State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
BMS14156	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
BOB KILPATRICK
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED
02/20/2014

BID OPENING DATE: 03/26/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
				REQUEST FOR PROPOSAL (RFP)		
				THE WEST VIRGINIA PURCHASING DIVISION, ON BEHALF OF THE WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES, IS SOLICITING PROPOSALS TO PROVIDE A FULL-RISK CAPITATION BROKER TO DIRECTLY COORDINATE A STATEWIDE NON-EMERGENCY MEDICAL TRANSPORT (NEMT) PROGRAM, PER THE ATTACHED SPECIFICATIONS.		
0001	1	EA		948-55		
				IMPLEMENTATION COST		
0002	1	EA		948-55		
				STAFFING		
0003	1	EA		948-55		
				COMPUTER, INCLUDING SOFTWARE		

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
BMS14156	2

ADDRESS CORRESPONDENCE TO ATTENTION OF:
BOB KILPATRICK
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED: 02/20/2014

BID OPENING DATE: 03/26/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
0004	1	EA		948-55		
	TELEPHONE/COMMUNICATIONS					
0005	1	EA		948-55		
	FACILITIES					
0006	1	EA		948-55		
	CONSULTING SERVICES					
0007	1	EA		948-55		
	OTHER					
0008	1	EA		948-55		
	OPERATIONS COST					

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
BMS14156	3

ADDRESS CORRESPONDENCE TO ATTENTION OF:
BOB KILPATRICK
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO
HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
ROOM 251
350 CAPITOL STREET
CHARLESTON, WV
25301-3709 304-558-1737

DATE PRINTED
02/20/2014

BID OPENING DATE: 03/26/2014 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
0009	429,867	EA		948-55		
	SFY2015 (JULY 2014 - JUNE 2015)					
0010	442,327	EA		948-55		
	SFY2016 (JULY 2015- JUNE 2016) OPTIONAL RENEWAL					
0011	446,303	EA		948-55		
	SFY2017 (JULY 2016 - JUNE 2017) OPTIONAL RENEWAL					
	****** THIS IS THE END OF RFQ BMS14156 ****** TOTAL:					

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

TABLE OF CONTENTS

1. **Table of Contents**
2. **Section 1: General Information and Instructions**
3. **Section 2: Instructions to Vendors Submitting Bids**
4. **Section 3: General Terms and Conditions**
5. **Section 4: Project Specifications**
6. **Section 5: Vendor Proposal**
7. **Section 6: Evaluation and Award**
8. **Certification and Signature Page**
9. **Appendix 1: Operational Specifications**
10. **Appendix 2: Implementation Specifications**
11. **Appendix 3: BMS-Specific Reporting Requirements**
12. **Appendix 4: Service Level Agreements (SLAs)**
13. **Appendix 5: Implementation Deliverables, Milestones and Payments**
14. **Appendix 6: Glossary**

SECTION ONE: GENERAL INFORMATION

1. Purpose: The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the "Purchasing Division") is soliciting proposals pursuant to **West Virginia Code** §5A-3-10b for the Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) (hereinafter referred to as the "Agency") to provide a full-risk capitation broker to directly coordinate a statewide Non-Emergency Medical Transportation (NEMT) Program.

2. By signing and submitting its proposal, the successful Vendor agrees to be bound by all the terms contained in this Request for Proposal ("RFP").

   An RFP is generally used for the procurement of services in situations where price is not the sole determining factor and the award will be based on a combination of cost and technical factors (Best Value). Through its proposal, the bidder offers a solution to the objectives, problem, or need specified in the RFP, and defines how it intends to meet (or exceed) the RFP requirements.

3. Schedule of Events:

Vendor's Written Questions Submission Deadline	3/12/2014, 12:00pm EST
Mandatory Pre-bid Conference	NA
Addendum Issued (estimated)	3/18/2014
Bid Opening Date	3/26/2014, 1:30pm EST
Oral Presentation *(Agency Option)*	NA

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

SECTION TWO: INSTRUCTIONS TO VENDORS SUBMITTING BIDS

Instructions begin on next page.

INSTRUCTIONS TO VENDORS SUBMITTING BIDS

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

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

3. **PREBID MEETING:** The item identified below shall apply to this Solicitation.

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

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

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

All Vendors submitting a bid must attend the mandatory pre-bid meeting. Failure to attend the mandatory pre-bid meeting shall result in disqualification of the Vendor's bid. No one person attending the pre-bid meeting may represent more than one Vendor.

An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. The State will not accept any other form of proof or documentation to verify attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing. Additionally, the person attending the pre-bid meeting should include the Vendor's E-Mail address, phone number, and Fax number on the attendance sheet. It is the Vendor's responsibility to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

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

Questions submitted at least five business days prior to a scheduled pre-bid will be discussed at the pre-bid meeting if possible. Any discussions or answers to questions at the pre-bid meeting are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

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

Question Submission Deadline: March 12, 2014, by 12:00pm EST

Submit Questions to: Robert P Kilpatrick, Senior Buyer, Purchasing Division
2019 Washington Street, East
Charleston, WV 25305
Fax: 304-558-4115
Email: robert.p.kilpatrick@wv.gov

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

6. **BID SUBMISSION:** All bids must be signed and delivered by the Vendor to the Purchasing Division at the address listed below on or before the date and time of the bid opening. Any bid received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason. The Purchasing Division will not accept bids, modification of bids, or addendum acknowledgment forms via e-mail. Acceptable delivery methods include hand delivery, delivery by courier, or facsimile. The bid delivery address is:

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

The bid should contain the information listed below on the face of the envelope or the bid maynot be considered:

SEALED BID
BUYER: Robert P Kilpatrick
SOLICITATION NO.: BMS14156
BID OPENING DATE: March 26, 2014
BID OPENING TIME: 1:30pm EST
FAX NUMBER: 304-558-3970

In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal plus 12 convenience copies of each to the Purchasing Division at the address shown above. Additionally, the Vendor should identifythe bid type as either a technical or cost proposal on the face of each bid envelope submitted in response to a request for proposal as follows:

BID TYPE: ☑ Technical
☑ Cost

7. **BID OPENING:** Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when time stamped bythe official Purchasing Division time clock.

Bid Opening Date and Time:	March 26, 2014, 1:30pm EST
Bid Opening Location:	Department of Administration, Purchasing Division 2019 Washington Street East Charleston, WV 25305-0130

8. **ADDENDUM ACKNOWLEDGEMENT:** Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, 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.

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

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

SECTION THREE: GENERAL TERMS AND CONDITIONS

Terms and conditions begin on next page.

GENERAL TERMS AND CONDITIONS:

1. **CONTRACTUAL AGREEMENT:** Issuance of a Purchase Order signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

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

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

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

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

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

   2.5 "Purchase Order" means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the successful bidder and Contract holder.

   2.6 "Solicitation" means the official solicitation published by the Purchasing Division and identified by number on the first page thereof.

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

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

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

☑ **Term Contract**

Initial Contract Term: This Contract becomes effective on award

and extends for a period of ONE (1) year(s).

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal must be submitted to the Purchasing Division Director thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Renewal of this Contract is limited to TWO (2) successive one (1) year periods. Automatic renewal of this Contract is prohibited. Notwithstanding the foregoing, Purchasing Division approval is not required on agency delegated or exempt purchases. Attorney General approval may be required for vendor terms and conditions.

