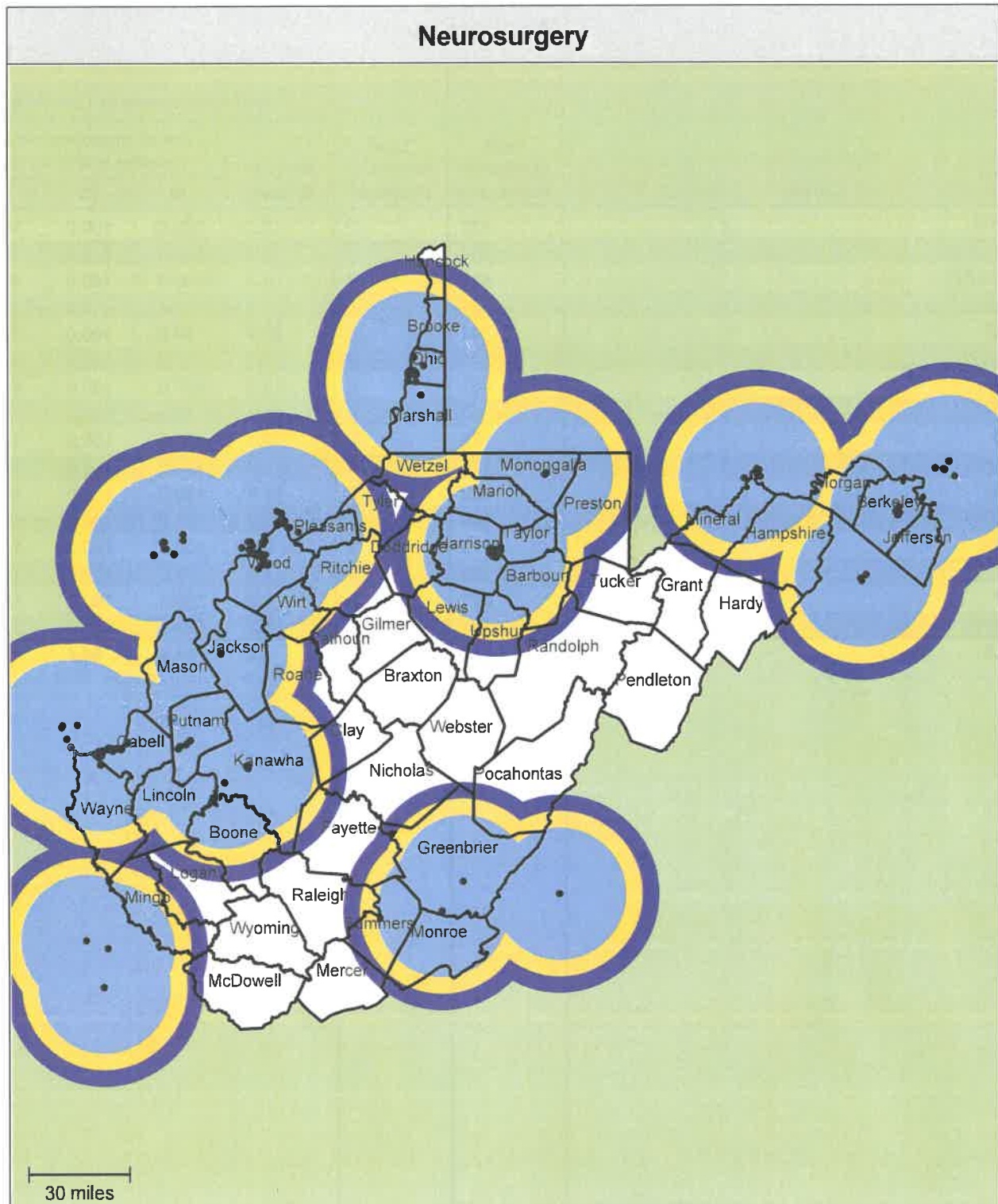
Provider group: Nephrology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	2	4.7	100.0	100.0	100.0
RALEIGH	984	3	2.1	100.0	100.0	100.0
RANDOLPH	412	4	0.8	100.0	100.0	100.0
RITCHIE	151	0	27.3	0.0	0.0	100.0
ROANE	242	0	20.4	44.6	100.0	100.0
SUMMERS	116	0	20.7	17.2	100.0	100.0
TAYLOR	301	0	13.2	100.0	100.0	100.0
TUCKER	52	0	19.1	76.9	100.0	100.0
TYLER	26	0	12.1	100.0	100.0	100.0
UPSHUR	245	1	1.9	100.0	100.0	100.0
WAYNE	522	0	11.8	100.0	100.0	100.0
WEBSTER	168	1	3.0	100.0	100.0	100.0
WETZEL	116	3	0.5	100.0	100.0	100.0
WIRT	63	0	17.9	74.6	100.0	100.0
WOOD	851	3	1.8	100.0	100.0	100.0
WYOMING	403	0	11.9	100.0	100.0	100.0
TOTALS	18,348	154	6.6	93.8	96.4	98.7

Provider group: Nephrology

Provider locations



- Provider locations (169)
- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	16.5	100.0	100.0	100.0
BERKELEY	694	5	3.3	100.0	100.0	100.0
BOONE	300	0	17.5	100.0	100.0	100.0
BRAXTON	201	0	55.7	0.0	0.0	0.0
BROOKE	56	0	13.4	100.0	100.0	100.0
CABELL	1,048	28	1.5	100.0	100.0	100.0
CALHOUN	171	0	38.8	0.0	0.0	0.0
CLAY	241	0	34.9	0.0	0.0	0.0
DODDRIDGE	37	0	26.4	0.0	18.9	100.0
FAYETTE	580	0	41.7	0.0	0.0	0.0
GILMER	70	0	46.5	0.0	0.0	0.0
GRANT	146	0	50.7	0.0	0.0	0.0
GREENBRIER	340	2	3.9	100.0	100.0	100.0
HAMPSHIRE	255	0	20.8	0.0	100.0	100.0
HANCOCK	392	0	29.6	0.0	5.9	58.9
HARDY	101	0	45.6	0.0	0.0	0.0
HARRISON	550	21	4.4	100.0	100.0	100.0
JACKSON	480	1	6.3	100.0	100.0	100.0
JEFFERSON	226	0	15.9	97.8	100.0	100.0
KANAWHA	1,619	10	5.5	100.0	100.0	100.0
LEWIS	126	0	25.0	0.0	65.1	92.1
LINCOLN	348	0	13.5	100.0	100.0	100.0
LOGAN	414	0	36.6	0.0	0.0	0.0
MARION	155	0	13.3	100.0	100.0	100.0
MARSHALL	165	0	8.2	100.0	100.0	100.0
MASON	939	0	18.3	89.6	100.0	100.0
MCDOWELL	507	0	48.9	0.0	0.0	0.0
MERCER	151	0	46.5	0.0	0.0	0.0
MINERAL	421	0	18.4	88.8	100.0	100.0
MINGO	417	0	15.7	94.2	100.0	100.0
MONONGALIA	117	19	1.6	100.0	100.0	100.0
MONROE	68	0	9.4	100.0	100.0	100.0
MORGAN	281	0	19.4	51.6	100.0	100.0
NICHOLAS	447	0	43.7	0.0	0.0	0.0
OHIO	366	11	1.2	100.0	100.0	100.0
PENDLETON	26	0	74.3	0.0	0.0	0.0
PLEASANTS	39	0	10.8	100.0	100.0	100.0
POCAHONTAS	88	0	37.2	0.0	0.0	0.0
PRESTON	342	0	22.0	13.5	100.0	100.0

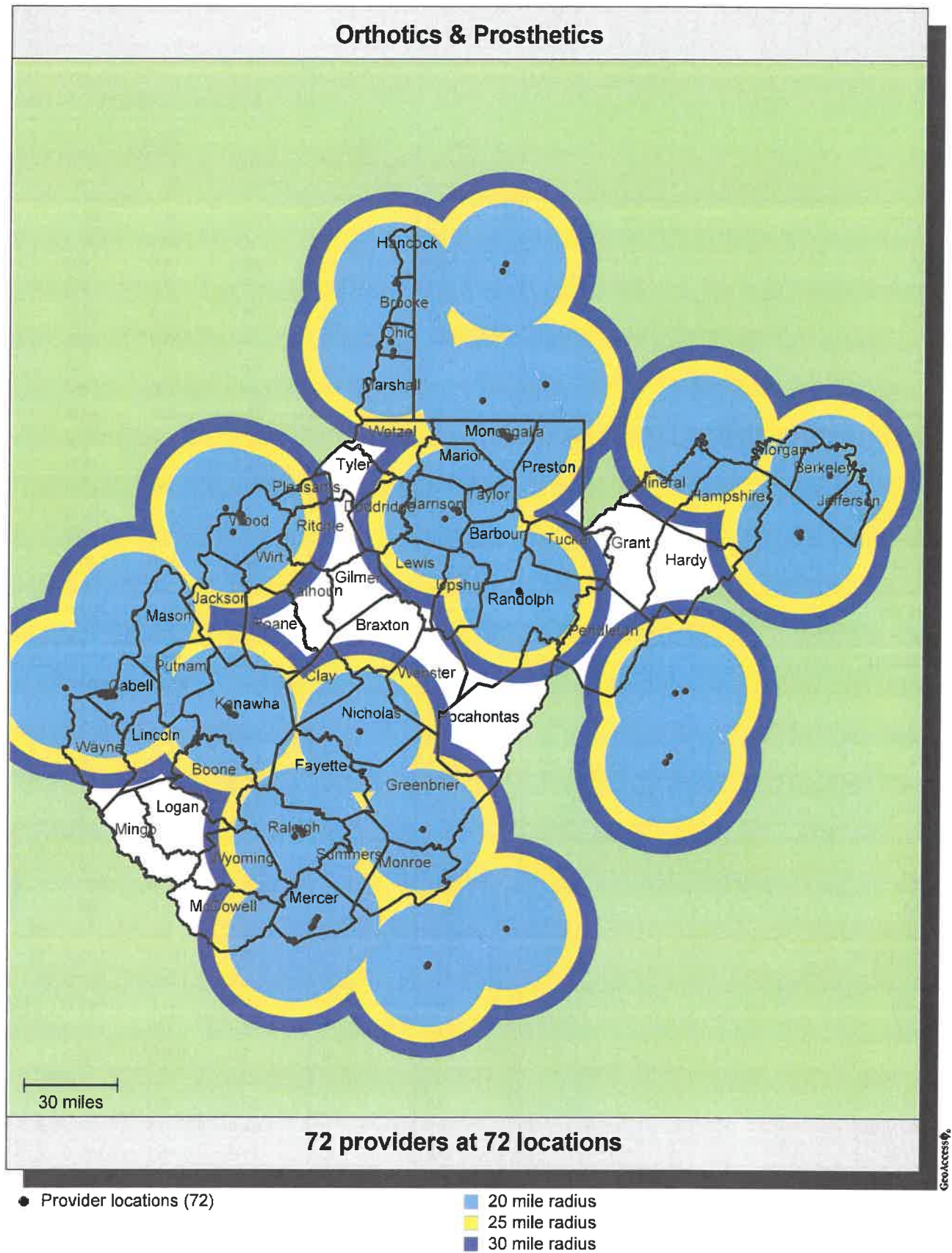
Provider group: Neurosurgery

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	5	6.5	100.0	100.0	100.0
RALEIGH	984	0	38.8	0.0	0.0	0.0
RANDOLPH	412	0	38.4	0.0	0.0	0.0
RITCHIE	151	0	25.0	0.0	49.7	100.0
ROANE	242	0	27.6	0.0	22.3	72.7
SUMMERS	116	0	21.5	0.0	100.0	100.0
TAYLOR	301	0	11.8	100.0	100.0	100.0
TUCKER	52	0	35.0	0.0	0.0	11.5
TYLER	26	0	29.0	0.0	0.0	100.0
UPSHUR	245	0	19.6	84.9	97.1	100.0
WAYNE	522	0	9.8	100.0	100.0	100.0
WEBSTER	168	0	44.6	0.0	0.0	0.0
WETZEL	116	0	30.0	0.0	0.0	32.8
WIRT	63	0	16.7	100.0	100.0	100.0
WOOD	851	10	1.0	100.0	100.0	100.0
WYOMING	403	0	49.7	0.0	0.0	0.0
TOTALS	18,348	112	19.9	60.4	67.2	70.2

Provider group: Neurosurgery

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	18.3	92.2	100.0	100.0
BERKELEY	694	1	4.2	100.0	100.0	100.0
BOONE	300	0	26.9	0.0	0.0	100.0
BRAXTON	201	0	32.3	0.0	8.0	22.9
BROOKE	56	0	8.7	100.0	100.0	100.0
CABELL	1,048	7	0.8	100.0	100.0	100.0
CALHOUN	171	0	40.1	0.0	0.0	0.0
CLAY	241	0	25.2	0.0	28.6	100.0
DODDRIDGE	37	0	25.0	0.0	18.9	100.0
FAYETTE	580	0	22.0	0.0	100.0	100.0
GILMER	70	0	42.6	0.0	0.0	0.0
GRANT	146	0	43.3	0.0	0.0	0.0
GREENBRIER	340	1	2.3	100.0	100.0	100.0
HAMPSHIRE	255	0	21.1	0.0	100.0	100.0
HANCOCK	392	0	12.5	100.0	100.0	100.0
HARDY	101	0	42.3	0.0	0.0	0.0
HARRISON	550	4	2.5	100.0	100.0	100.0
JACKSON	480	0	27.3	0.0	5.6	100.0
JEFFERSON	226	0	17.4	97.8	100.0	100.0
KANAWHA	1,619	5	1.7	100.0	100.0	100.0
LEWIS	126	0	21.0	34.1	92.1	96.0
LINCOLN	348	0	20.0	71.3	100.0	100.0
LOGAN	414	0	44.7	0.0	0.0	0.0
MARION	155	0	15.8	100.0	100.0	100.0
MARSHALL	165	0	10.7	100.0	100.0	100.0
MASON	939	0	9.2	100.0	100.0	100.0
MCDOWELL	507	0	26.8	0.0	12.6	100.0
MERCER	151	8	3.1	100.0	100.0	100.0
MINERAL	421	0	24.3	0.0	88.1	100.0
MINGO	417	0	51.1	0.0	0.0	0.0
MONONGALIA	117	7	0.7	100.0	100.0	100.0
MONROE	68	0	17.4	100.0	100.0	100.0
MORGAN	281	0	19.5	51.6	100.0	100.0
NICHOLAS	447	1	5.5	100.0	100.0	100.0
OHIO	366	4	2.0	100.0	100.0	100.0
PENDLETON	26	0	33.0	0.0	0.0	0.0
PLEASANTS	39	0	26.3	0.0	30.8	92.3
POCAHONTAS	88	0	41.4	0.0	0.0	0.0
PRESTON	342	0	21.3	13.5	100.0	100.0