Reasonable Time Extension: At the sole discretion of the Purchasing Division Director, and with approval from the Attorney General's office (Attorney General approval is as to form only), this Contract may be extended for a reasonable time after the initial Contract term or after any renewal term as may be necessary to obtain a new contract or renew this Contract. Any reasonable time extension shall not exceed twelve (12) months. Vendor may avoid a reasonable time extension by providing the Purchasing Division Director with written notice of Vendor's desire to terminate this Contract 30 days prior to the expiration of the then current term. During any reasonable time extension period, the Vendor may terminate this Contract for any reason upon giving the Purchasing Division Director 30 days written notice. Automatic extension of this Contract is prohibited. Notwithstanding the foregoing, Purchasing Division approval is not required on agency delegated or exempt purchases, but Attorney General approval may be required.

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

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

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

☐ **Other:** See attached.

4. **NOTICE TO PROCEED:** Vendor shall begin performance of this Contract immediately upon receiving notice to proceed unless otherwise instructed by the Agency. Unless otherwise specified, the fully executed Purchase Order will be considered notice to proceed

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

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

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

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

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

6. **PRICING:** The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification.

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

8. **REQUIRED DOCUMENTS:** All of the items checked below must be provided to the Purchasing Division by the Vendor as specified below.

☐ **BID BOND:** All Vendors shall furnish a bid bond in the amount of five percent (5%) of the total amount of the bid protecting the State of West Virginia. The bid bond must be submitted with the bid.

☐ **PERFORMANCE BOND:** The apparent successful Vendor shall provide a performance bond in the amount of . The performance bond must be issued and received by the Purchasing Division prior to Contract award. On construction contracts, the performance bond must be 100% of the Contract value.

☐ **LABOR/MATERIAL PAYMENT BOND:** The apparent successful Vendor shall provide a labor/material payment bond in the amount of 100% of the Contract value. The labor/material payment bond must be issued and delivered to the Purchasing Division prior to Contract award.

In lieu of the Bid Bond, Performance Bond, and Labor/Material Payment Bond, the Vendor may provide certified checks, cashier's checks, or irrevocable letters of credit. Any certified check, cashier's check, or irrevocable letter of credit provided in lieu of a bond must be of the same amount and delivered on the same schedule as the bond it replaces. A letter of credit submitted in lieu of a performance and labor/material payment bond will only be allowed for projects under $100,000. Personal or business checks are not acceptable.

☐ **MAINTENANCE BOND:** The apparent successful Vendor shall provide a two (2) year maintenance bond covering the roofing system. The maintenance bond must be issued and delivered to the Purchasing Division prior to Contract award.

☑ **WORKERS' COMPENSATION INSURANCE:** The apparent successful Vendor shall have appropriate workers' compensation insurance and shall provide proof thereof upon request.

☑ **INSURANCE:** The apparent successful Vendor shall furnish proof of the following insurance prior to Contract award and shall list the state as a certificate holder:

☑ **Commercial General Liability Insurance:**
$1,000,000.00 PER OCCURRENCE or more.

☐ **Builders Risk Insurance:** builders risk – all risk insurance in an amount equal to 100% of the amount of the Contract.

☑ PROPERTY DAMAGE: Minimum of $1,000,000.00 per occurrence.

☑ PROFESSIONAL LIABILITY: Minimum of $1,000,000.00 per occurrence.

☐

☐

☐

The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether or not that insurance requirement is listed above.

☐ **LICENSE(S) / CERTIFICATIONS / PERMITS:** In addition to anything required under the Section entitled Licensing, of the General Terms and Conditions, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits prior to Contract award, in a form acceptable to the Purchasing Division.

☐

☐

☐

☐

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

9. **LITIGATION BOND:** The Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or $5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.

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

11. **EXCEPTIONS AND CLARIFICATIONS:** The Solicitation contains the specifications that shall form the basis of a contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or

other proposed modifications in its bid. Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

12. **LIQUIDATED DAMAGES:** Vendor shall pay liquidated damages in the amount See specifications for See specifications

This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy.

13. **ACCEPTANCE/REJECTION:** The State may accept or reject any bid in whole, or in part. Vendor's signature on its bid signifies acceptance of the terms and conditions contained in the Solicitation and Vendor agrees to be bound by the terms of the Contract, as reflected in the Purchase Order, upon receipt.

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

15. **COMMUNICATION LIMITATIONS:** In accordance with West Virginia Code of State Rules §148-1-6.6, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. Purchasing Division approval for such communication is implied for all agency delegated and exempt purchases.

16. **FUNDING:** This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available.

17. **PAYMENT:** Payment in advance is prohibited under this Contract. Payment may only be made after the delivery and acceptance of goods or services. The Vendor shall submit invoices, in arrears, to the Agency at the address on the face of the purchase order labeled "Invoice To."

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

19. **DELIVERY:** All quotations are considered freight on board destination ("F.O.B. destination") unless alternate shipping terms are clearly identified in the bid. Vendor's listing of shipping terms that contradict the shipping terms expressly required by this Solicitation may result in bid disqualification.

20. **INTEREST:** Interest attributable to late payment will only be permitted if authorized by the West Virginia Code. Presently, there is no provision in the law for interest on late payments.

21. **PREFERENCE:** Vendor Preference may only be granted upon written request and only in accordance with the West Virginia Code § 5A-3-37 and the West Virginia Code of State Rules. A Resident Vendor Certification form has been attached hereto to allow Vendor to apply for the preference. Vendor's

failure to submit the Resident Vendor Certification form with its bid will result in denial of Vendor Preference. Vendor Preference does not apply to construction projects.

22. **SMALL, WOMEN-OWNED, OR MINORITY-OWNED BUSINESSES:** For any solicitations publicly advertised for bid on or after July 1, 2012, in accordance with West Virginia Code §5A-3-37(a)(7) and W. Va. CSR § 148-22-9, any non-resident vendor certified as a small, women-owned, or minority-owned business under W. Va. CSR § 148-22-9 shall be provided the same preference made available to any resident vendor. Any non-resident small, women-owned, or minority-owned business must identify itself as such in writing, must submit that writing to the Purchasing Division with its bid, and must be properly certified under W. Va. CSR § 148-22-9 prior to submission of its bid to receive the preferences made available to resident vendors. Preference for a non-resident small, women-owned, or minorityowned business shall be applied in accordance with W. Va. CSR § 148-22-9.

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

24. **CANCELLATION:** The Purchasing Division Director reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The Purchasing Division Director may cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules § 148-1-7.16.2.

25. **WAIVER OF MINOR IRREGULARITIES:** The Director reserves the right to waive minor irregularities in bids or specifications in accordance with West Virginia Code of State Rules § 148-1-4.6.

26. **TIME:** Time is of the essence with regard to all matters of time and performance in this Contract.

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

28. **COMPLIANCE**: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendors acknowledge that they have reviewed, understand, and will comply with all applicable law.

29. **PREVAILING WAGE:** On any contract for the construction of a public improvement, Vendor and any subcontractors utilized by Vendor shall pay a rate or rates of wages which shall not be less than the fair minimum rate or rates of wages (prevailing wage), as established by the West Virginia Division of Labor under West Virginia Code §§ 21-5A-1 et seq. and available at http://www.sos.wv.gov/administrative-law/wagerates/Pages/default.aspx. Vendor shall be responsible for ensuring compliance with prevailing wage requirements and determining when prevailing wage

requirements are applicable. The required contract provisions contained in West Virginia Code of State Rules § 42-7-3 are specifically incorporated herein by reference.

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

31. **MODIFICATIONS**: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary, no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). **No Change shall be implemented by the Vendor until such time as the Vendor receives an approved written change order from the Purchasing Division.**

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

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

34. **ASSIGNMENT**: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments. Notwithstanding the foregoing, Purchasing Division approval may or may not be required on certain agency delegated or exempt purchases.

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

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

37. **BANKRUPTCY**: In the event the Vendor files for bankruptcy protection, the State of West Virginia may deem this Contract null and void, and terminate this Contract without notice.

38. [RESERVED]

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

40. DISCLOSURE: Vendor's response to the Solicitation and the resulting Contract are considered public documents and will be disclosed to the public in accordance with the laws, rules, and policies governing the West Virginia Purchasing Division. Those laws include, but are not limited to, the Freedom of Information Act found in West Virginia Code § 29B-1-1 et seq.

If a Vendor considers any part of its bid to be exempt from public disclosure, Vendor must so indicate by specifically identifying the exempt information, identifying the exemption that applies, providing a detailed justification for the exemption, segregating the exempt information from the general bid information, and submitting the exempt information as part of its bid but in a segregated and clearly identifiable format. Failure to comply with the foregoing requirements will result in public disclosure of the Vendor's bid without further notice. A Vendor's act of marking all or nearly all of its bid as exempt is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor's act of marking a bid or any part thereof as "confidential" or "proprietary" is not sufficient to avoid disclosure and WILL NOT BE HONORED. In addition, a legend or other statement indicating that all or substantially all of the bid is exempt from disclosure is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor will be required to defend any claimed exemption for nondisclosure in the event of an administrative or judicial challenge to the State's nondisclosure. Vendor must indemnify the State for any costs incurred related to any exemptions claimed by Vendor. Any questions regarding the applicability of the various public records laws should be addressed to your own legal counsel prior to bid submission.

41. LICENSING: In accordance with West Virginia Code of State Rules §148-1-6.1.7, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

42. ANTITRUST: In submitting a bid to, signing a contract with, or accepting a Purchase Order from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired

by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

43. **VENDOR CERTIFICATIONS:** By signing its bid or entering into this Contract, Vendor certifies (1) that its bid was made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, person or entity submitting a bid for the same material, supplies, equipment or services; (2) that its bid is in all respects fair and without collusion or fraud; (3) that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; and (4) that it has reviewed this RFQ in its entirety; understands the requirements, terms and conditions, and other information contained herein. Vendor's signature on its bid also affirms that neither it nor its representatives have any interest, nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency.

    The individual signing this bid on behalf of Vendor certifies that he or she is authorized by the Vendor to execute this bid or any documents related thereto on Vendor's behalf; that he or she is authorized to bind the Vendor in a contractual relationship; and that, to the best of his or her knowledge, the Vendor has properly registered with any State agency that may require registration.

44. **PURCHASING CARD ACCEPTANCE:** The State of West Virginia currently utilizes a Purchasing Card program, administered under contract by a banking institution, to process payment for goods and services. The Vendor must accept the State of West Virginia's Purchasing Card for payment of all orders under this Contract unless the box below is checked.

    ☐ Vendor is not required to accept the State of West Virginia's Purchasing Card as payment for all goods and services.

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

46. **INDEMNIFICATION:** The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered

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

47. **PURCHASING AFFIDAVIT:** In accordance with West Virginia Code § 5A-3-10a, all Vendors are required to sign, notarize, and submit the Purchasing Affidavit stating that neither the Vendor nor a related party owe a debt to the State in excess of $1,000. The affidavit must be submitted prior to award, but should be submitted with the Vendor's bid. A copy of the Purchasing Affidavit is included herewith.

48. **ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE:** This Contract may be utilized by and extends to other agencies, spending units, and political subdivisions of the State of West Virginia; county, municipal, and other local government bodies; and school districts ("Other Government Entities"). This Contract shall be extended to the aforementioned Other Government Entities on the same prices, terms, and conditions as those offered and agreed to in this Contract. If the Vendor does not wish to extend the prices, terms, and conditions of its bid and subsequent contract to the Other Government Entities, the Vendor must clearly indicate such refusal in its bid. A refusal to extend this Contract to the Other Government Entities shall not impact or influence the award of this Contract in any manner.

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

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

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

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

51. **BACKGROUND CHECK:** In accordance with W. Va. Code § 15-2D-3, the Director of the Division of Protective Services shall require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information

to submit to a fingerprint-based state and federal background inquiry through the state repository. The service provider is responsible for any costs associated with the fingerprint-based state and federal background inquiry.

After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision.

The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check.

Service providers should contact the West Virginia Division of Protective Services by phone at (304)558-9911 for more information.

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

    a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.

    b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making process.

    The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:

    a. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars ($2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or

    b. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

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

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products.

This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

SECTION FOUR: PROJECT SPECIFICATIONS

1. **Location:** Agency is located at 350 Capitol Street, Room 251, Charleston, West Virginia.

2. **Background and Current Operating Environment:** The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and state Governments jointly fund the Medicaid program. At the federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each state administers its Medicaid program in accordance with a CMS-approved state plan. Although the state has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements.

   Pursuant to 42 CFR § 440.170, the transportation benefit includes transportation expenses and related travel expenses deemed necessary by the State Medicaid agency to secure medical examinations and treatment for a beneficiary. Examples of modes of transportation that states authorize include ambulances; specialized motor vehicles (e.g., wheelchair-accessible vans); and common carriers (e.g., taxis, personal vehicles, and public transportation).

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

   The Bureau for Medical Services, within the West Virginia Department of Health and Human Resources (DHHR), is the single state agency responsible for statewide administration of the Title XIX Medicaid Program. The nature, extent, and scope of West Virginia Medicaid Program coverage, including reimbursement rates and methodologies, are federally approved by the Centers for Medicare and Medicaid Services (CMS). The Bureau also interacts with other interdepartmental divisions as well as with all medical service practitioners, providers and provider organizations.

   The West Virginia Medicaid Program covers the federal mandatory services and a number of optional services. Benefits available under all programs are considered to be last resource benefits. By statute, West Virginia State Code §9-5-11, the Department is legally subrogated to the rights of the Member regarding third party recovery.

   The total Medicaid expenditures for State Fiscal Year 2013 (July 2012 – June 2013) were approximately $3.0 billion. The Medicaid program provided health care benefits to 410,770 people during SFY 2013 (about 333,000+ monthly average) in 55 counties, using a network of approximately 27,000 active providers. The Medicaid Management Information Systems (MMIS) processes about 15.4 million claims (claim headers) per year: 7.7 million medical/dental claims and 7.7 million pharmacy claims. These figures include federal, and Third Party Administrator (TPA) members and claims.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

As of December 2013, approximately 185,000 Medicaid members (families with dependent children, low-income children, and pregnant women) were enrolled in three Managed Care Organizations (MCOs). The Medicaid program has historically paid for certain carved-out services for these MCO members, such as long-term care, non-emergency transportation, and behavioral health services.