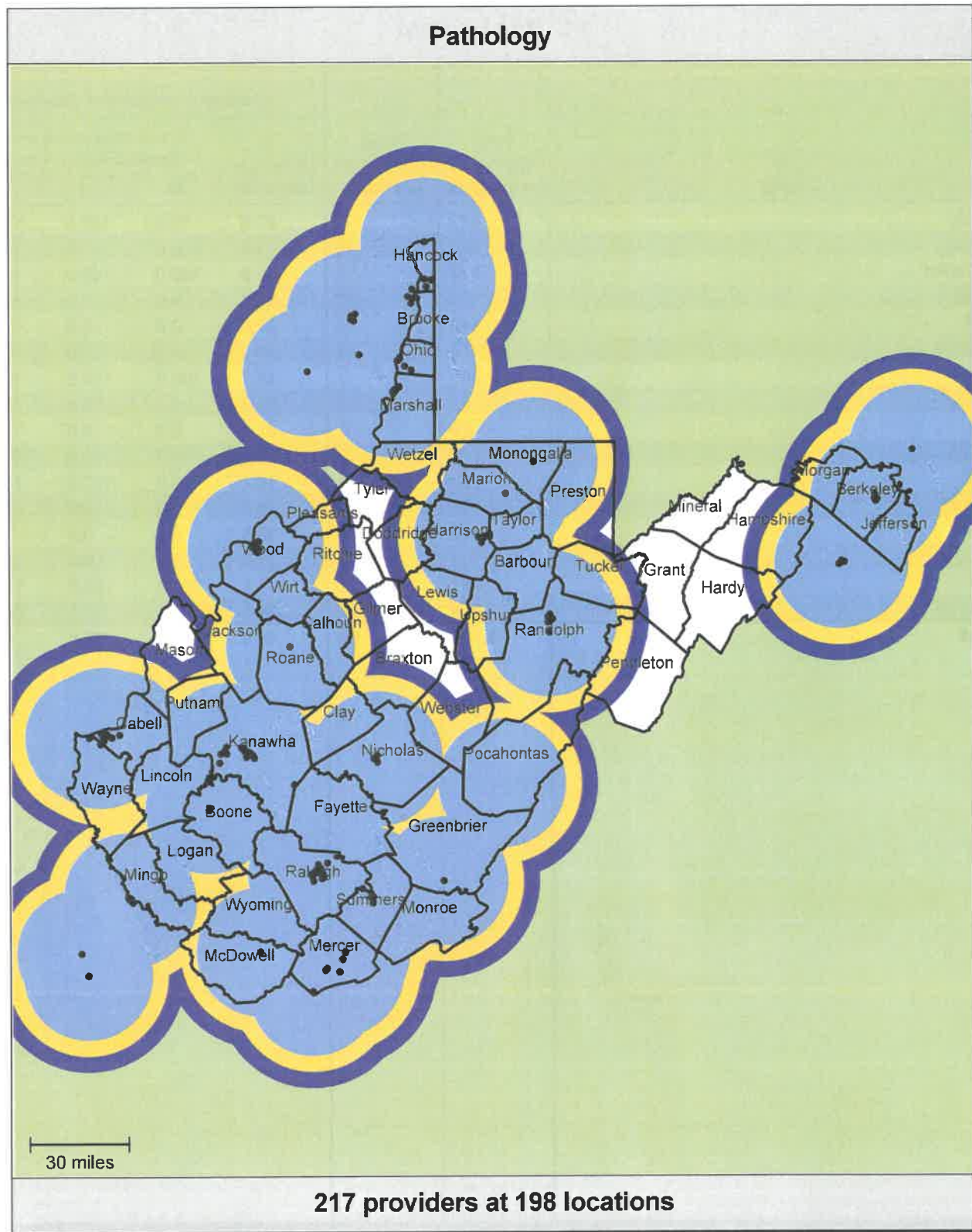
Provider group: Orthotics & Prosthetics

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	0	20.9	30.8	100.0	100.0
RALEIGH	984	6	1.9	100.0	100.0	100.0
RANDOLPH	412	1	1.9	100.0	100.0	100.0
RITCHIE	151	0	27.7	0.0	0.0	100.0
ROANE	242	0	37.0	0.0	0.0	0.0
SUMMERS	116	0	20.0	34.5	100.0	100.0
TAYLOR	301	0	14.7	100.0	100.0	100.0
TUCKER	52	0	21.8	0.0	88.5	100.0
TYLER	26	0	41.7	0.0	0.0	0.0
UPSHUR	245	0	20.7	14.3	100.0	100.0
WAYNE	522	0	14.2	100.0	100.0	100.0
WEBSTER	168	0	35.0	0.0	0.0	11.9
WETZEL	116	0	32.8	0.0	0.0	0.0
WIRT	63	0	17.9	74.6	100.0	100.0
WOOD	851	5	1.1	100.0	100.0	100.0
WYOMING	403	0	24.9	0.0	50.1	100.0
TOTALS	18,348	50	15.0	62.2	78.1	88.4

Provider group: Orthotics & Prosthetics

Provider locations



- Single provider locations (197)
- Multiple provider locations (1)

- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	17.1	100.0	100.0	100.0
BERKELEY	694	7	3.5	100.0	100.0	100.0
BOONE	300	1	1.0	100.0	100.0	100.0
BRAXTON	201	0	28.8	0.0	22.9	76.6
BROOKE	56	0	7.9	100.0	100.0	100.0
CABELL	1,048	14	1.2	100.0	100.0	100.0
CALHOUN	171	0	20.5	0.0	100.0	100.0
CLAY	241	0	20.5	28.6	100.0	100.0
DODDRIDGE	37	0	26.5	0.0	18.9	100.0
FAYETTE	580	1	16.9	100.0	100.0	100.0
GILMER	70	0	34.0	0.0	0.0	0.0
GRANT	146	0	41.3	0.0	0.0	0.0
GREENBRIER	340	1	5.7	100.0	100.0	100.0
HAMPSHIRE	255	0	38.2	0.0	0.0	0.0
HANCOCK	392	3	4.2	100.0	100.0	100.0
HARDY	101	0	45.6	0.0	0.0	0.0
HARRISON	550	9	4.8	100.0	100.0	100.0
JACKSON	480	0	20.4	40.0	94.6	100.0
JEFFERSON	226	0	16.5	97.8	100.0	100.0
KANAWHA	1,619	25	0.6	100.0	100.0	100.0
LEWIS	126	0	25.0	0.0	65.1	92.1
LINCOLN	348	0	17.8	100.0	100.0	100.0
LOGAN	414	0	21.8	13.3	100.0	100.0
MARION	155	1	3.8	100.0	100.0	100.0
MARSHALL	165	25	2.5	100.0	100.0	100.0
MASON	939	0	39.4	0.0	0.0	0.0
MCDOWELL	507	1	2.8	100.0	100.0	100.0
MERCER	151	6	2.5	100.0	100.0	100.0
MINERAL	421	0	53.1	0.0	0.0	0.0
MINGO	417	0	1.9	100.0	100.0	100.0
MONONGALIA	117	23	1.7	100.0	100.0	100.0
MONROE	68	0	14.2	100.0	100.0	100.0
MORGAN	281	0	18.9	57.3	100.0	100.0
NICHOLAS	447	3	2.9	100.0	100.0	100.0
OHIO	366	2	2.2	100.0	100.0	100.0
PENDLETON	26	0	38.8	0.0	0.0	0.0
PLEASANTS	39	0	25.2	7.7	38.5	100.0
POCAHONTAS	88	20	5.6	100.0	100.0	100.0
PRESTON	342	0	21.9	13.5	100.0	100.0

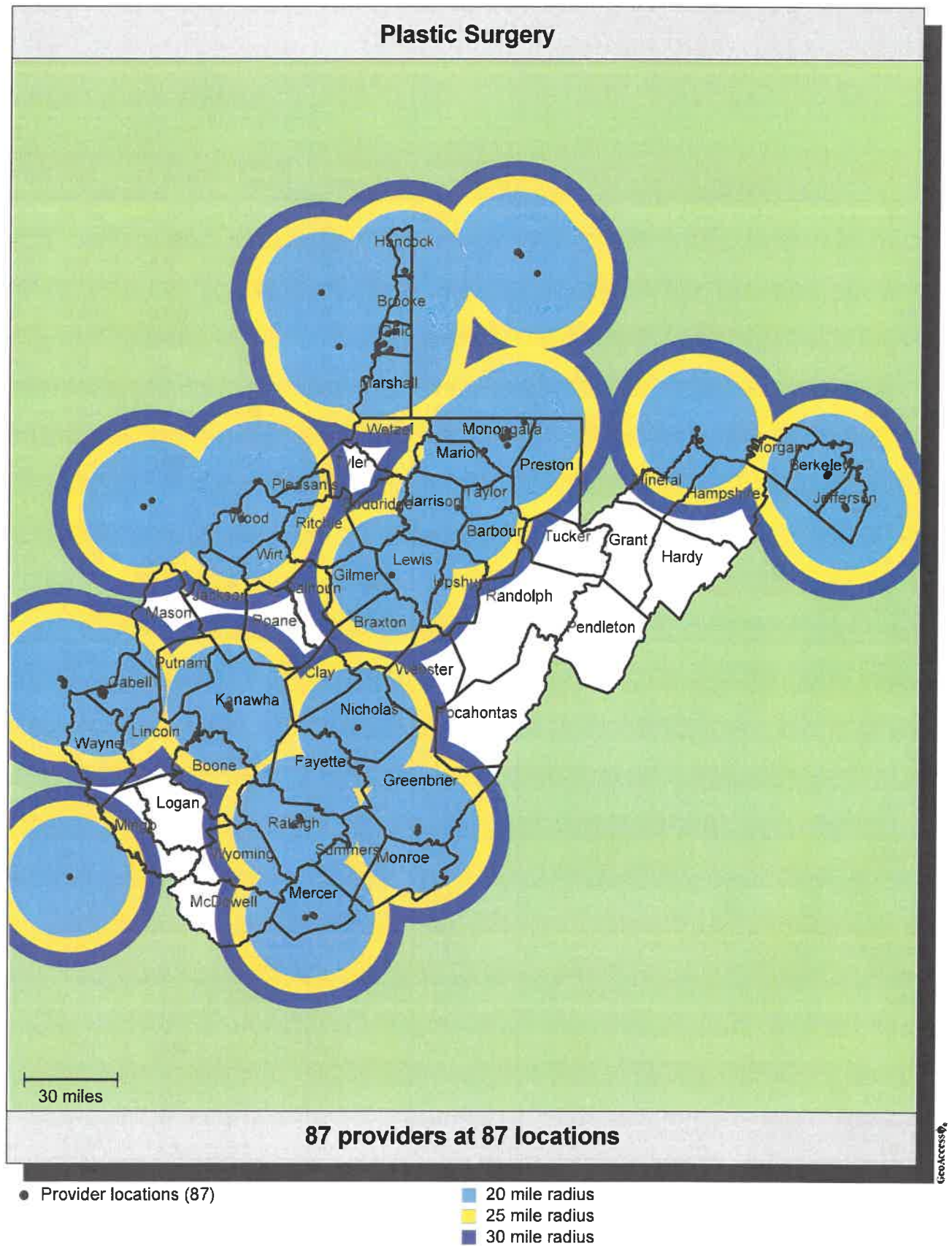
Provider group: Pathology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	0	18.3	69.0	100.0	100.0
RALEIGH	984	13	1.2	100.0	100.0	100.0
RANDOLPH	412	20	0.2	100.0	100.0	100.0
RITCHIE	151	0	27.1	0.0	0.0	100.0
ROANE	242	1	4.6	100.0	100.0	100.0
SUMMERS	116	6	0.3	100.0	100.0	100.0
TAYLOR	301	0	11.8	100.0	100.0	100.0
TUCKER	52	0	19.1	76.9	100.0	100.0
TYLER	26	0	36.0	0.0	0.0	0.0
UPSHUR	245	0	20.1	37.1	100.0	100.0
WAYNE	522	0	10.2	100.0	100.0	100.0
WEBSTER	168	0	30.5	0.0	0.0	37.5
WETZEL	116	0	23.7	0.0	87.9	100.0
WIRT	63	0	17.3	74.6	100.0	100.0
WOOD	851	8	1.0	100.0	100.0	100.0
WYOMING	403	0	11.9	100.0	100.0	100.0
TOTALS	18,348	190	12.2	75.1	85.9	88.3

Provider group: Pathology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	18.3	92.2	100.0	100.0
BERKELEY	694	2	4.4	100.0	100.0	100.0
BOONE	300	0	26.9	0.0	0.0	100.0
BRAXTON	201	0	23.9	15.9	77.1	100.0
BROOKE	56	0	7.5	100.0	100.0	100.0
CABELL	1,048	6	1.7	100.0	100.0	100.0
CALHOUN	171	0	27.2	0.0	0.0	100.0
CLAY	241	0	25.2	0.0	28.6	100.0
DODDRIDGE	37	0	26.8	0.0	18.9	100.0
FAYETTE	580	0	19.8	71.6	100.0	100.0
GILMER	70	0	12.9	100.0	100.0	100.0
GRANT	146	0	56.9	0.0	0.0	0.0
GREENBRIER	340	3	3.6	100.0	100.0	100.0
HAMPSHIRE	255	0	22.9	0.0	100.0	100.0
HANCOCK	392	2	8.1	100.0	100.0	100.0
HARDY	101	0	51.8	0.0	0.0	0.0
HARRISON	550	1	7.0	100.0	100.0	100.0
JACKSON	480	0	33.2	0.0	0.0	16.7
JEFFERSON	226	2	3.1	100.0	100.0	100.0
KANAWHA	1,619	12	4.2	100.0	100.0	100.0
LEWIS	126	1	12.5	100.0	100.0	100.0
LINCOLN	348	0	22.0	14.4	85.6	100.0
LOGAN	414	0	43.8	0.0	0.0	0.0
MARION	155	0	10.0	100.0	100.0	100.0
MARSHALL	165	0	7.1	100.0	100.0	100.0
MASON	939	0	31.6	0.0	0.0	10.8
MCDOWELL	507	0	27.5	0.0	0.0	100.0
MERCER	151	3	3.3	100.0	100.0	100.0
MINERAL	421	0	25.2	0.0	55.8	100.0
MINGO	417	0	25.4	0.0	58.8	100.0
MONONGALIA	117	18	1.2	100.0	100.0	100.0
MONROE	68	0	14.4	100.0	100.0	100.0
MORGAN	281	0	20.5	48.8	100.0	100.0
NICHOLAS	447	1	5.5	100.0	100.0	100.0
OHIO	366	12	1.0	100.0	100.0	100.0
PENDLETON	26	0	76.6	0.0	0.0	0.0
PLEASANTS	39	0	16.1	92.3	100.0	100.0
POCAHONTAS	88	0	41.4	0.0	0.0	0.0
PRESTON	342	0	18.8	80.1	100.0	100.0