The Medicaid program also manages a Primary Care Case Management (PCCM) program – the Physician Assured Access System (PAAS). The Bureau's MMIS processes claims for three Home and Community-Based Services (HCBS) waiver programs and several state funded eligibility programs. It also functions as a Third Party Administrator (TPA) for other state agencies.

Currently, NEMT services are administered at the county level by the Bureau for Children and Families (BCF) with DHHR and BMS providing program oversight. Medicaid recipients, Medicaid/Medicare dual eligible recipients, and foster children are eligible to receive NEMT services. The SFY2013 total expenditures for non emergency medical services were $25.1 million.

3. **Qualifications and Experience:** Vendors will provide in **Attachment A: Vendor Response Sheet** information regarding their firm, such as staff qualifications and experience in at least three (3) other states completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met.

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

The Vendor's proposed staffing plan should include the following components:

1. Organizational chart(s)[1] showing the number and geographic location of all staff that will perform duties under the Contract, including Vendor and subcontractor staff. Key staff members, off-site (i.e., location other than the Vendor's call center facility) Vendor staff, and subcontractor staff should be clearly identified as such on each organizational chart. The Vendor should provide a chart showing the Vendor's entire organizational structure, including all parent entities. This chart should show the relationship of the Vendor's proposed project organization to its overall organizational structure. The Vendor should provide a revised organizational chart at any time during the Contract period that a change is made in the organizational structure.
2. Description of the roles, responsibilities and skills associated with each position on the organization chart(s).

[1] Vendors may submit separate organization charts for each phase of the project (Implementation, Operations, Close-Out and Turnover).

3. Job descriptions and requirements for Call Center staff demonstrating a high school diploma or equivalent certification and all management staff demonstrating a bachelor degree and at least two years qualifying experience for this project.
4. Key staff positions, such as Project Manager, Assistant Manager, Provider Relations Manager, Outreach and Communications Manager and Call Center management staff, identified with named individuals and resumes demonstrating a bachelor degree, licenses, skills and at least two (2) years experience that qualifies them for their role in this project. The bachelor's degree may be substituted with four (4) years of full-time or equivalent part-time paid NEMT experience in addition to the two years already specified. Resumes should be limited to three (3) single-sided pages.
5. Resumes of all other named individuals included in the Vendor's proposal, including any temporary staff that may be assigned to the project to provide specific, fixed-length services (e.g., training specialists, implementation staff). Resumes should include licenses, skills and relevant experience as it pertains to this project. Resumes should be limited to three (3) single-sided pages.
6. For any proposed work to be performed off-site, including work of subcontractor(s), the bidder should describe the assurance of quality and timeliness of the work done off-site or through subcontractors.
7. Approach to staff retention and ensuring continuity of staff.
8. Approach to personnel management.

3.2 The Vendor should provide credible, detailed evidence of their related experience and capabilities in providing Non-Emergency Medical Transportation Services in a full brokerage program. At least three (3) Vendor references from government entities work within the last five (5) years should be provided. A reference from a Managed Care Organization (MCO) is allowed if accompanied with a letter from that States' Medicaid agency explaining the relationship and size of the population served.

3.3 The Vendor should describe their experience within the last five (5) years operating a full brokerage NEMT Services program(s) for a population similar to that of West Virginia Medicaid, including with the following:

1. State Medicaid and/or other governmental NEMT programs;
2. Providing NEMT or other transportation services;
3. Brokering NEMT or other transportation services;
4. Recruiting NEMT Providers;
5. Operating an automatic call distribution (ACD) system;
6. Staffing a NEMT or other transportation services customer service call center; and
7. Developing and managing a transportation database, including reporting and transportation utilization analysis activities.

4. **Project and Goals:** The project goals and objectives are:

4.1 Vendor should describe their approach to the West Virginia Non-Emergency Medical Transportation Program utilizing a full-risk capitation brokerage model that demonstrates a clear understanding of the overall engagement and services to be provided, including a timeline

showing how they propose to meet project deliverables. The Vendor's approach should address the following:

1. Appendix 1, Operational Specifications, including all deliverables and proposal components described therein.
2. Appendix 2, Implementation Specifications, including all deliverables and proposal components described therein.

The Vendor's approach should exhibit an up-to-date knowledge and understanding of the Non-Emergency Medical Transportation (NEMT) Brokerage Program and NEMT Services in general, including the requirements of Chapter 524 of the West Virginia State Medicaid Manual, Chapter 27 of the West Virginia Bureau for Children and Families Income Maintenance Manual and 42 CFR § 440.170.

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

1. List the subcontractor's name, address, contact person, and phone number.
2. Detail the exact nature of the subcontractor's responsibility for the NEMT Brokerage Program, and the projected dates the subcontractor will begin and end work.
3. Detail the time period, scope of work, and quality of performance for any past work performed by the subcontractor in conjunction with the Vendor.
4. State the consequences of failure to perform.
5. Provide three (3) references for the subcontractor.
6. Provide a draft of the proposed subcontract.

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

4.4 The Vendor should describe their approach and methodology for reporting and should also provide examples of reports produced for projects of the type, size, and scope of that described in the RFP.

4.5 The Vendor should describe their plan to supply all deliverables as described in Appendix 3 (Reporting Requirements) and perform according to approved Service Level Agreements listed in Appendix 4 (Service Level Agreements).

4.6 The Vendor should describe their approach to supply all written material, including (but not limited to) reports, letters, training materials, Member education materials, Provider manuals, and operations manuals, to the Bureau for approval in advance of distribution.

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

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

4.9 The Vendor should describe their communication plan that addresses communication with all stakeholders, including the Bureau, which could include face to face, video conference, or teleconference meetings to discuss and resolve administrative and operational issues.

4.10 The Vendor should describe their grievance process to ensure compliance with the Bureau's fair hearing process for Members and allow Providers a review process.

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

4.12 The Vendor should describe their plan for assuring staff and providers are qualified and verifying they have not had previous felony convictions.

5. Mandatory Requirements

The following mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory specifications shall result in the disqualification of the proposal. The terms "must", "will", "shall", "minimum", "maximum", or "is/are required" identify a mandatory item or factor. Decisions regarding compliance with any mandatory requirements shall be at the sole discretion of the Purchasing Division.

5.1 The Vendor must comply with all current and future state and federal regulations, including those relating to the Medicaid Non-Emergency Transportation program. The Vendor must also comply with Chapter 524 (excluding Attachment 3) of the West Virginia State Medicaid Manual, Chapter 27 of the West Virginia Bureau for Children and Families Income Maintenance Manual, 42 CFR § 440.170, and follow the Bureau's exclusions.

5.2 The Vendor must agree to provide increased staffing levels if requirements, timelines, quality or other standards are not being met, based solely on the discretion of and without additional cost to the Bureau. In making this determination, the Bureau will evaluate whether the Vendor is meeting deliverable dates, producing quality materials, consistently maintaining high quality and production rates, and meeting contract standards without significant rework or revision. Beginning thirty (30) calendar days prior to the Operations Start Date and commencing through the end of the Contract, the Vendor may not reduce staffing without BMS approval.

5.3 The Vendor agrees to locate and operate the NEMT Call Center within 15 miles proximity of the West Virginia State Medicaid agency located at 350 Capitol Street, Charleston, WV so the State agency can easily perform on-site monitoring duties. The Vendor shall never route calls outside of the continental United States of America. The Vendor will not delegate screening,

authorization or scheduling duties. The Vendor may delegate dispatch activities to the NEMT Provider, but the Vendor will retain responsibility for the proper performance of dispatch activities.

5.4 The Vendor must agree to provide NEMT services described in the RFP from the operations start date until service delivery is turned over to a successor Vendor at the end of the contract, including any optional additional periods or extensions.

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

6. **Oral Presentations (Agency Option):** The Agency has the option of requiring oral presentations of all Vendors participating in the RFP process. If this option is exercised, it would be listed in the Schedule of Events (Section 1.3) of this RFP. During oral presentations, Vendors may not alter or add to their submitted proposal, but only clarify information. A description of the materials and information to be presented is provided below:

6.1 There will not be an Oral Presentation required for this solicitation.

SECTION FIVE: VENDOR PROPOSAL

1 **Economy of Preparation:** Proposals should be prepared simply and economically providing a straightforward, concise description of the Vendor's abilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of the content.

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

3 **Proposal Format:** Vendors should provide responses in the format listed below:

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

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

Attachment A: Within the attached response sheet (**Attachment A: Vendor Response Sheet**), provide the following: firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of

past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were met.

Also, describe the approach and methodology proposed for this project. This should include how each of the goals and objectives listed is to be met.

Attachment B: Complete **Attachment B: Mandatory Specification Checklist**. By signing and dating this attachment, the Vendor acknowledges that they meet or exceed each of these specifications as outlined in Section Four: Project Specifications. The State reserves the right to require documentation detailing how each is met at its discretion.

Attachment C: Complete **Attachment C: Cost Sheet** included in this RFP and submit in a separate sealed envelope. Cost should be clearly marked.

Oral Presentations: If established by the Agency in the Schedule of Events (Section 1.3), all Vendors participating in this RFP will be required to provide an oral presentation, based on the criteria set in Section 4.6. During oral presentations, Vendors may not alter or add to their submitted proposal, but only to clarify information.

4 **Proposal Submission:** Proposals must be received in **two distinct parts**: technical and cost.

- **Technical proposals** must not contain any cost information relating to the project.
- **Cost proposal** shall be sealed in a separate envelope and will not be opened initially.

All proposals must be submitted to the Purchasing Division **prior** to the date and time stipulated in the RFP as the opening date. All bids will be dated and time stamped to verify official time and date of receipt. All submissions must be in accordance with the provisions listed below and in Section Two: Instructions to Bidders Submitting Bids above.

5 **Technical Bid Opening**: The Purchasing Division will open and announce only the technical proposals received prior to the date and time specified in the Request for Proposal. The technical proposals shall then be provided to the Agency evaluation committee.

6 **Cost Bid Opening**: The Purchasing Division shall schedule a date and time to publicly open and announce cost proposals when the Purchasing Division has approved the technical recommendation of the evaluation committee. All cost bids for qualifying proposals will be opened. Cost bids for non-qualifying proposals will also be opened but shall not be considered. A proposal may be deemed non-qualifying for a number of reasons including, but not limited to, the bidder's technical proposal failing to meet the minimum acceptable score and the bidder's technical proposal failing to meet a mandatory requirement of the contract. Certain information, such as technical scores and reasons for disqualification, will not be available until after the

contract award, pursuant to ***West Virginia Code*** §5A-3-11(h) and ***West Virginia Code of State Rules*** §148-1-6.2.5. The State anticipates that it may conduct discussions with, and obtain best and final offers (BAFO) from, responsive and responsible bidders who submit proposals determined to be reasonably susceptible of being selected for award for the purpose of clarification to assure full understanding of, and responsiveness to, the solicitation requirements in accordance with **West Virginia Code §5A-3-11b**. The State, at its sole discretion and deemed to be in the best interest of the State, may provide clarification in the request for BAFO regarding the anticipated scope of the project as described in the RFP and instruct vendors to adjust their technical proposal and cost proposal accordingly to reflect the clarification provided by the State. If deemed appropriate, the State reserves the right to adjust the point allocations for the BAFO Technical Proposal and Cost Proposal evaluation as provided in Section 6.2 Evaluation Criteria to reflect the scope clarification.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

SECTION SIX: EVALUATION AND AWARD

1 **Evaluation Process**: Proposals will be evaluated by a committee of three (3) or more individuals against the established criteria with points deducted for deficiencies. The Vendor who demonstrates that they meet all of the mandatory specifications required; and has appropriately presented within their written response and/or during the oral demonstration (if applicable) their understanding in meeting the goals and objectives of the project; and attains the highest overall point score of all Vendors shall be awarded the contract. The selection of the successful Vendor will be made by a consensus of the evaluation committee.

2 **Evaluation Criteria**: All evaluation criteria is defined in the specifications section and based on a 100 point total score. Cost shall represent a minimum of 30 of the 100 total points.

The following are the evaluation factors and maximum points possible for technical point scores:

• Qualifications and experience	40 Points Possible
• Approach and methodology	30 Points Possible
• (Oral interview, if applicable)	0 Points Possible
• Cost	30 Points Possible
Total	100 Points Possible

Each cost proposal cost will be scored by use of the following formula for all Vendors who attained the minimum acceptable score:

$$\frac{\text{Lowest price of all proposal}}{\text{Price of Proposal being evaluated}} \times 30 = \text{Price Score}$$

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

2.2 Minimum Acceptable Score: Vendors must score a minimum of 70% (49 points) of the total technical points possible. All Vendors not attaining the minimum acceptable score (MAS) shall be considered as non-qualifying. A proposal may be deemed non-qualifying for a number of reasons including, but not limited to, the bidder's technical proposal failing to meet the minimum acceptable score and the bidder's technical proposal failing to meet a mandatory requirement of the contract. Cost bids for non-qualifying proposals will also be opened but shall not be considered. Certain information, such as technical scores and reasons for disqualification, will not be available until after the contract award, pursuant to ***West Virginia Code*** §5A-3-11(h) and ***West Virginia Code of State Rules*** §148-1-6.2.5.

2.3 Cost Evaluation: The Agency evaluation committee will review the cost proposals, assign appropriate points, and make a final recommendation to the Purchasing Division.

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Attachment A: Vendor Response Sheet

Section 4 – Vendor should provide a response to Subsection 3

Provide a response regarding the following: firm and staff qualifications and experience in completing similar projects; references; copies of any staff certifications or degrees applicable to this project; proposed staffing plan; descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives where and how they were met.

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

The Vendor's proposed staffing plan should include the following components:

1. Organizational chart(s)[2] showing the number and geographic location of all staff that will perform duties under the Contract, including Vendor and subcontractor staff. Key staff members, off-site (i.e., location other than the Vendor's call center facility) Vendor staff, and subcontractor staff should be clearly identified as such on each organizational chart. The Vendor should provide a chart showing the Vendor's entire organizational structure, including all parent entities. This chart should show the relationship of the Vendor's proposed project organization to its overall organizational structure. The Vendor should provide a revised organizational chart at any time during the Contract period that a change is made in the organizational structure.
2. Description of the roles, responsibilities and skills associated with each position on the organization chart(s).
3. Job descriptions and requirements for Call Center staff demonstrating a high school diploma or equivalent certification and all management staff demonstrating a bachelor degree and at least two years qualifying experience for this project.
4. Key staff positions, such as Project Manager, Assistant Manager, Provider Relations Manager, Outreach and Communications Manager and Call Center management staff, identified with named individuals and resumes demonstrating a bachelor degree, licenses, skills and at least two (2) years experience that qualifies them for their role in this project. The bachelor's degree may be substituted with four (4) years of full-time or equivalent part-time paid NEMT experience in addition to the two years already specified. Resumes should be limited to three (3) single-sided pages.
5. Resumes of all other named individuals included in the Vendor's proposal, including any temporary staff that may be assigned to the project to provide specific, fixed-length services (e.g., training specialists, implementation staff). Resumes should include licenses, skills and

[2] Vendors may submit separate organization charts for each phase of the project (Implementation, Operations, Close-Out and Turnover).

relevant experience as it pertains to this project. Resumes should be limited to three (3) single-sided pages.