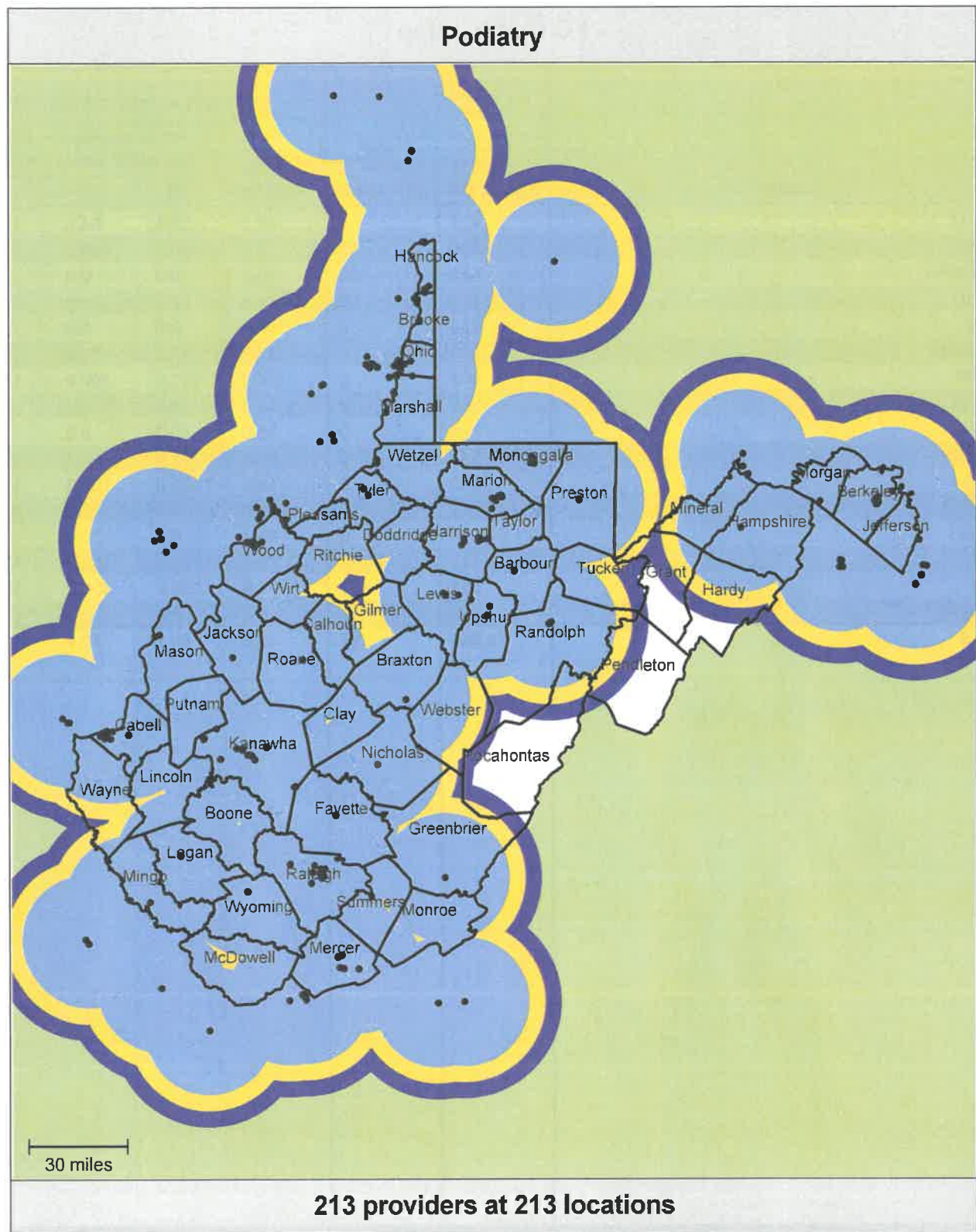
Provider group: Plastic Surgery

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	0	22.1	30.8	84.5	100.0
RALEIGH	984	3	2.3	100.0	100.0	100.0
RANDOLPH	412	0	40.2	0.0	0.0	0.0
RITCHIE	151	0	28.5	0.0	0.0	100.0
ROANE	242	0	37.7	0.0	0.0	0.0
SUMMERS	116	0	23.1	17.2	92.2	100.0
TAYLOR	301	0	14.0	100.0	100.0	100.0
TUCKER	52	0	36.6	0.0	0.0	11.5
TYLER	26	0	32.0	0.0	0.0	0.0
UPSHUR	245	0	21.4	11.4	97.1	100.0
WAYNE	522	0	13.6	100.0	100.0	100.0
WEBSTER	168	0	35.0	0.0	0.0	12.5
WETZEL	116	0	28.7	0.0	0.0	83.6
WIRT	63	0	18.8	74.6	100.0	100.0
WOOD	851	1	1.9	100.0	100.0	100.0
WYOMING	403	0	26.3	0.0	0.0	100.0
TOTALS	18,348	67	16.6	58.3	70.1	84.2

Provider group: Plastic Surgery

Provider locations



● Provider locations (213)

■ 20 mile radius

■ 25 mile radius

■ 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	1	1.3	100.0	100.0	100.0
BERKELEY	694	9	3.3	100.0	100.0	100.0
BOONE	300	0	19.3	100.0	100.0	100.0
BRAXTON	201	1	6.7	100.0	100.0	100.0
BROOKE	56	1	1.9	100.0	100.0	100.0
CABELL	1,048	9	1.6	100.0	100.0	100.0
CALHOUN	171	0	20.4	0.0	100.0	100.0
CLAY	241	0	22.4	0.0	100.0	100.0
DODDRIDGE	37	0	18.8	100.0	100.0	100.0
FAYETTE	580	4	1.2	100.0	100.0	100.0
GILMER	70	0	25.1	0.0	40.0	100.0
GRANT	146	0	37.7	0.0	0.0	0.0
GREENBRIER	340	1	3.6	100.0	100.0	100.0
HAMPSHIRE	255	1	0.4	100.0	100.0	100.0
HANCOCK	392	5	5.5	100.0	100.0	100.0
HARDY	101	0	31.5	0.0	11.9	44.6
HARRISON	550	8	1.4	100.0	100.0	100.0
JACKSON	480	1	4.5	100.0	100.0	100.0
JEFFERSON	226	0	8.4	100.0	100.0	100.0
KANAWHA	1,619	14	0.8	100.0	100.0	100.0
LEWIS	126	3	2.3	100.0	100.0	100.0
LINCOLN	348	0	17.3	100.0	100.0	100.0
LOGAN	414	1	2.3	100.0	100.0	100.0
MARION	155	7	1.2	100.0	100.0	100.0
MARSHALL	165	2	2.8	100.0	100.0	100.0
MASON	939	2	2.0	100.0	100.0	100.0
MCDOWELL	507	0	20.2	51.7	100.0	100.0
MERCER	151	5	2.8	100.0	100.0	100.0
MINERAL	421	0	17.3	96.4	100.0	100.0
MINGO	417	2	2.1	100.0	100.0	100.0
MONONGALIA	117	9	0.8	100.0	100.0	100.0
MONROE	68	0	16.2	100.0	100.0	100.0
MORGAN	281	1	11.6	91.5	100.0	100.0
NICHOLAS	447	1	3.8	100.0	100.0	100.0
OHIO	366	7	1.5	100.0	100.0	100.0
PENDLETON	26	0	41.1	0.0	0.0	0.0
PLEASANTS	39	0	12.0	100.0	100.0	100.0
POCAHONTAS	88	0	43.3	0.0	0.0	0.0
PRESTON	342	2	1.7	100.0	100.0	100.0

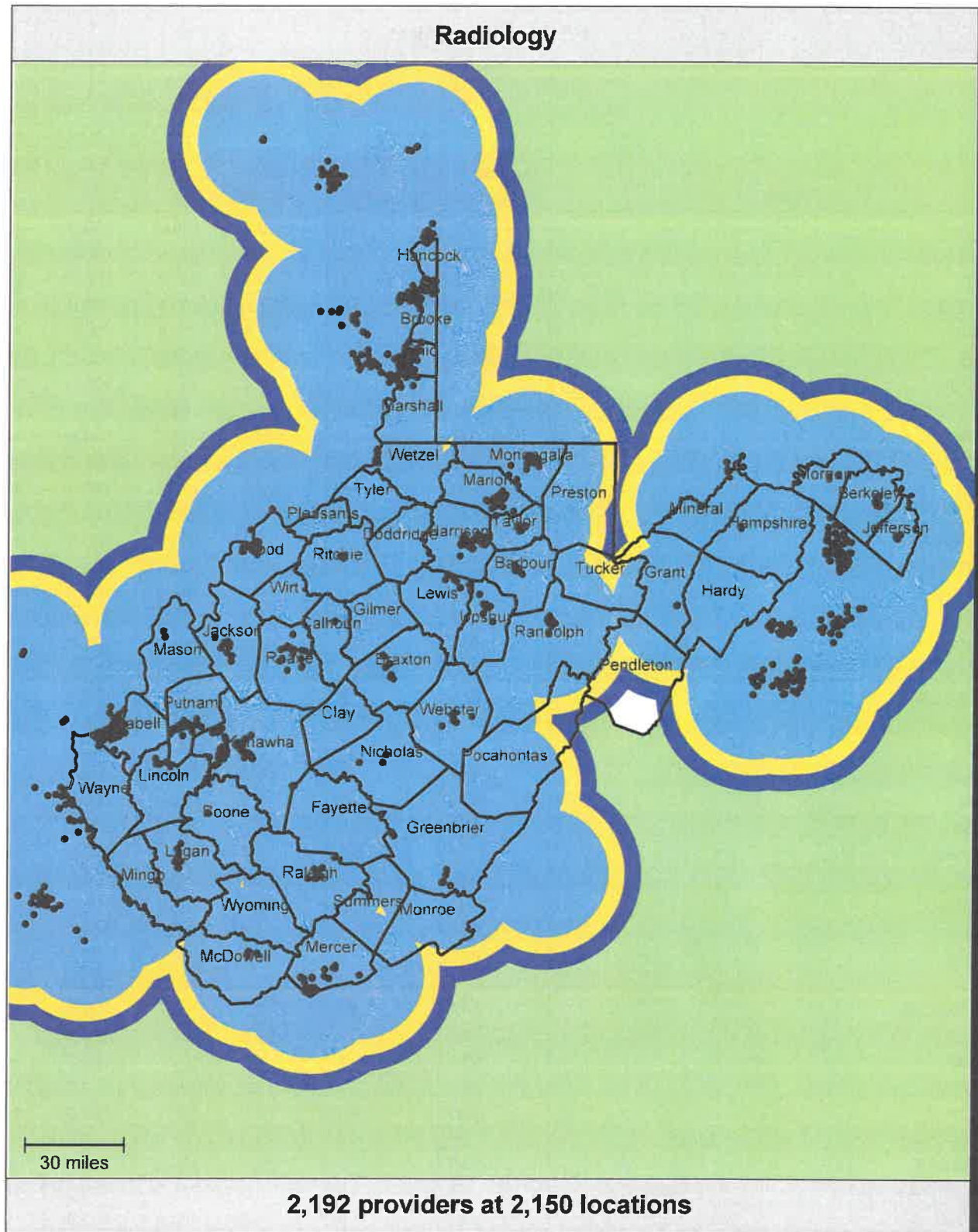
Provider group: Podiatry

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	0	9.4	100.0	100.0	100.0
RALEIGH	984	9	1.1	100.0	100.0	100.0
RANDOLPH	412	2	1.0	100.0	100.0	100.0
RITCHIE	151	0	24.6	0.0	100.0	100.0
ROANE	242	1	5.5	100.0	100.0	100.0
SUMMERS	116	0	20.8	17.2	100.0	100.0
TAYLOR	301	0	13.2	100.0	100.0	100.0
TUCKER	52	0	19.4	65.4	100.0	100.0
TYLER	26	2	0.4	100.0	100.0	100.0
UPSHUR	245	3	1.6	100.0	100.0	100.0
WAYNE	522	0	12.6	100.0	100.0	100.0
WEBSTER	168	0	20.2	50.0	100.0	100.0
WETZEL	116	4	0.8	100.0	100.0	100.0
WIRT	63	0	19.5	49.2	100.0	100.0
WOOD	851	3	1.7	100.0	100.0	100.0
WYOMING	403	4	10.9	100.0	100.0	100.0
TOTALS	18,348	125	6.5	91.8	97.9	98.3

Provider group: Podiatry

Provider locations



- Single provider locations (2,146)
- Multiple provider locations (4)

- 20 mile radius
- 25 mile radius
- 30 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	24	0.0	100.0	100.0	100.0
BERKELEY	694	32	2.9	100.0	100.0	100.0
BOONE	300	1	0.7	100.0	100.0	100.0
BRAXTON	201	18	5.6	100.0	100.0	100.0
BROOKE	56	0	4.5	100.0	100.0	100.0
CABELL	1,048	141	0.0	100.0	100.0	100.0
CALHOUN	171	3	0.1	100.0	100.0	100.0
CLAY	241	0	17.6	100.0	100.0	100.0
DODDRIDGE	37	0	18.4	100.0	100.0	100.0
FAYETTE	580	8	18.1	100.0	100.0	100.0
GILMER	70	0	12.0	100.0	100.0	100.0
GRANT	146	2	1.1	100.0	100.0	100.0
GREENBRIER	340	14	1.0	100.0	100.0	100.0
HAMPSHIRE	255	2	0.3	100.0	100.0	100.0
HANCOCK	392	16	4.0	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	120	0.1	100.0	100.0	100.0
JACKSON	480	26	0.0	100.0	100.0	100.0
JEFFERSON	226	6	3.0	100.0	100.0	100.0
KANAWHA	1,619	197	0.5	100.0	100.0	100.0
LEWIS	126	24	5.6	100.0	100.0	100.0
LINCOLN	348	25	0.0	100.0	100.0	100.0
LOGAN	414	25	0.0	100.0	100.0	100.0
MARION	155	49	0.2	100.0	100.0	100.0
MARSHALL	165	29	4.4	100.0	100.0	100.0
MASON	939	3	2.4	100.0	100.0	100.0
MCDOWELL	507	31	0.1	100.0	100.0	100.0
MERCER	151	111	1.8	100.0	100.0	100.0
MINERAL	421	2	0.9	100.0	100.0	100.0
MINGO	417	0	1.9	100.0	100.0	100.0
MONONGALIA	117	68	0.3	100.0	100.0	100.0
MONROE	68	0	14.1	100.0	100.0	100.0
MORGAN	281	2	4.6	100.0	100.0	100.0
NICHOLAS	447	3	2.3	100.0	100.0	100.0
OHIO	366	145	0.0	100.0	100.0	100.0
PENDLETON	26	0	31.9	0.0	0.0	0.0
PLEASANTS	39	0	15.1	100.0	100.0	100.0
POCAHONTAS	88	14	5.6	100.0	100.0	100.0
PRESTON	342	0	19.7	33.6	100.0	100.0