6. For any proposed work to be performed off-site, including work of subcontractor(s), the bidder should describe the assurance of quality and timeliness of the work done off-site or through subcontractors.
7. Approach to staff retention and ensuring continuity of staff.
8. Approach to personnel management.

Vendor Response:

3.2 The Vendor should provide credible, detailed evidence of their related experience and capabilities in providing Non-Emergency Medical Transportation Services in a full brokerage program. At least three (3) Vendor references from government entities work within the last five (5) years should be provided. A reference from a Managed Care Organization (MCO) is allowed if accompanied with a letter from that States' Medicaid agency explaining the relationship and size of the population served.

:

Vendor Response:

3.3 The Vendor should describe their experience within the last five (5) years operating a full brokerage NEMT Services program(s) for a population similar to that of West Virginia Medicaid, including with the following

1. Providing NEMT or other transportation services;
2. Brokering NEMT or other transportation services;
3. Recruiting NEMT Providers;
4. Operating an automatic call distribution (ACD) system;
5. Staffing a NEMT or other transportation services customer service call center; and
6. Developing and managing a transportation database, including reporting and transportation utilization analysis activities.

Vendor Response:

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

List project goals and objectives contained in Section 4, Subsection 4:

Section 4, Subsection 4.1: Vendor should describe their approach to the West Virginia Non-Emergency Medical Transportation Program utilizing a full-risk capitation brokerage model that demonstrates a clear understanding of the overall engagement and services to be provided, including a timeline showing how they propose to meet project deliverables. The Vendor's approach should address the following:

1. Appendix 1, Operational Specifications, including all deliverables and proposal components described therein.
2. Appendix 2, Implementation Specifications, including all deliverables and proposal components described therein.

The Vendor's approach should exhibit an up-to-date knowledge and understanding of the NEMT Brokerage Program and NEMT Services in general, including the requirements of Chapter 524 of the West Virginia State Medicaid Manual, Chapter 27 of the West Virginia Bureau for Children and Families Income Maintenance Manual and 42 CFR § 440.170.

Vendor Response:

Section 4, Subsection 4.2: The Vendor should list all subcontractors that the Vendor intends to use for any administrative functions of the NEMT Brokerage Program, other than NEMT Providers. Additionally, for each subcontractor, the Vendor should:

1. List the subcontractor's name, address, contact person, and phone number.
2. Detail the exact nature of the subcontractor's responsibility for the NEMT Brokerage Program, and the projected dates the subcontractor will begin and end work.
3. Detail the time period, scope of work, and quality of performance for any past work performed by the subcontractor in conjunction with the Vendor.
4. State the consequences of failure to perform.
5. Provide three (3) references for the subcontractor.
6. Provide a draft of the proposed subcontract.

Vendor Response:

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Section 4, Subsection 4.3: The Vendor should describe their approach and methodology for developing and managing a database for a statewide NEMT brokerage system for a population similar to that of WV Medicaid, including the ability to submit data via batch mode, perform statistical analysis (including transportation utilization analysis), and provide detailed reports as listed in Appendix 3, and the flexibility to produce additional ad hoc reports based on the data collected.

Vendor Response:

Section 4, Subsection 4.4: The Vendor should describe their approach and methodology for reporting and should also provide examples of reports produced for projects of the type, size, and scope of that described in the RFP.

Vendor Response:

Section 4, Subsection 4.5: The Vendor should describe their plan to supply all deliverables as described in Appendix 3 (Reporting Requirements) and perform according to approved Service Level Agreements listed in Appendix 4 (Service Level Agreements).

Vendor Response:

Section 4, Subsection 4.6: The Vendor should describe their approach to supply all written material, including (but not limited to) reports, letters, training materials, Member education materials, Provider manuals, and operations manuals, to the Bureau for approval in advance of distribution.

Vendor Response:

Section 4, Subsection 4.7: The Vendor should describe their plan to adjust and/or provide increased training of NEMT Providers without additional cost to the Bureau, if the Vendor or the Bureau determine that requirements, quality or other standards (Appendix 1) are not being met.

Vendor Response:

Section 4, Subsection 4.8: The Vendor should describe their plan to follow formalized change control procedures for all changes to project scope, including (but not limited to) changes arising during the Implementation and Operations phases of the project, and changes necessitated as a result of new and amended federal and state regulations and requirements.

Vendor Response:

Section 4, Subsection 4.9: The Vendor should describe their communication plan that addresses communication with all stakeholders, including the Bureau, which could include face to face, video conference, or teleconference meetings to discuss and resolve administrative and operational issues.

Vendor Response:

Section 4, Subsection 4.10: The Vendor should describe their grievance process to ensure compliance with the Bureau's fair hearing process for Members and allow Providers a review process.

Vendor Response:

Section 4, Subsection 4.11: The Vendor should describe their plan for contracting with qualified NEMT Providers, including examples of reasons they would terminate a Provider service agreement and timeframes.

Vendor Response:

Section 4, Subsection 4.12: The Vendor should describe their plan for assuring staff and providers are qualified and verifying they have not had previous felony convictions.

Vendor Response:

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Attachment B: Mandatory Specification Checklist

List mandatory specifications contained in Section 4, Subsection 5:

Section 4, Subsection 5.1: The Vendor must comply with all current and future state and federal regulations, including those relating to the Medicaid Non-Emergency Transportation program. The Vendor must also comply with Chapter 524 (excluding Attachment 3) of the West Virginia State Medicaid Manual, Chapter 27 of the West Virginia Bureau for Children and Families Income Maintenance Manual, 42 CFR § 440.170, and follow the Bureau's exclusions.

Vendor Response:

Section 4, Subsection 5.2: The Vendor must agree to provide increased staffing levels if requirements, timelines, quality or other standards are not being met, based solely on the discretion of and without additional cost to the Bureau. In making this determination, the Bureau will evaluate whether the Vendor is meeting deliverable dates, producing quality materials, consistently maintaining high quality and production rates, and meeting contract standards without significant rework or revision. Beginning thirty (30) calendar days prior to the Operations Start Date and commencing through the end of the Contract, the Vendor may not reduce staffing without BMS approval.

Vendor Response:

Section 4, Subsection 5.3: The Vendor agrees to locate and operate the NEMT Call Center within 15 miles proximity of the West Virginia State Medicaid agency located at 350 Capitol Street, Charleston, WV so the State agency can easily perform on-site monitoring duties. The Vendor shall never route calls outside of the continental United States of America. The Vendor will not delegate screening, authorization or scheduling duties. The Vendor may delegate dispatch activities to the NEMT Provider, but the Vendor will retain responsibility for the proper performance of dispatch activities.