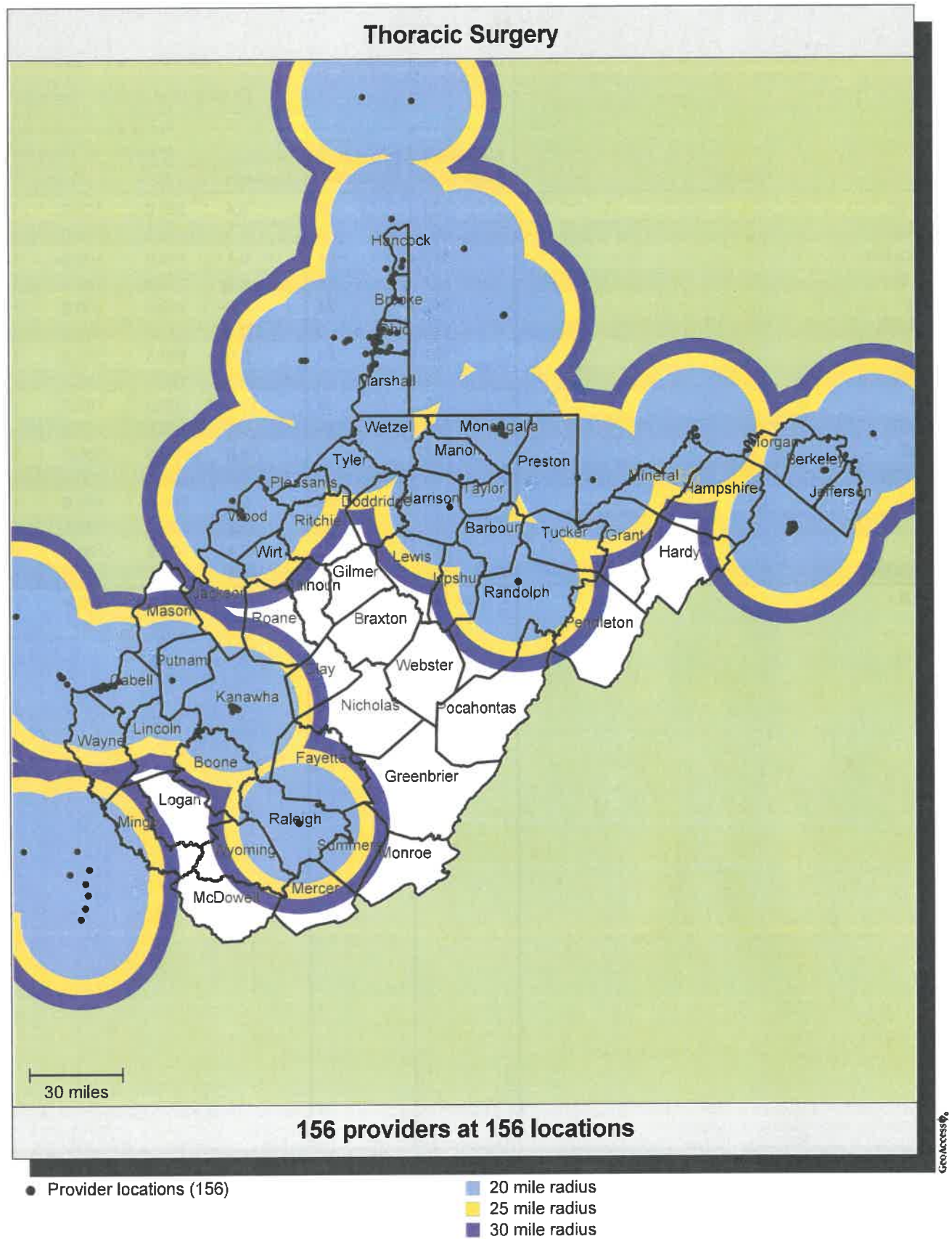
Provider group: Radiology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	68	3.4	100.0	100.0	100.0
RALEIGH	984	8	1.3	100.0	100.0	100.0
RANDOLPH	412	24	0.1	100.0	100.0	100.0
RITCHIE	151	25	0.0	100.0	100.0	100.0
ROANE	242	25	0.0	100.0	100.0	100.0
SUMMERS	116	0	20.2	17.2	100.0	100.0
TAYLOR	301	24	0.0	100.0	100.0	100.0
TUCKER	52	0	18.0	100.0	100.0	100.0
TYLER	26	0	11.6	100.0	100.0	100.0
UPSHUR	245	24	0.4	100.0	100.0	100.0
WAYNE	522	0	9.8	100.0	100.0	100.0
WEBSTER	168	9	0.0	100.0	100.0	100.0
WETZEL	116	28	0.0	100.0	100.0	100.0
WIRT	63	0	15.2	100.0	100.0	100.0
WOOD	851	38	0.4	100.0	100.0	100.0
WYOMING	403	0	11.9	100.0	100.0	100.0
TOTALS	18,348	1,414	3.3	98.1	99.9	99.9

Provider group: Radiology

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	19.6	69.4	100.0	100.0
BERKELEY	694	2	4.7	100.0	100.0	100.0
BOONE	300	0	25.7	0.0	0.0	100.0
BRAXTON	201	0	55.2	0.0	0.0	0.0
BROOKE	56	2	1.5	100.0	100.0	100.0
CABELL	1,048	13	1.6	100.0	100.0	100.0
CALHOUN	171	0	39.8	0.0	0.0	0.0
CLAY	241	0	33.8	0.0	0.0	0.0
DODDRIDGE	37	0	25.6	0.0	18.9	100.0
FAYETTE	580	0	23.6	0.0	93.3	100.0
GILMER	70	0	46.6	0.0	0.0	0.0
GRANT	146	0	37.6	0.0	0.0	0.0
GREENBRIER	340	0	43.1	0.0	0.0	0.0
HAMPSHIRE	255	0	21.4	0.0	100.0	100.0
HANCOCK	392	3	4.6	100.0	100.0	100.0
HARDY	101	0	41.6	0.0	0.0	0.0
HARRISON	550	1	4.5	100.0	100.0	100.0
JACKSON	480	0	33.6	0.0	0.0	0.0
JEFFERSON	226	0	15.6	100.0	100.0	100.0
KANAWHA	1,619	9	0.6	100.0	100.0	100.0
LEWIS	126	0	25.2	0.0	63.5	92.1
LINCOLN	348	0	17.2	100.0	100.0	100.0
LOGAN	414	0	40.1	0.0	0.0	0.0
MARION	155	1	5.8	100.0	100.0	100.0
MARSHALL	165	6	2.5	100.0	100.0	100.0
MASON	939	0	32.3	0.0	0.0	5.3
MCDOWELL	507	0	38.1	0.0	0.0	0.0
MERCER	151	0	31.9	0.0	0.0	15.2
MINERAL	421	0	22.5	3.6	100.0	100.0
MINGO	417	0	18.6	88.2	100.0	100.0
MONONGALIA	117	35	0.5	100.0	100.0	100.0
MONROE	68	0	44.0	0.0	0.0	0.0
MORGAN	281	0	20.8	40.2	100.0	100.0
NICHOLAS	447	0	40.4	0.0	0.0	0.0
OHIO	366	15	1.0	100.0	100.0	100.0
PENDLETON	26	0	41.1	0.0	0.0	0.0
PLEASANTS	39	0	13.1	100.0	100.0	100.0
POCAHONTAS	88	0	54.8	0.0	0.0	0.0
PRESTON	342	0	14.3	100.0	100.0	100.0

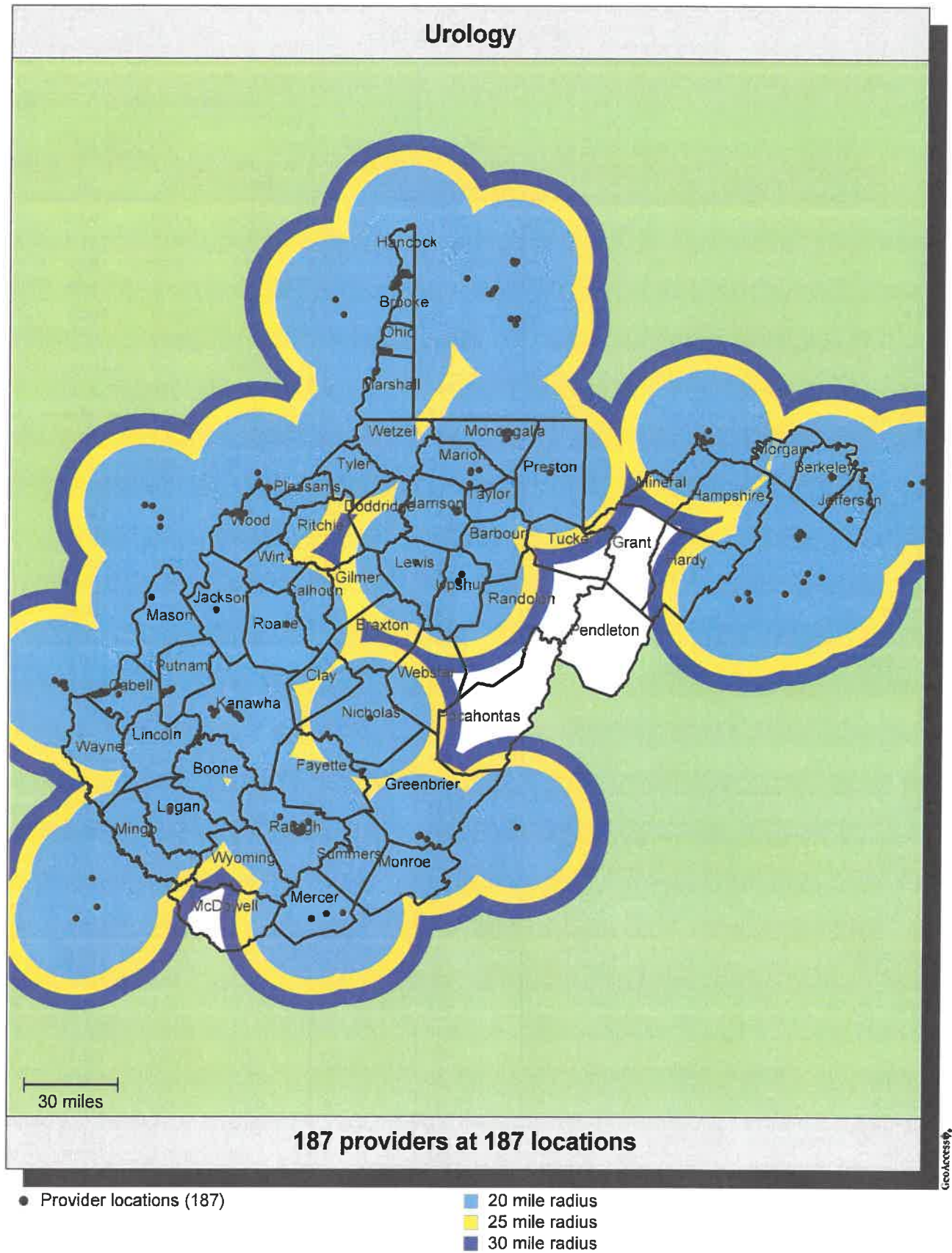
Provider group: Thoracic Surgery

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	1	8.0	100.0	100.0	100.0
RALEIGH	984	1	3.0	100.0	100.0	100.0
RANDOLPH	412	2	0.9	100.0	100.0	100.0
RITCHIE	151	0	27.2	0.0	0.0	100.0
ROANE	242	0	37.1	0.0	0.0	0.0
SUMMERS	116	0	22.0	17.2	100.0	100.0
TAYLOR	301	0	14.6	100.0	100.0	100.0
TUCKER	52	0	20.0	76.9	100.0	100.0
TYLER	26	0	11.8	100.0	100.0	100.0
UPSHUR	245	0	21.7	11.4	100.0	100.0
WAYNE	522	0	13.2	100.0	100.0	100.0
WEBSTER	168	0	51.5	0.0	0.0	0.0
WETZEL	116	2	0.9	100.0	100.0	100.0
WIRT	63	0	17.7	74.6	100.0	100.0
WOOD	851	5	1.3	100.0	100.0	100.0
WYOMING	403	0	26.9	0.0	0.0	100.0
TOTALS	18,348	98	17.3	58.0	68.6	74.2

Provider group: Thoracic Surgery

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
BARBOUR	281	0	18.2	100.0	100.0	100.0
BERKELEY	694	4	4.1	100.0	100.0	100.0
BOONE	300	0	20.3	25.3	100.0	100.0
BRAXTON	201	0	25.7	8.0	30.8	100.0
BROOKE	56	0	7.1	100.0	100.0	100.0
CABELL	1,048	16	1.5	100.0	100.0	100.0
CALHOUN	171	0	20.5	0.0	100.0	100.0
CLAY	241	0	24.7	0.0	57.7	100.0
DODDRIDGE	37	0	26.1	0.0	18.9	100.0
FAYETTE	580	0	18.1	93.3	100.0	100.0
GILMER	70	0	23.6	0.0	100.0	100.0
GRANT	146	0	36.8	0.0	0.0	0.0
GREENBRIER	340	4	4.7	100.0	100.0	100.0
HAMPSHIRE	255	0	20.4	5.9	100.0	100.0
HANCOCK	392	6	6.0	100.0	100.0	100.0
HARDY	101	0	31.2	0.0	0.0	21.8
HARRISON	550	7	5.1	100.0	100.0	100.0
JACKSON	480	1	2.2	100.0	100.0	100.0
JEFFERSON	226	1	3.5	100.0	100.0	100.0
KANAWHA	1,619	13	0.8	100.0	100.0	100.0
LEWIS	126	1	3.6	100.0	100.0	100.0
LINCOLN	348	0	11.6	100.0	100.0	100.0
LOGAN	414	2	1.9	100.0	100.0	100.0
MARION	155	4	1.6	100.0	100.0	100.0
MARSHALL	165	2	2.6	100.0	100.0	100.0
MASON	939	1	2.7	100.0	100.0	100.0
MCDOWELL	507	0	28.1	0.0	0.0	100.0
MERCER	151	3	2.6	100.0	100.0	100.0
MINERAL	421	0	22.7	3.8	88.8	100.0
MINGO	417	1	2.0	100.0	100.0	100.0
MONONGALIA	117	15	0.7	100.0	100.0	100.0
MONROE	68	0	14.1	100.0	100.0	100.0
MORGAN	281	0	19.9	48.8	100.0	100.0
NICHOLAS	447	1	5.7	100.0	100.0	100.0
OHIO	366	3	2.5	100.0	100.0	100.0
PENDLETON	26	0	51.8	0.0	0.0	0.0
PLEASANTS	39	0	13.1	100.0	100.0	100.0
POCAHONTAS	88	0	36.6	0.0	0.0	0.0
PRESTON	342	1	1.8	100.0	100.0	100.0

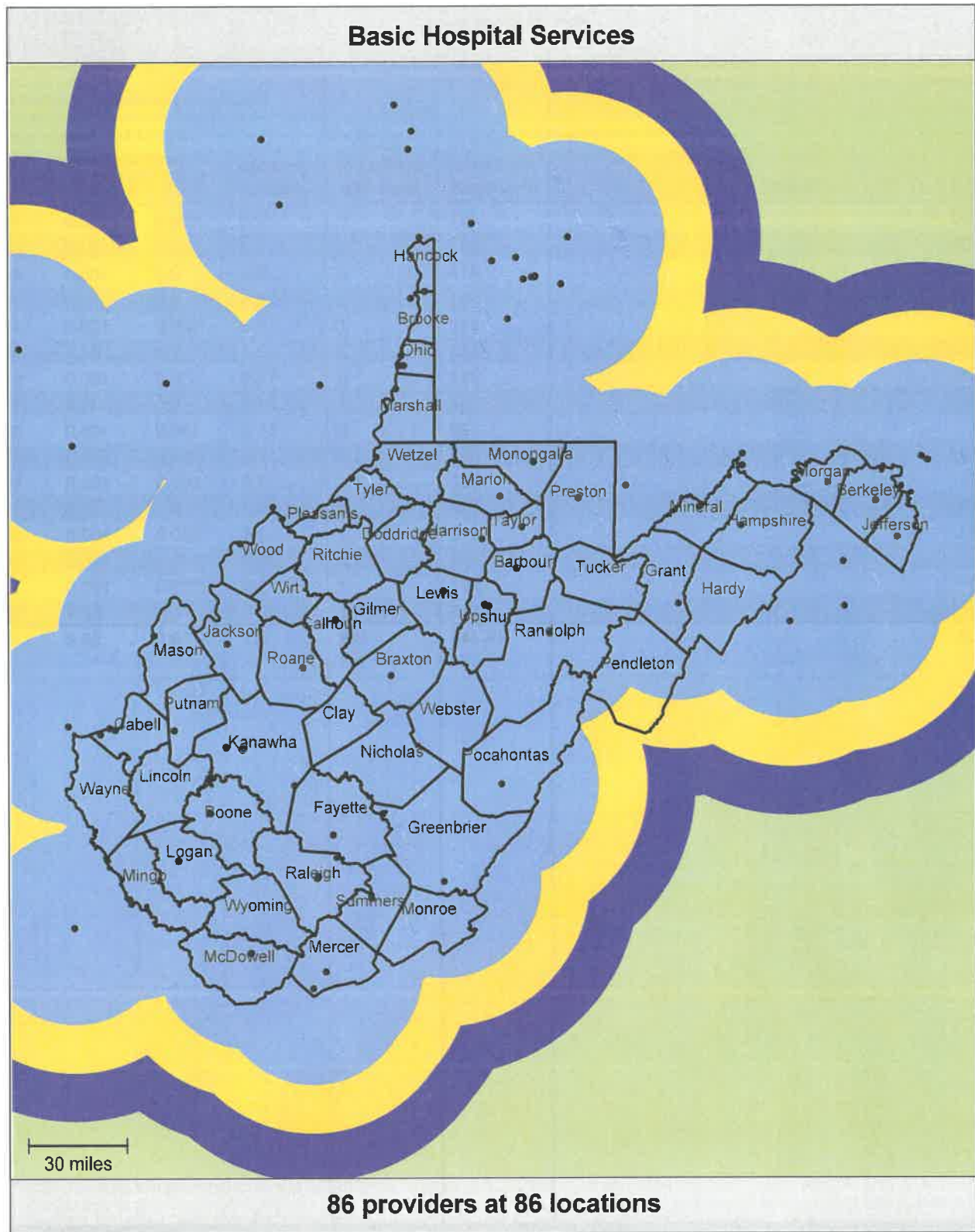
Provider group: Urology

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				20	25	30
PUTNAM	491	5	9.0	100.0	100.0	100.0
RALEIGH	984	11	1.0	100.0	100.0	100.0
RANDOLPH	412	0	22.5	0.0	100.0	100.0
RITCHIE	151	0	28.4	0.0	0.0	100.0
ROANE	242	1	5.5	100.0	100.0	100.0
SUMMERS	116	0	20.1	17.2	100.0	100.0
TAYLOR	301	0	12.8	100.0	100.0	100.0
TUCKER	52	0	24.9	0.0	34.6	100.0
TYLER	26	0	11.6	100.0	100.0	100.0
UPSHUR	245	2	1.6	100.0	100.0	100.0
WAYNE	522	0	11.6	100.0	100.0	100.0
WEBSTER	168	0	28.8	0.0	12.5	75.0
WETZEL	116	1	1.8	100.0	100.0	100.0
WIRT	63	0	20.2	49.2	100.0	100.0
WOOD	851	3	1.6	100.0	100.0	100.0
WYOMING	403	0	25.5	0.0	50.1	100.0
TOTALS	18,348	109	9.2	78.5	90.6	97.9

Provider group: Urology

Provider locations



● Provider locations (86)

■ 30 mile radius

■ 45 mile radius

■ 60 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				30	35	40
BARBOUR	281	1	1.1	100.0	100.0	100.0
BERKELEY	694	1	4.4	100.0	100.0	100.0
BOONE	300	1	0.7	100.0	100.0	100.0
BRAXTON	201	1	6.7	100.0	100.0	100.0
BROOKE	56	0	9.0	100.0	100.0	100.0
CABELL	1,048	2	2.6	100.0	100.0	100.0
CALHOUN	171	1	0.4	100.0	100.0	100.0
CLAY	241	0	25.7	100.0	100.0	100.0
DODDRIDGE	37	0	26.7	100.0	100.0	100.0
FAYETTE	580	2	7.2	100.0	100.0	100.0
GILMER	70	0	14.5	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	1	5.3	100.0	100.0	100.0
HAMPSHIRE	255	1	0.4	100.0	100.0	100.0
HANCOCK	392	1	6.9	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	1	5.9	100.0	100.0	100.0
JACKSON	480	1	2.3	100.0	100.0	100.0
JEFFERSON	226	1	3.2	100.0	100.0	100.0
KANAWHA	1,619	4	5.5	100.0	100.0	100.0
LEWIS	126	1	3.3	100.0	100.0	100.0
LINCOLN	348	0	13.5	100.0	100.0	100.0
LOGAN	414	1	1.8	100.0	100.0	100.0
MARION	155	1	2.4	100.0	100.0	100.0
MARSHALL	165	1	3.5	100.0	100.0	100.0
MASON	939	1	2.9	100.0	100.0	100.0
MCDOWELL	507	1	1.0	100.0	100.0	100.0
MERCER	151	2	5.4	100.0	100.0	100.0
MINERAL	421	1	1.5	100.0	100.0	100.0
MINGO	417	1	2.0	100.0	100.0	100.0
MONONGALIA	117	2	1.5	100.0	100.0	100.0
MONROE	68	0	14.5	100.0	100.0	100.0
MORGAN	281	1	7.2	100.0	100.0	100.0
NICHOLAS	447	0	27.4	94.4	100.0	100.0
OHIO	366	2	2.3	100.0	100.0	100.0
PENDLETON	26	0	32.3	0.0	100.0	100.0
PLEASANTS	39	0	13.2	100.0	100.0	100.0
POCAHONTAS	88	1	5.6	100.0	100.0	100.0
PRESTON	342	1	1.8	100.0	100.0	100.0

Provider group: Basic Hospital Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				30	35	40
PUTNAM	491	1	11.7	100.0	100.0	100.0
RALEIGH	984	2	2.7	100.0	100.0	100.0
RANDOLPH	412	1	4.5	100.0	100.0	100.0
RITCHIE	151	0	21.3	100.0	100.0	100.0
ROANE	242	1	7.2	100.0	100.0	100.0
SUMMERS	116	1	1.9	100.0	100.0	100.0
TAYLOR	301	1	1.0	100.0	100.0	100.0
TUCKER	52	0	20.9	100.0	100.0	100.0
TYLER	26	1	9.2	100.0	100.0	100.0
UPSHUR	245	2	1.6	100.0	100.0	100.0
WAYNE	522	0	13.0	100.0	100.0	100.0
WEBSTER	168	0	28.9	100.0	100.0	100.0
WETZEL	116	1	1.3	100.0	100.0	100.0
WIRT	63	0	21.6	100.0	100.0	100.0
WOOD	851	1	5.9	100.0	100.0	100.0
WYOMING	403	0	13.8	100.0	100.0	100.0
TOTALS	18,348	49	6.1	99.7	100.0	100.0

Provider group: Basic Hospital Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				60	65	70
BARBOUR	281	1	1.1	100.0	100.0	100.0
BERKELEY	694	1	4.4	100.0	100.0	100.0
BOONE	300	1	0.7	100.0	100.0	100.0
BRAXTON	201	1	6.7	100.0	100.0	100.0
BROOKE	56	0	9.0	100.0	100.0	100.0
CABELL	1,048	2	2.6	100.0	100.0	100.0
CALHOUN	171	1	0.4	100.0	100.0	100.0
CLAY	241	0	25.7	100.0	100.0	100.0
DODDRIDGE	37	0	26.7	100.0	100.0	100.0
FAYETTE	580	2	7.2	100.0	100.0	100.0
GILMER	70	0	14.5	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	1	5.3	100.0	100.0	100.0
HAMPSHIRE	255	1	0.4	100.0	100.0	100.0
HANCOCK	392	1	6.9	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	1	5.9	100.0	100.0	100.0
JACKSON	480	1	2.3	100.0	100.0	100.0
JEFFERSON	226	1	3.2	100.0	100.0	100.0
KANAWHA	1,619	4	5.5	100.0	100.0	100.0
LEWIS	126	1	3.3	100.0	100.0	100.0
LINCOLN	348	0	13.5	100.0	100.0	100.0
LOGAN	414	1	1.8	100.0	100.0	100.0
MARION	155	1	2.4	100.0	100.0	100.0
MARSHALL	165	1	3.5	100.0	100.0	100.0
MASON	939	1	2.9	100.0	100.0	100.0
MCDOWELL	507	1	1.0	100.0	100.0	100.0
MERCER	151	2	5.4	100.0	100.0	100.0
MINERAL	421	1	1.5	100.0	100.0	100.0
MINGO	417	1	2.0	100.0	100.0	100.0
MONONGALIA	117	2	1.5	100.0	100.0	100.0
MONROE	68	0	14.5	100.0	100.0	100.0
MORGAN	281	1	7.2	100.0	100.0	100.0
NICHOLAS	447	0	27.4	100.0	100.0	100.0
OHIO	366	2	2.3	100.0	100.0	100.0
PENDLETON	26	0	32.3	100.0	100.0	100.0
PLEASANTS	39	0	13.2	100.0	100.0	100.0
POCAHONTAS	88	1	5.6	100.0	100.0	100.0
PRESTON	342	1	1.8	100.0	100.0	100.0

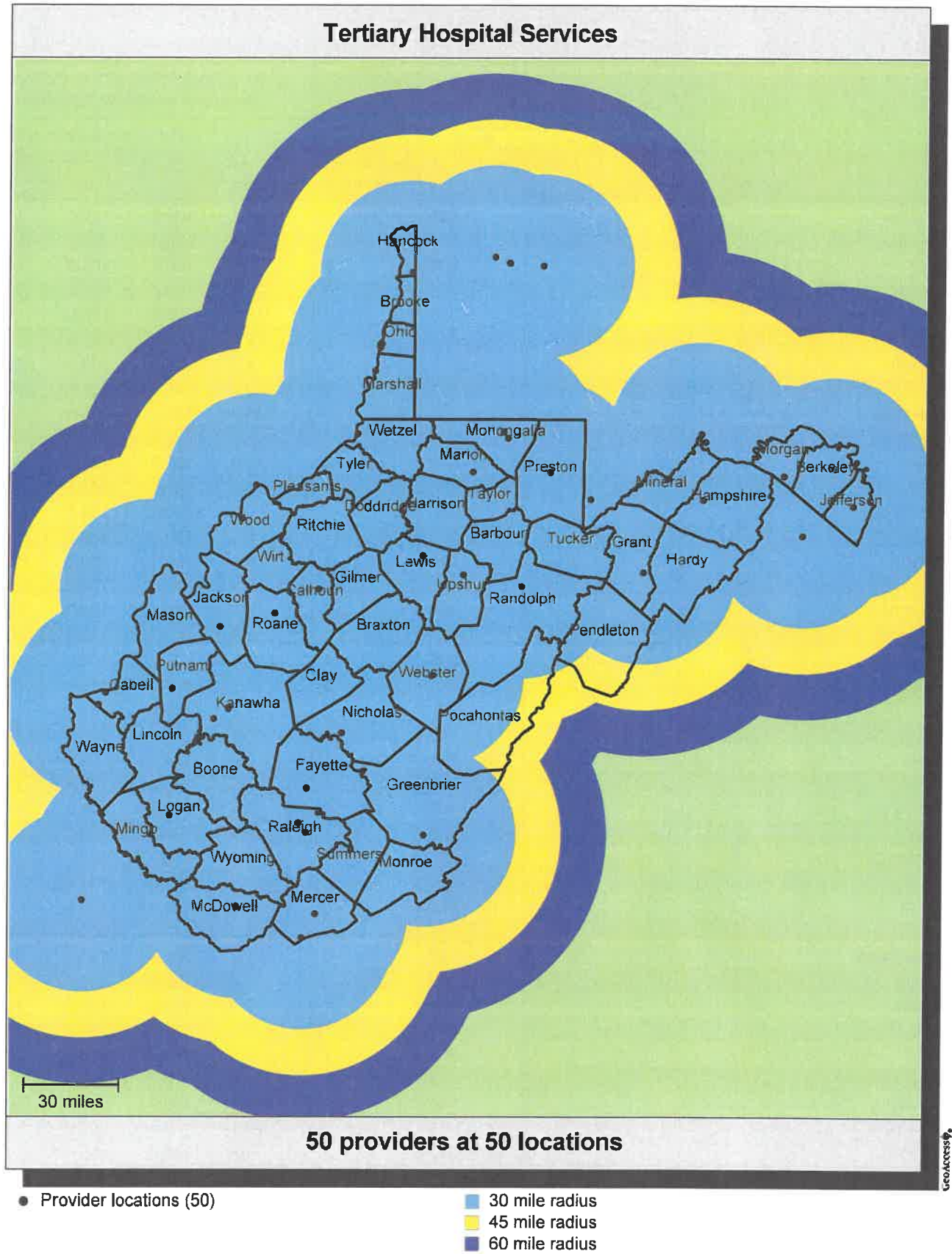
Provider group: Basic Hospital Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				60	65	70
PUTNAM	491	1	11.7	100.0	100.0	100.0
RALEIGH	984	2	2.7	100.0	100.0	100.0
RANDOLPH	412	1	4.5	100.0	100.0	100.0
RITCHIE	151	0	21.3	100.0	100.0	100.0
ROANE	242	1	7.2	100.0	100.0	100.0
SUMMERS	116	1	1.9	100.0	100.0	100.0
TAYLOR	301	1	1.0	100.0	100.0	100.0
TUCKER	52	0	20.9	100.0	100.0	100.0
TYLER	26	1	9.2	100.0	100.0	100.0
UPSHUR	245	2	1.6	100.0	100.0	100.0
WAYNE	522	0	13.0	100.0	100.0	100.0
WEBSTER	168	0	28.9	100.0	100.0	100.0
WETZEL	116	1	1.3	100.0	100.0	100.0
WIRT	63	0	21.6	100.0	100.0	100.0
WOOD	851	1	5.9	100.0	100.0	100.0
WYOMING	403	0	13.8	100.0	100.0	100.0
TOTALS	18,348	49	6.1	100.0	100.0	100.0

Provider group: Basic Hospital Services

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				30	35	40
BARBOUR	281	0	19.2	100.0	100.0	100.0
BERKELEY	694	1	4.3	100.0	100.0	100.0
BOONE	300	0	20.5	100.0	100.0	100.0
BRAXTON	201	0	23.0	100.0	100.0	100.0
BROOKE	56	0	12.6	100.0	100.0	100.0
CABELL	1,048	2	2.9	100.0	100.0	100.0
CALHOUN	171	1	0.3	100.0	100.0	100.0
CLAY	241	0	20.8	100.0	100.0	100.0
DODDRIDGE	37	0	26.9	100.0	100.0	100.0
FAYETTE	580	1	8.1	100.0	100.0	100.0
GILMER	70	0	15.0	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	1	4.3	100.0	100.0	100.0
HAMPSHIRE	255	1	0.4	100.0	100.0	100.0
HANCOCK	392	1	9.2	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	0	19.1	100.0	100.0	100.0
JACKSON	480	1	5.8	100.0	100.0	100.0
JEFFERSON	226	1	4.1	100.0	100.0	100.0
KANAWHA	1,619	3	6.2	100.0	100.0	100.0
LEWIS	126	1	4.2	100.0	100.0	100.0
LINCOLN	348	0	16.4	100.0	100.0	100.0
LOGAN	414	1	1.8	100.0	100.0	100.0
MARION	155	1	2.5	100.0	100.0	100.0
MARSHALL	165	1	3.1	100.0	100.0	100.0
MASON	939	1	4.4	100.0	100.0	100.0
MCDOWELL	507	1	1.8	100.0	100.0	100.0
MERCER	151	2	4.1	100.0	100.0	100.0
MINERAL	421	1	1.3	100.0	100.0	100.0
MINGO	417	1	3.3	100.0	100.0	100.0
MONONGALIA	117	2	1.0	100.0	100.0	100.0
MONROE	68	0	15.4	100.0	100.0	100.0
MORGAN	281	1	10.9	100.0	100.0	100.0
NICHOLAS	447	1	9.1	100.0	100.0	100.0
OHIO	366	2	3.0	100.0	100.0	100.0
PENDLETON	26	0	32.3	0.0	100.0	100.0
PLEASANTS	39	0	17.2	100.0	100.0	100.0
POCAHONTAS	88	0	32.1	9.1	100.0	100.0
PRESTON	342	1	1.8	100.0	100.0	100.0