Vendor Response:

Section 4, Subsection 5.4: The Vendor must agree to provide NEMT services described in the RFP from the operations start date until service delivery is turned over to a successor Vendor at the end of the contract, including any optional additional periods or extensions.

Vendor Response:

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Section 4, Subsection 5.5: The Vendor will be responsible for reimbursing NEMT Providers. The Vendor will not be required to reimburse for unauthorized NEMT Services to out-of-network providers. The Vendor will not use NEMT Providers with which the Vendor has not executed a contract. The Vendor must maintain an appropriate reserve equivalent to ten (10) percent of the annual contract cost bid for NEMT services during the contract period. The vendor shall enroll as a West Virginia Medicaid provider and receive payment for services through the State's claim system, Medicaid Management Information System (MMIS).

Vendor Response:

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.

_____
(Company)

_____
(Representative Name, Title)

_____
(Contact Phone/Fax Number)

_____
(Date)

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Attachment C: Cost Sheet

Cost information below as detailed in the Request for Proposal and submitted in a separate sealed envelope. Cost should be clearly marked.

Vendors are to use their business expertise in pricing the work described in this RFP, taking into consideration any intervening steps or activities that must be performed in order to complete the work and offer their rates accordingly, even if BMS does not explicitly identify those intervening steps or activities in this RFP.

Implementation Cost (All Inclusive)	
Expense	**Cost**
1. Staffing	$ _____
2. Computer, including Software	$ _____
3. Telephone/Communications	$ _____
4. Facilities	$ _____
5. Consulting Services	$ _____
6. Other *(detail on separate page)*	$ _____
Total Not to Exceed Implementation Cost[1] *(Sum of Expense Costs.)*	$ _____

Operations Cost			
Contract Year	**Estimated Average Member Months**[2]	**Per Member Per Month Rate**	**Cost**
Base Contract Period: Year 1: Assumed SFY15	429,867	$_____ x 12	$ _____
Optional Year 1: Assumed SFY 16	442,327	$_____ x 12	$ _____
Optional Year 2: Assumed SFY17	446,303	$_____ x 12	$ _____
Total Operations Cost[3] *(Sum of Operations Costs for all Contract Years.)*			$ _____

Total Cost of Contract[4] (See Notes Page)	
Total Cost of Contract *(Sum of Total Implementation Cost and Total Operations Cost)*	$ _____

REQUEST FOR PROPOSAL

Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Notes:

1. *The Vendor shall be paid an Implementation price of the amount specified in the Vendor's proposal set forth in Attachment C. Payment of the implementation cost of the contract shall be made by BMS in accordance with Appendix 5 (Milestones, Deliverables, and Payments) during the implementation phase of the contract. The amount paid for implementation costs shall not exceed the amount bid in this section.*
2. *Participant population estimates were developed based on the best information available at the time of the solicitation. The participant population estimates are to be used for purposes of cost proposal and evaluation only. The participant population estimates include the following estimated Medicaid adult expansion participation for each of the following years included in Attachment C: Year 1 – 78,500; Year 2 – 88,500 and Year 3 – 90,000.*
3. *During the Operation Phase of the Contract, the Vendor will be paid on a monthly basis in accordance with the Vendor's bid Per Member Per Month (PMPM) price proposals as set forth in Attachment C which shall be firm and fixed for the period of the Contract. The PMPM will be paid based on the actual monthly Medicaid enrollment. No specific or lump sum payment shall be made by BMS for Close-out and Turnover activities, whether the Vendor performs those activities before or after the date of Contract termination.*
4. *The cost proposal will be evaluated based on the Total Cost of Contract. The cost bid should include all anticipated training, travel and related expenses, including supplies and general administrative expenses.*

_____
(Company)

_____
(Representative Name, Title)

_____
(Contact Phone/Fax Number)

_____
(Date)

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or 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.

_____
(Company)

_____
(Authorized Signature)

_____
(Representative Name, Title)

_____
(Phone Number) (Fax Number)

_____
(Date)

Rev. 07/12

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 Resident Vendor Preference, if applicable.

1. **Application is made for 2.5% resident vendor preference for the reason checked:**

____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **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 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who 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 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% resident 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% resident vendor preference for the reason checked:**

____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. **Application is made for 5% resident 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% resident 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% resident 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.

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) reject the bid; 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.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), 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: _____ **Signed:** _____

Date: _____ **Title:** _____

RFQ No. _____

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

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

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

DEFINITIONS:

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

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

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

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

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: _____

Authorized Signature: _____ Date: _____

State of _____

County of _____, to-wit:

Taken, subscribed, and sworn to before me this ___ day of _____, 20___.

My Commission expires _____, 20___.

AFFIX SEAL HERE **NOTARY PUBLIC** _____

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

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

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

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

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

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

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

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures.** Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction.** Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

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

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

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

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

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

4. **Addendum Administration.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Name of Agency:_____ Name of Associate:_____

Signature:_____ Signature:_____

Title:_____ Title:_____

Date:_____ Date:_____

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY OF January 20 17
Patrick Morrisey
Attorney General
BY _____

Appendix A

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

Name of Associate: _____

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

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

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Appendix 1: Operational Specifications

The following operational specifications have been developed by BMS to describe expectations for the provision of NEMT Services by the Vendor. BMS is to consider responses to this RFP that propose modifications to the following specifications. Modifications should be clearly stated in the Vendor's proposal.

I. NEMT Service Request Processing

The Vendor is to provide screening, assignment, dispatch, and monitoring of NEMT requests to ensure consistent application of guidelines. The Vendor should fully and specifically describe in its Proposal how it intends to screen, authorize, schedule, and assign trips to NEMT Providers and communicate the information in a timely and efficient manner. The Vendor should also describe its procedure for assigning standing orders, urgent trips, and re-routed and refused trips.

A. Screening

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

1. Requests for NEMT Services may be made by Members, their families, guardians or representatives, and by Providers.
2. The Vendor is to screen all NEMT requests to determine each of the following items:
    a. The Member's eligibility for NEMT Services.
    b. The Member's medical need which requires NEMT Services.
    c. The Member's lack of access to available transportation. The Vendor is to require the Member to verbally certify this.
    d. The Member's service, for which the NEMT Service is requested, meets one or more of the following criteria:
        - is to be provided by an in-network/in-state provider (an enrolled WV Medicaid provider located within the state or within thirty (30) miles of its border);
        - or the Member received prior authorization from

the Utilization Management Contractor (UMC) to receive medical services from an out-of-network/out–of-state provider, (a provider not enrolled in WV Medicaid located out of state beyond the 30-mile border), or an in-network/out-of-state provider (limited providers that are enrolled with WV Medicaid located beyond the 30-mile border that are allowed enrollment for their specialty services).

e. That the medical service for which NEMT Service is requested is a Covered Medical Service and if it requires prior authorization that it has been granted by the appropriate entity.

f. The most economical Mode of Transportation appropriate to meet the medical needs of the Member, based on the Member's mobility status and personal capabilities on the date of service. Reasons for approval of Mode of Transportation that is not the most economical should be documented in detail.

g. The nearest appropriate Provider to the Member. If the Medical Provider is an excessive distance from the Member's residence (as described in Section IV (Part A) of this Appendix); and

h. Necessity of attendant or assistance request. The Vendor may require a medical certification statement from the Member's Provider in order to approve door-to-door service or hand-to-hand service.

i.