Provider group: Tertiary Hospital Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				30	35	40
PUTNAM	491	1	8.8	100.0	100.0	100.0
RALEIGH	984	2	2.5	100.0	100.0	100.0
RANDOLPH	412	1	1.3	100.0	100.0	100.0
RITCHIE	151	0	21.9	100.0	100.0	100.0
ROANE	242	1	4.6	100.0	100.0	100.0
SUMMERS	116	0	19.7	100.0	100.0	100.0
TAYLOR	301	0	15.5	100.0	100.0	100.0
TUCKER	52	0	19.8	100.0	100.0	100.0
TYLER	26	0	13.0	100.0	100.0	100.0
UPSHUR	245	1	1.9	100.0	100.0	100.0
WAYNE	522	0	10.4	100.0	100.0	100.0
WEBSTER	168	1	3.1	100.0	100.0	100.0
WETZEL	116	1	1.2	100.0	100.0	100.0
WIRT	63	0	18.5	100.0	100.0	100.0
WOOD	851	1	2.2	100.0	100.0	100.0
WYOMING	403	0	14.9	100.0	100.0	100.0
TOTALS	18,348	40	7.1	99.4	100.0	100.0

Provider group: Tertiary Hospital Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				60	65	70
BARBOUR	281	0	19.2	100.0	100.0	100.0
BERKELEY	694	1	4.3	100.0	100.0	100.0
BOONE	300	0	20.5	100.0	100.0	100.0
BRAXTON	201	0	23.0	100.0	100.0	100.0
BROOKE	56	0	12.6	100.0	100.0	100.0
CABELL	1,048	2	2.9	100.0	100.0	100.0
CALHOUN	171	1	0.3	100.0	100.0	100.0
CLAY	241	0	20.8	100.0	100.0	100.0
DODDRIDGE	37	0	26.9	100.0	100.0	100.0
FAYETTE	580	1	8.1	100.0	100.0	100.0
GILMER	70	0	15.0	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	1	4.3	100.0	100.0	100.0
HAMPSHIRE	255	1	0.4	100.0	100.0	100.0
HANCOCK	392	1	9.2	100.0	100.0	100.0
HARDY	101	0	9.9	100.0	100.0	100.0
HARRISON	550	0	19.1	100.0	100.0	100.0
JACKSON	480	1	5.8	100.0	100.0	100.0
JEFFERSON	226	1	4.1	100.0	100.0	100.0
KANAWHA	1,619	3	6.2	100.0	100.0	100.0
LEWIS	126	1	4.2	100.0	100.0	100.0
LINCOLN	348	0	16.4	100.0	100.0	100.0
LOGAN	414	1	1.8	100.0	100.0	100.0
MARION	155	1	2.5	100.0	100.0	100.0
MARSHALL	165	1	3.1	100.0	100.0	100.0
MASON	939	1	4.4	100.0	100.0	100.0
MCDOWELL	507	1	1.8	100.0	100.0	100.0
MERCER	151	2	4.1	100.0	100.0	100.0
MINERAL	421	1	1.3	100.0	100.0	100.0
MINGO	417	1	3.3	100.0	100.0	100.0
MONONGALIA	117	2	1.0	100.0	100.0	100.0
MONROE	68	0	15.4	100.0	100.0	100.0
MORGAN	281	1	10.9	100.0	100.0	100.0
NICHOLAS	447	1	9.1	100.0	100.0	100.0
OHIO	366	2	3.0	100.0	100.0	100.0
PENDLETON	26	0	32.3	100.0	100.0	100.0
PLEASANTS	39	0	17.2	100.0	100.0	100.0
POCAHONTAS	88	0	32.1	100.0	100.0	100.0
PRESTON	342	1	1.8	100.0	100.0	100.0

Provider group: Tertiary Hospital Services

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				60	65	70
PUTNAM	491	1	8.8	100.0	100.0	100.0
RALEIGH	984	2	2.5	100.0	100.0	100.0
RANDOLPH	412	1	1.3	100.0	100.0	100.0
RITCHIE	151	0	21.9	100.0	100.0	100.0
ROANE	242	1	4.6	100.0	100.0	100.0
SUMMERS	116	0	19.7	100.0	100.0	100.0
TAYLOR	301	0	15.5	100.0	100.0	100.0
TUCKER	52	0	19.8	100.0	100.0	100.0
TYLER	26	0	13.0	100.0	100.0	100.0
UPSHUR	245	1	1.9	100.0	100.0	100.0
WAYNE	522	0	10.4	100.0	100.0	100.0
WEBSTER	168	1	3.1	100.0	100.0	100.0
WETZEL	116	1	1.2	100.0	100.0	100.0
WIRT	63	0	18.5	100.0	100.0	100.0
WOOD	851	1	2.2	100.0	100.0	100.0
WYOMING	403	0	14.9	100.0	100.0	100.0
TOTALS	18,348	40	7.1	100.0	100.0	100.0

Provider group: Tertiary Hospital Services

Provider locations



330 providers at 326 locations

- Single provider locations (325)
- Multiple provider locations (1)

- 45 mile radius
- 50 mile radius
- 55 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
BARBOUR	281	4	1.9	100.0	100.0	100.0
BERKELEY	694	16	3.5	100.0	100.0	100.0
BOONE	300	0	16.1	100.0	100.0	100.0
BRAXTON	201	1	23.8	100.0	100.0	100.0
BROOKE	56	0	10.0	100.0	100.0	100.0
CABELL	1,048	46	1.1	100.0	100.0	100.0
CALHOUN	171	1	15.6	100.0	100.0	100.0
CLAY	241	0	19.7	100.0	100.0	100.0
DODDRIDGE	37	0	18.7	100.0	100.0	100.0
FAYETTE	580	1	18.8	100.0	100.0	100.0
GILMER	70	1	14.5	100.0	100.0	100.0
GRANT	146	0	28.5	100.0	100.0	100.0
GREENBRIER	340	3	1.8	100.0	100.0	100.0
HAMPSHIRE	255	2	0.6	100.0	100.0	100.0
HANCOCK	392	2	7.9	100.0	100.0	100.0
HARDY	101	0	29.8	100.0	100.0	100.0
HARRISON	550	15	1.7	100.0	100.0	100.0
JACKSON	480	3	5.3	100.0	100.0	100.0
JEFFERSON	226	4	7.1	100.0	100.0	100.0
KANAWHA	1,619	49	0.9	100.0	100.0	100.0
LEWIS	126	2	6.4	100.0	100.0	100.0
LINCOLN	348	0	11.0	100.0	100.0	100.0
LOGAN	414	5	2.1	100.0	100.0	100.0
MARION	155	11	1.8	100.0	100.0	100.0
MARSHALL	165	0	10.1	100.0	100.0	100.0
MASON	939	4	3.3	100.0	100.0	100.0
MCDOWELL	507	1	12.0	100.0	100.0	100.0
MERCER	151	10	3.1	100.0	100.0	100.0
MINERAL	421	3	1.1	100.0	100.0	100.0
MINGO	417	5	2.1	100.0	100.0	100.0
MONONGALIA	117	48	0.5	100.0	100.0	100.0
MONROE	68	5	0.8	100.0	100.0	100.0
MORGAN	281	0	19.6	100.0	100.0	100.0
NICHOLAS	447	2	9.7	100.0	100.0	100.0
OHIO	366	9	2.4	100.0	100.0	100.0
PENDLETON	26	0	39.4	100.0	100.0	100.0
PLEASANTS	39	0	15.1	100.0	100.0	100.0
POCAHONTAS	88	2	16.0	100.0	100.0	100.0
PRESTON	342	1	18.8	100.0	100.0	100.0

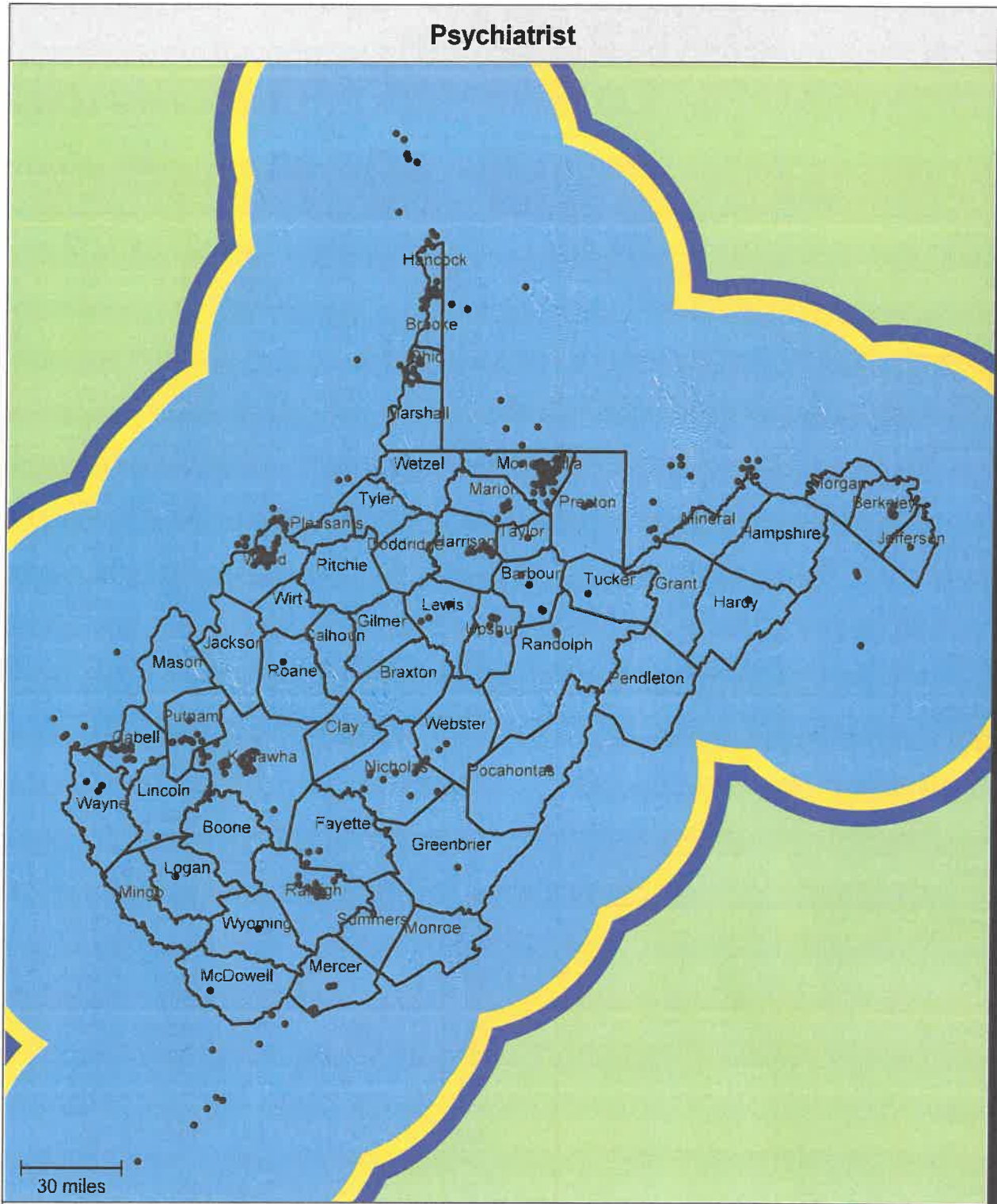
Provider group: Psychologist

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
PUTNAM	491	7	5.9	100.0	100.0	100.0
RALEIGH	984	10	2.1	100.0	100.0	100.0
RANDOLPH	412	6	1.4	100.0	100.0	100.0
RITCHIE	151	5	0.5	100.0	100.0	100.0
ROANE	242	1	17.4	100.0	100.0	100.0
SUMMERS	116	1	19.3	100.0	100.0	100.0
TAYLOR	301	1	11.2	100.0	100.0	100.0
TUCKER	52	3	12.5	100.0	100.0	100.0
TYLER	26	0	24.4	100.0	100.0	100.0
UPSHUR	245	1	11.6	100.0	100.0	100.0
WAYNE	522	2	12.6	100.0	100.0	100.0
WEBSTER	168	0	31.3	100.0	100.0	100.0
WETZEL	116	0	31.8	100.0	100.0	100.0
WIRT	63	1	13.5	100.0	100.0	100.0
WOOD	851	20	1.3	100.0	100.0	100.0
WYOMING	403	2	2.8	100.0	100.0	100.0
TOTALS	18,348	316	7.0	100.0	100.0	100.0

Provider group: Psychologist

Provider locations



469 providers at 468 locations

- Single provider locations (467)
- Multiple provider locations (1)
- 45 mile radius
- 50 mile radius
- 55 mile radius

GeoAccess

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
BARBOUR	281	4	3.7	100.0	100.0	100.0
BERKELEY	694	13	3.8	100.0	100.0	100.0
BOONE	300	0	20.5	100.0	100.0	100.0
BRAXTON	201	0	22.5	100.0	100.0	100.0
BROOKE	56	1	7.0	100.0	100.0	100.0
CABELL	1,048	31	1.2	100.0	100.0	100.0
CALHOUN	171	0	27.2	100.0	100.0	100.0
CLAY	241	0	18.6	100.0	100.0	100.0
DODDRIDGE	37	0	21.9	100.0	100.0	100.0
FAYETTE	580	4	10.8	100.0	100.0	100.0
GILMER	70	0	16.0	100.0	100.0	100.0
GRANT	146	0	29.9	100.0	100.0	100.0
GREENBRIER	340	4	7.1	100.0	100.0	100.0
HAMPSHIRE	255	0	20.0	100.0	100.0	100.0
HANCOCK	392	14	4.8	100.0	100.0	100.0
HARDY	101	1	29.8	100.0	100.0	100.0
HARRISON	550	21	1.4	100.0	100.0	100.0
JACKSON	480	0	27.4	100.0	100.0	100.0
JEFFERSON	226	1	15.5	100.0	100.0	100.0
KANAWHA	1,619	49	0.0	100.0	100.0	100.0
LEWIS	126	3	9.2	100.0	100.0	100.0
LINCOLN	348	1	12.1	100.0	100.0	100.0
LOGAN	414	1	16.8	100.0	100.0	100.0
MARION	155	9	1.7	100.0	100.0	100.0
MARSHALL	165	0	8.8	100.0	100.0	100.0
MASON	939	0	29.2	100.0	100.0	100.0
MCDOWELL	507	1	16.6	100.0	100.0	100.0
MERCER	151	9	4.9	100.0	100.0	100.0
MINERAL	421	1	16.5	100.0	100.0	100.0
MINGO	417	0	23.8	100.0	100.0	100.0
MONONGALIA	117	124	0.3	100.0	100.0	100.0
MONROE	68	0	26.0	100.0	100.0	100.0
MORGAN	281	0	19.5	100.0	100.0	100.0
NICHOLAS	447	11	4.5	100.0	100.0	100.0
OHIO	366	17	1.4	100.0	100.0	100.0
PENDLETON	26	0	41.9	100.0	100.0	100.0
PLEASANTS	39	0	13.2	100.0	100.0	100.0
POCAHONTAS	88	1	24.5	100.0	100.0	100.0
PRESTON	342	2	2.9	100.0	100.0	100.0

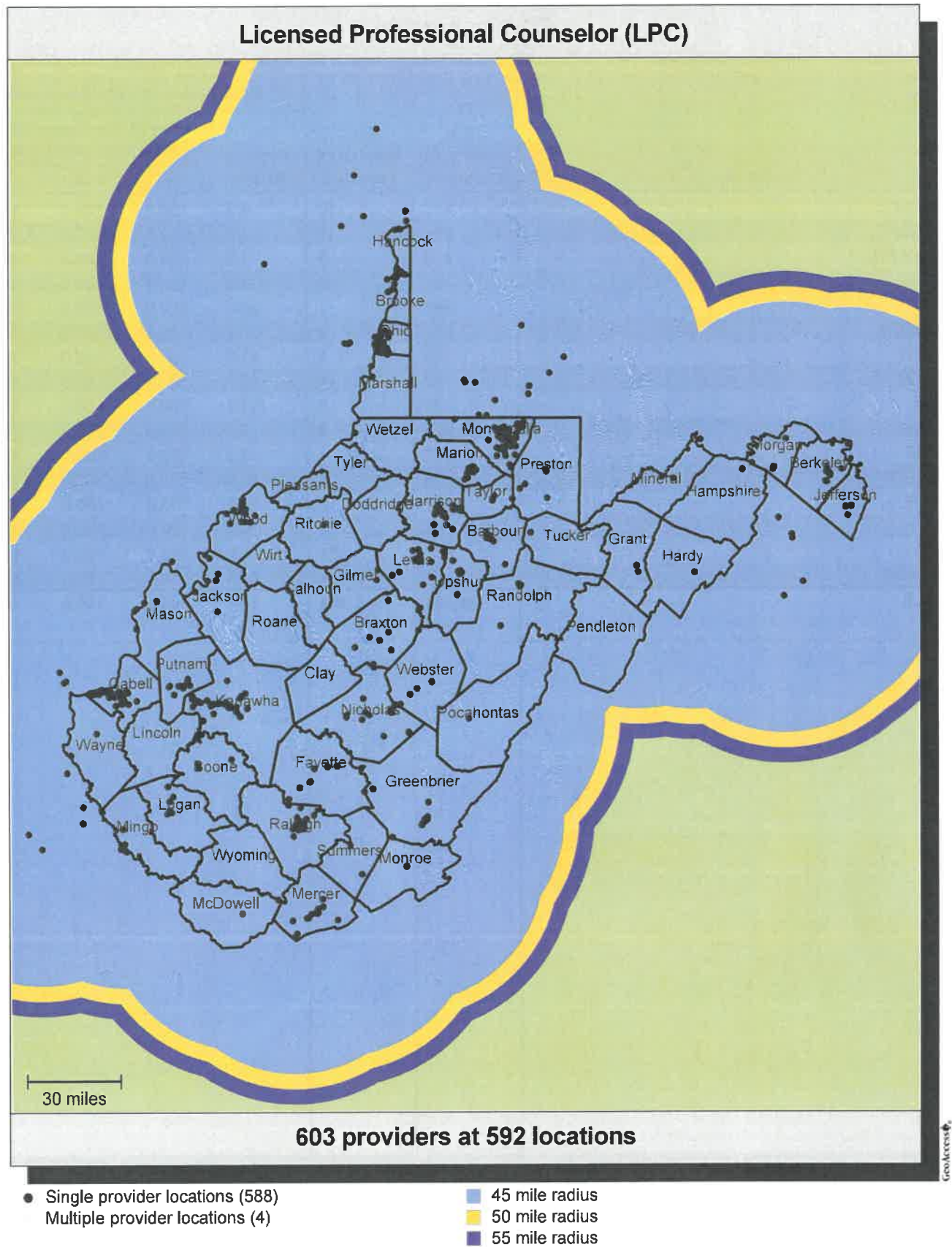
Provider group: Psychiatrist

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
PUTNAM	491	10	4.2	100.0	100.0	100.0
RALEIGH	984	15	1.5	100.0	100.0	100.0
RANDOLPH	412	3	1.3	100.0	100.0	100.0
RITCHIE	151	0	24.2	100.0	100.0	100.0
ROANE	242	1	33.0	100.0	100.0	100.0
SUMMERS	116	0	20.9	100.0	100.0	100.0
TAYLOR	301	1	11.7	100.0	100.0	100.0
TUCKER	52	1	17.6	100.0	100.0	100.0
TYLER	26	0	16.2	100.0	100.0	100.0
UPSHUR	245	8	1.5	100.0	100.0	100.0
WAYNE	522	4	3.2	100.0	100.0	100.0
WEBSTER	168	3	10.9	100.0	100.0	100.0
WETZEL	116	0	16.2	100.0	100.0	100.0
WIRT	63	0	15.4	100.0	100.0	100.0
WOOD	851	24	1.5	100.0	100.0	100.0
WYOMING	403	1	24.8	100.0	100.0	100.0
TOTALS	18,348	394	10.4	100.0	100.0	100.0

Provider group: Psychiatrist

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
BARBOUR	281	12	0.5	100.0	100.0	100.0
BERKELEY	694	13	3.8	100.0	100.0	100.0
BOONE	300	7	0.5	100.0	100.0	100.0
BRAXTON	201	9	4.6	100.0	100.0	100.0
BROOKE	56	0	6.4	100.0	100.0	100.0
CABELL	1,048	44	1.0	100.0	100.0	100.0
CALHOUN	171	0	21.9	100.0	100.0	100.0
CLAY	241	0	18.5	100.0	100.0	100.0
DODDRIDGE	37	0	21.4	100.0	100.0	100.0
FAYETTE	580	12	4.9	100.0	100.0	100.0
GILMER	70	2	10.0	100.0	100.0	100.0
GRANT	146	2	2.6	100.0	100.0	100.0
GREENBRIER	340	14	1.1	100.0	100.0	100.0
HAMPSHIRE	255	2	17.4	100.0	100.0	100.0
HANCOCK	392	9	5.5	100.0	100.0	100.0
HARDY	101	1	11.3	100.0	100.0	100.0
HARRISON	550	39	0.6	100.0	100.0	100.0
JACKSON	480	7	10.3	100.0	100.0	100.0
JEFFERSON	226	3	3.8	100.0	100.0	100.0
KANAWHA	1,619	48	0.0	100.0	100.0	100.0
LEWIS	126	20	1.6	100.0	100.0	100.0
LINCOLN	348	0	12.4	100.0	100.0	100.0
LOGAN	414	9	1.4	100.0	100.0	100.0
MARION	155	14	1.3	100.0	100.0	100.0
MARSHALL	165	1	4.3	100.0	100.0	100.0
MASON	939	2	3.3	100.0	100.0	100.0
MCDOWELL	507	2	13.6	100.0	100.0	100.0
MERCER	151	13	2.4	100.0	100.0	100.0
MINERAL	421	2	4.5	100.0	100.0	100.0
MINGO	417	8	1.8	100.0	100.0	100.0
MONONGALIA	117	115	0.3	100.0	100.0	100.0
MONROE	68	1	14.1	100.0	100.0	100.0
MORGAN	281	3	10.3	100.0	100.0	100.0
NICHOLAS	447	12	3.6	100.0	100.0	100.0
OHIO	366	32	1.0	100.0	100.0	100.0
PENDLETON	26	0	32.8	100.0	100.0	100.0
PLEASANTS	39	0	22.6	100.0	100.0	100.0
POCAHONTAS	88	1	24.4	100.0	100.0	100.0
PRESTON	342	6	1.8	100.0	100.0	100.0

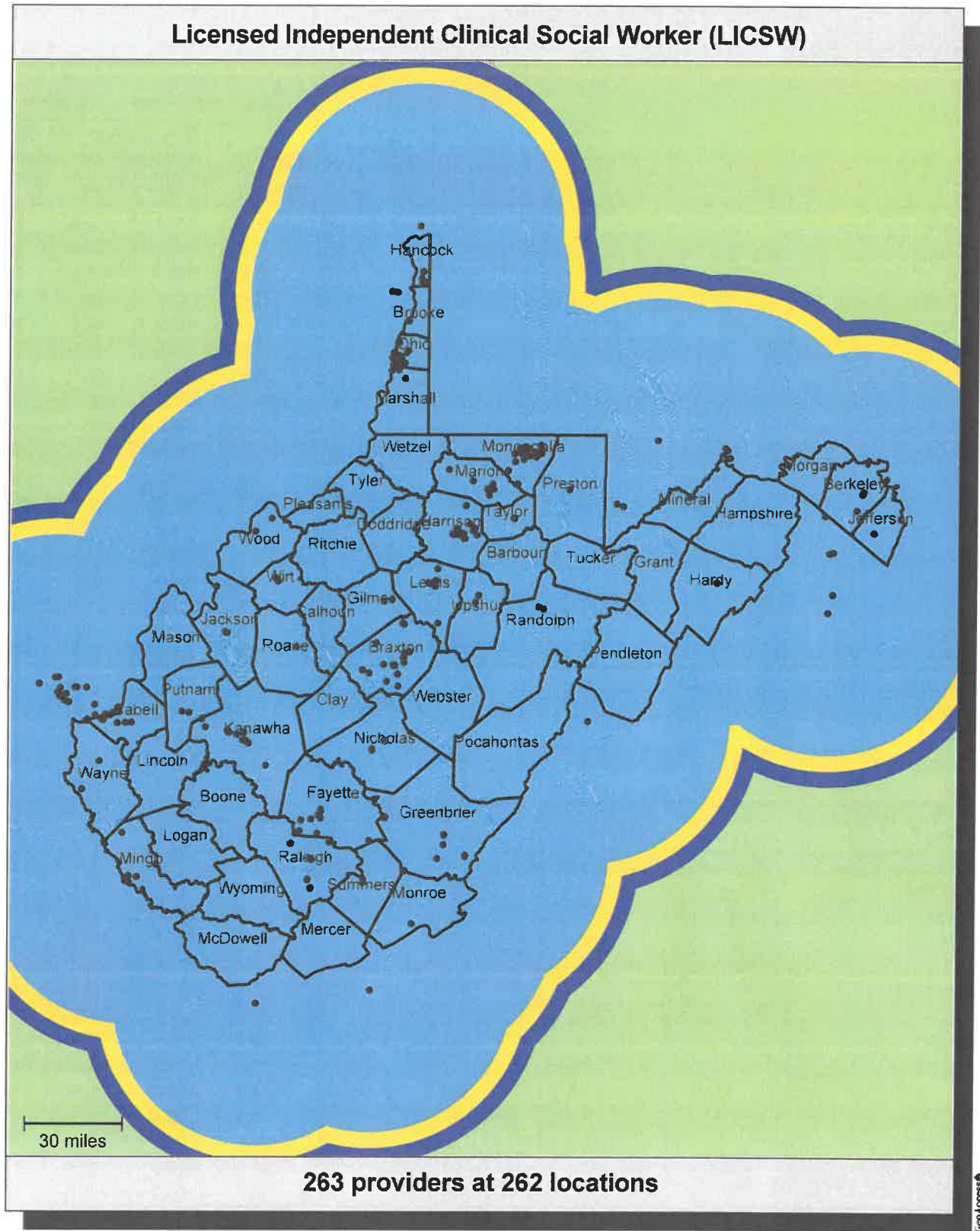
Provider group: Licensed Professional Counselor (LPC)

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
PUTNAM	491	16	3.1	100.0	100.0	100.0
RALEIGH	984	24	1.3	100.0	100.0	100.0
RANDOLPH	412	7	1.0	100.0	100.0	100.0
RITCHIE	151	1	24.8	100.0	100.0	100.0
ROANE	242	0	27.2	100.0	100.0	100.0
SUMMERS	116	2	17.0	100.0	100.0	100.0
TAYLOR	301	8	0.9	100.0	100.0	100.0
TUCKER	52	1	15.6	100.0	100.0	100.0
TYLER	26	0	24.7	100.0	100.0	100.0
UPSHUR	245	11	1.3	100.0	100.0	100.0
WAYNE	522	2	12.9	100.0	100.0	100.0
WEBSTER	168	4	7.6	100.0	100.0	100.0
WETZEL	116	1	22.3	100.0	100.0	100.0
WIRT	63	0	16.3	100.0	100.0	100.0
WOOD	851	12	1.9	100.0	100.0	100.0
WYOMING	403	0	20.8	100.0	100.0	100.0
TOTALS	18,348	554	5.5	100.0	100.0	100.0

Provider group: Licensed Professional Counselor (LPC)

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
BARBOUR	281	0	14.2	100.0	100.0	100.0
BERKELEY	694	3	4.9	100.0	100.0	100.0
BOONE	300	0	25.5	100.0	100.0	100.0
BRAXTON	201	19	2.0	100.0	100.0	100.0
BROOKE	56	1	10.5	100.0	100.0	100.0
CABELL	1,048	12	2.4	100.0	100.0	100.0
CALHOUN	171	0	20.4	100.0	100.0	100.0
CLAY	241	0	21.2	100.0	100.0	100.0
DODDRIDGE	37	0	22.0	100.0	100.0	100.0
FAYETTE	580	15	5.6	100.0	100.0	100.0
GILMER	70	2	7.6	100.0	100.0	100.0
GRANT	146	0	35.0	100.0	100.0	100.0
GREENBRIER	340	10	4.5	100.0	100.0	100.0
HAMPSHIRE	255	0	21.4	100.0	100.0	100.0
HANCOCK	392	4	6.8	100.0	100.0	100.0
HARDY	101	1	30.3	100.0	100.0	100.0
HARRISON	550	20	0.8	100.0	100.0	100.0
JACKSON	480	3	2.6	100.0	100.0	100.0
JEFFERSON	226	1	13.6	100.0	100.0	100.0
KANAWHA	1,619	12	1.3	100.0	100.0	100.0
LEWIS	126	6	2.9	100.0	100.0	100.0
LINCOLN	348	0	17.0	100.0	100.0	100.0
LOGAN	414	0	21.8	100.0	100.0	100.0
MARION	155	11	1.7	100.0	100.0	100.0
MARSHALL	165	1	8.2	100.0	100.0	100.0
MASON	939	0	24.2	100.0	100.0	100.0
MCDOWELL	507	0	31.6	100.0	100.0	100.0
MERCER	151	0	23.2	100.0	100.0	100.0
MINERAL	421	1	22.5	100.0	100.0	100.0
MINGO	417	4	3.3	100.0	100.0	100.0
MONONGALIA	117	37	0.6	100.0	100.0	100.0
MONROE	68	1	14.8	100.0	100.0	100.0
MORGAN	281	0	20.5	100.0	100.0	100.0
NICHOLAS	447	3	3.9	100.0	100.0	100.0
OHIO	366	22	1.4	100.0	100.0	100.0
PENDLETON	26	0	40.8	100.0	100.0	100.0
PLEASANTS	39	0	24.9	100.0	100.0	100.0
POCAHONTAS	88	0	36.0	100.0	100.0	100.0
PRESTON	342	1	16.6	100.0	100.0	100.0

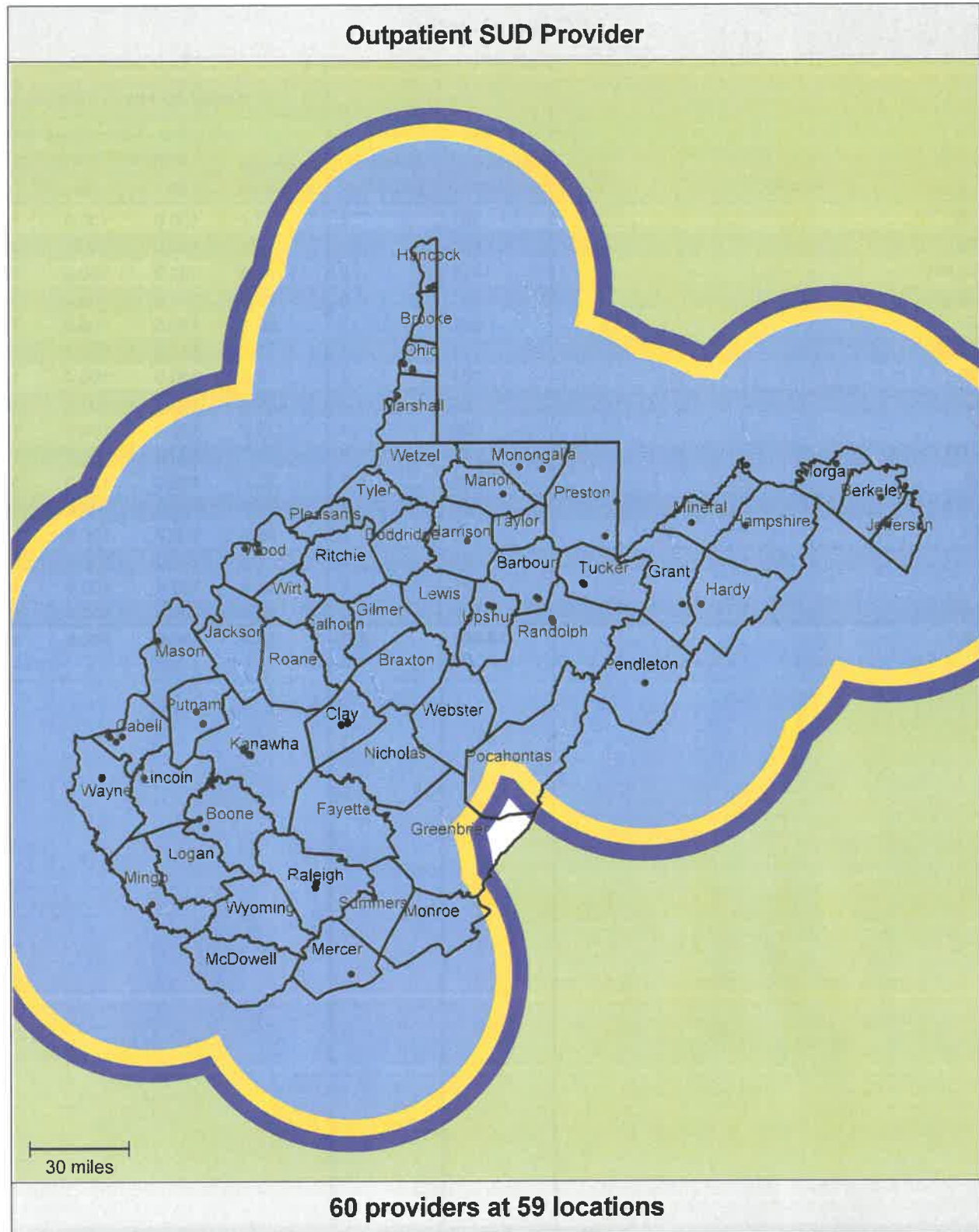
Provider group: Licensed Independent Clinical Social Worker (LICSW)

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 2 providers			
			Average distance	Pct of employees with 2 providers within x miles		
				45	50	55
PUTNAM	491	2	7.1	100.0	100.0	100.0
RALEIGH	984	11	2.8	100.0	100.0	100.0
RANDOLPH	412	2	2.0	100.0	100.0	100.0
RITCHIE	151	0	26.9	100.0	100.0	100.0
ROANE	242	1	20.7	100.0	100.0	100.0
SUMMERS	116	3	2.0	100.0	100.0	100.0
TAYLOR	301	2	1.2	100.0	100.0	100.0
TUCKER	52	0	20.2	100.0	100.0	100.0
TYLER	26	0	35.2	100.0	100.0	100.0
UPSHUR	245	2	3.7	100.0	100.0	100.0
WAYNE	522	2	12.7	100.0	100.0	100.0
WEBSTER	168	0	23.4	100.0	100.0	100.0
WETZEL	116	0	29.5	100.0	100.0	100.0
WIRT	63	2	3.8	100.0	100.0	100.0
WOOD	851	2	11.5	100.0	100.0	100.0
WYOMING	403	0	20.8	100.0	100.0	100.0
TOTALS	18,348	219	10.8	100.0	100.0	100.0

Provider group: Licensed Independent Clinical Social Worker (LICSW)

Provider locations



- Single provider locations (58)
- Multiple provider locations (1)

- 45 mile radius
- 50 mile radius
- 55 mile radius

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				45	50	55
BARBOUR	281	2	13.0	100.0	100.0	100.0
BERKELEY	694	1	4.3	100.0	100.0	100.0
BOONE	300	2	4.9	100.0	100.0	100.0
BRAXTON	201	0	27.5	100.0	100.0	100.0
BROOKE	56	0	11.4	100.0	100.0	100.0
CABELL	1,048	6	1.0	100.0	100.0	100.0
CALHOUN	171	0	32.2	100.0	100.0	100.0
CLAY	241	2	0.5	100.0	100.0	100.0
DODDRIDGE	37	0	22.5	100.0	100.0	100.0
FAYETTE	580	0	25.0	100.0	100.0	100.0
GILMER	70	0	34.9	100.0	100.0	100.0
GRANT	146	1	1.2	100.0	100.0	100.0
GREENBRIER	340	0	44.5	77.9	100.0	100.0
HAMPSHIRE	255	1	0.4	100.0	100.0	100.0
HANCOCK	392	2	8.2	100.0	100.0	100.0
HARDY	101	1	5.3	100.0	100.0	100.0
HARRISON	550	1	1.8	100.0	100.0	100.0
JACKSON	480	0	23.3	100.0	100.0	100.0
JEFFERSON	226	1	8.5	100.0	100.0	100.0
KANAWHA	1,619	6	2.3	100.0	100.0	100.0
LEWIS	126	0	16.1	100.0	100.0	100.0
LINCOLN	348	2	7.5	100.0	100.0	100.0
LOGAN	414	0	16.2	100.0	100.0	100.0
MARION	155	1	2.8	100.0	100.0	100.0
MARSHALL	165	1	1.6	100.0	100.0	100.0
MASON	939	2	3.1	100.0	100.0	100.0
MCDOWELL	507	0	34.0	100.0	100.0	100.0
MERCER	151	1	5.9	100.0	100.0	100.0
MINERAL	421	1	9.2	100.0	100.0	100.0
MINGO	417	1	8.2	100.0	100.0	100.0
MONONGALIA	117	2	4.6	100.0	100.0	100.0
MONROE	68	0	38.0	100.0	100.0	100.0
MORGAN	281	1	6.0	100.0	100.0	100.0
NICHOLAS	447	0	20.5	100.0	100.0	100.0
OHIO	366	4	2.3	100.0	100.0	100.0
PENDLETON	26	1	0.0	100.0	100.0	100.0
PLEASANTS	39	0	26.4	100.0	100.0	100.0
POCAHONTAS	88	0	53.7	0.0	9.1	100.0
PRESTON	342	2	11.8	100.0	100.0	100.0

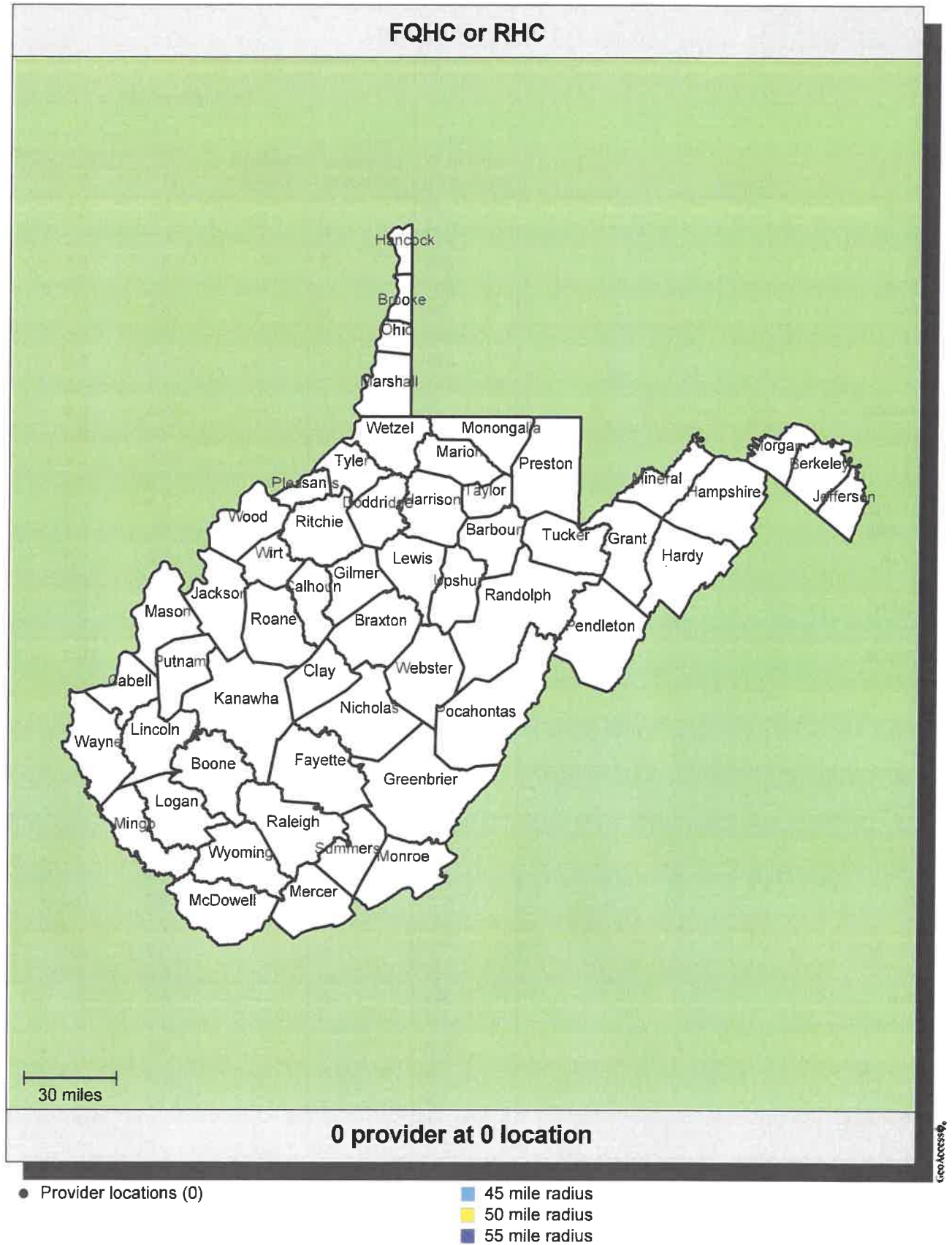
Provider group: Outpatient SUD Provider

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				45	50	55
PUTNAM	491	2	2.3	100.0	100.0	100.0
RALEIGH	984	2	4.2	100.0	100.0	100.0
RANDOLPH	412	2	1.0	100.0	100.0	100.0
RITCHIE	151	0	27.9	100.0	100.0	100.0
ROANE	242	0	31.5	100.0	100.0	100.0
SUMMERS	116	0	21.5	100.0	100.0	100.0
TAYLOR	301	0	15.8	100.0	100.0	100.0
TUCKER	52	2	2.6	100.0	100.0	100.0
TYLER	26	0	35.7	100.0	100.0	100.0
UPSHUR	245	2	1.7	100.0	100.0	100.0
WAYNE	522	2	1.3	100.0	100.0	100.0
WEBSTER	168	0	34.5	100.0	100.0	100.0
WETZEL	116	0	23.5	100.0	100.0	100.0
WIRT	63	0	18.1	100.0	100.0	100.0
WOOD	851	3	1.2	100.0	100.0	100.0
WYOMING	403	0	23.8	100.0	100.0	100.0
TOTALS	18,348	60	10.2	99.1	99.6	100.0

Provider group: Outpatient SUD Provider

Provider locations



County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				45	50	55
BARBOUR	281	0	---	0.0	0.0	0.0
BERKELEY	694	0	---	0.0	0.0	0.0
BOONE	300	0	---	0.0	0.0	0.0
BRAXTON	201	0	---	0.0	0.0	0.0
BROOKE	56	0	---	0.0	0.0	0.0
CABELL	1,048	0	---	0.0	0.0	0.0
CALHOUN	171	0	---	0.0	0.0	0.0
CLAY	241	0	---	0.0	0.0	0.0
DODDRIDGE	37	0	---	0.0	0.0	0.0
FAYETTE	580	0	---	0.0	0.0	0.0
GILMER	70	0	---	0.0	0.0	0.0
GRANT	146	0	---	0.0	0.0	0.0
GREENBRIER	340	0	---	0.0	0.0	0.0
HAMPSHIRE	255	0	---	0.0	0.0	0.0
HANCOCK	392	0	---	0.0	0.0	0.0
HARDY	101	0	---	0.0	0.0	0.0
HARRISON	550	0	---	0.0	0.0	0.0
JACKSON	480	0	---	0.0	0.0	0.0
JEFFERSON	226	0	---	0.0	0.0	0.0
KANAWHA	1,619	0	---	0.0	0.0	0.0
LEWIS	126	0	---	0.0	0.0	0.0
LINCOLN	348	0	---	0.0	0.0	0.0
LOGAN	414	0	---	0.0	0.0	0.0
MARION	155	0	---	0.0	0.0	0.0
MARSHALL	165	0	---	0.0	0.0	0.0
MASON	939	0	---	0.0	0.0	0.0
MCDOWELL	507	0	---	0.0	0.0	0.0
MERCER	151	0	---	0.0	0.0	0.0
MINERAL	421	0	---	0.0	0.0	0.0
MINGO	417	0	---	0.0	0.0	0.0
MONONGALIA	117	0	---	0.0	0.0	0.0
MONROE	68	0	---	0.0	0.0	0.0
MORGAN	281	0	---	0.0	0.0	0.0
NICHOLAS	447	0	---	0.0	0.0	0.0
OHIO	366	0	---	0.0	0.0	0.0
PENDLETON	26	0	---	0.0	0.0	0.0
PLEASANTS	39	0	---	0.0	0.0	0.0
POCAHONTAS	88	0	---	0.0	0.0	0.0
PRESTON	342	0	---	0.0	0.0	0.0

Provider group: FQHC or RHC

County access standard detail information

FC Membership						
County	Total number of employees	Total number of providers	Employee access to 1 provider			
			Average distance	Pct of employees with 1 provider within x miles		
				45	50	55
PUTNAM	491	0	---	0.0	0.0	0.0
RALEIGH	984	0	---	0.0	0.0	0.0
RANDOLPH	412	0	---	0.0	0.0	0.0
RITCHIE	151	0	---	0.0	0.0	0.0
ROANE	242	0	---	0.0	0.0	0.0
SUMMERS	116	0	---	0.0	0.0	0.0
TAYLOR	301	0	---	0.0	0.0	0.0
TUCKER	52	0	---	0.0	0.0	0.0
TYLER	26	0	---	0.0	0.0	0.0
UPSHUR	245	0	---	0.0	0.0	0.0
WAYNE	522	0	---	0.0	0.0	0.0
WEBSTER	168	0	---	0.0	0.0	0.0
WETZEL	116	0	---	0.0	0.0	0.0
WIRT	63	0	---	0.0	0.0	0.0
WOOD	851	0	---	0.0	0.0	0.0
WYOMING	403	0	---	0.0	0.0	0.0
TOTALS	18,348	0	---	0.0	0.0	0.0

Provider group: FQHC or RHC

GeoNetworks Report

S:\Benefit Services\Josh (Networking)\INDEPENDENT PROJECTS\2019\FC 2019\FC.rpt

Summary Information:

Date created: August 07, 2019 **Version:** Release 3 2018
Author:
Company:
Network:
Notes:

Tables:

Employee tables:	Records:	Provider tables:	Records:
Members\$ @ S:\Be...\Foster Care Members.xlsx	18348	Providers\$ @ S:\Be...\Foster Care Providers.xlsx	31086

Calculations:

Started at: 16:13:11 - August 08, 2019 **Elapsed time:** 5 minutes, 59 seconds
Completed at: 16:19:10 - August 08, 2019
Calculation method: Estimated driving distance
Capacity option: Unlimited

Printing:

Started at: 16:13:11 - August 08, 2019 **Elapsed time:** 6 minutes, 0 seconds
Completed at: 16:19:11 - August 08, 2019
Pages printed: 91 of 91 (all pages)