3. The Vendor should determine whether the Member is eligible for NEMT at the time of service.
4. The Vendor is not responsible for arranging the transportation of the remains of a Member who expires while receiving medical treatment. If a Member expires while in transit, the Vendor's NEMT Provider should contact the nearest law enforcement agency for instructions. The Vendor is to notify BMS of the occurrence within one (1) business day.

B. Advance Reservations

The Vendor is to educate the Members on how to request NEMT Services. The Vendor should instruct the Members that requests for NEMT Services are to be

made at least five (5) business days before NEMT Service is needed. Because scheduling issues do occasionally occur, the Vendor is to develop processes for handling urgent trips, last minute and evening, weekend and holiday requests from Members, scheduling changes, and NEMT Providers who do not arrive for scheduled pick-ups. Policy and procedures for these trips are to be approved by BMS.

C. Notification of Arrangements

Vendor is to inform the Member or the Member's representatives of the transportation arrangements during the phone call requesting the NEMT Service. Otherwise, the Vendor should inform the Member or the Member's representative in a timely manner by later phone call, by facsimile, or by letter. If the Vendor sends a letter, the letter is to be mailed in time to be received by the Member at least two (2) calendar days prior to the date of NEMT Services.

D. Scheduling and Dispatching Trips

The Vendor is to schedule and assign authorized trips to an appropriate NEMT Provider. The following standards are to be maintained:

1. The Vendor is to ensure that the average waiting time for a pick-up does not exceed fifteen (15) minutes. The Vendor may propose a method to ensure that Members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return trip if the Covered Medical Service follows a reliable schedule. The pre-arranged times may not be changed by the NEMT Provider or driver without prior permission from the Vendor.
2. The Vendor and NEMT Provider may group Members and trips to promote efficiency and cost effectiveness. The Vendor may contact Providers in this process.
3. Members receiving behavioral health services should have transportation services scheduled with a licensed behavioral health center.
4. NEMT Members should not be allowed absolute freedom to choose transportation by particular NEMT Provider. However, the Vendor should strive to maintain existing relationships between NEMT Providers and Members, and should try to accommodate a Member's request for specific NEMT Provider enrolled with BMS.
5. The Vendor is to notify the NEMT Provider of the assignment at least two (2) business days prior to the trip, if possible, and is to timely assign the trip to another NEMT Provider if necessary.
6. The Vendor is to contact an appropriate NEMT Provider so that pick-up occurs within one (1) hour after notification of a hospital discharge.

7. **Trip Types.** Specific scheduling and dispatching standards unique to specific trip types are defined as follows:

   a) **Single Trips Requests:** The Vendor is to require that requests for NEMT Services to a single appointment be made via a toll-free telephone number. Other methods of single trip requests may be allowed with BMS approval.

   b) **Standing Order Trip Requests:** The Vendor is to establish procedures to handle trip requests so that Members are not required to continually make arrangement for repetitive appointments. The Vendor is to include in its procedure to recertify the need of a Standing Order with the Medical Provider at least every ninety (90) calendar days.

   c) **Return Trip After Emergency Transports:** In limited situations, a Member may be transported by emergency medical air ambulance (fixed-wing or helicopter) or emergency medical ground ambulance to a medical facility. Upon discharge, if the Member can be transported home via private auto, basic vehicle, wheelchair vehicle, or commercial air, the Vendor shall make the appropriate arrangements for the one-way transport for the Member and up to one (1) attendant

   d) **Commercial Air Travel:** In limited situations, the medical care required for a Member cannot be provided within the State of West Virginia. WV Medicaid has enrolled specialty hospitals located elsewhere in the United States for which medical services have been prior authorized by WV Medicaid's UMC. The Vendor should receive, schedule, and arrange air transports as requested by the UMC.

   The Vendor should determine if the medical services have been prior authorized and that the medical certification of the need for commercial air travel is obtained from the Medical Provider. The Vendor is to be responsible for making the appropriate arrangements, purchasing the tickets, and distributing them to the member. The Vendor is to be responsible for purchasing tickets for the Member receiving medical services and up to one (1) attendant only.

   The Vendor is to use the most cost efficient arrangements possible with reasonable allowances for choosing a flight that would reduce the number of transfers and/or reduce

travel time, and/or choosing an appropriate departure/arrival time based on the medical needs of the member. All tickets purchased for commercial air travel are to be coach seating.

8. **Out-of-State Meals and Lodging**: In certain situations, meals and lodging may be provided for a Member and up to one (1) attendant for extended treatment out-of-state which requires at least an overnight stay. All requests for out-of-state meals and lodging are to be evaluated and pre-approved by the Vendor. The Vendor may propose a method to use discounted lodging and meal services that might be offered through the Medical Provider.

The Vendor should evaluate and arrange the most appropriate transport method based on the Member's medical condition, the reason for the transport, the urgency of the transport, and the destination of the transport. Appropriate air transport may be a commercial flight with or without a medical escort or private charter flight (non-air ambulance).

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

The Vendor may propose a method to prior authorize all fixed wing air transportation flights. The Vendor should make provisions for retroactive reviews of authorization requests for air ambulance transports in emergencies that occur after business hours, on weekends, and on holidays.

II. NEMT Providers

A. Network of NEMT Providers

The Vendor is to establish a network of NEMT Providers and negotiate reimbursement with interested, willing and qualified transportation entities, including licensed behavioral health centers that meet the transportation provider requirements. The Vendor is encouraged to develop innovative and creative strategies to reduce per-trip costs such as providing reimbursement for gasoline and making greater use of fixed-route public transportation. The Vendor is to establish and maintain a good working relationship with NEMT Providers, Medical Providers and professional associations with which it is required to be in contact in the performance of the Contract.

The Vendor is to submit with its Proposal Letters of Commitment from NEMT Providers with whom the Vendor intends to negotiate a contract for NEMT Services. Each letter of Commitment should include the number of vehicles by

type that the NEMT Provider operates and the geographic areas in which the NEMT Provider is to operate.

The Vendor should also include in its Proposal the proposed number of vehicles by type as of the anticipated Operations Start Date of the NEMT Broker Program. The Vendor should include contingency plans for the unexpected peak transportation demands, weather and other related natural disasters, and back up plans for instances when a vehicle is excessively late or is otherwise unavailable for service. The Vendor should identify NEMT Providers for bariatric transportation by geographic areas of coverage.

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

B. NEMT Provider Contracts

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

The Vendor is to submit with its Proposal a model contract that the Vendor intends to use with NEMT Providers. The model contract for each mode of transportation should be reviewed and approved by BMS prior to use.

The model contract should address the following items:

1. Payment administration and timely payment;
2. Modes of transportation;
3. Geographic coverage area(s);
4. Attendant services;
5. Telephone and vehicle communication services;
6. Information systems;
7. Scheduling;
8. Dispatching;
9. Pick-up and deliver standards;
10. Urgent trip requirements;

11. Driver qualifications;
12. Expectations for door-to-door, hand-to-hand, curb-to-curb;
13. Driver conduct;
14. Driver manifest delivery;
15. Vehicle requirements;
16. Back-up service;
17. Quality assurance;
18. Non-compliance with standards;
19. Training for drivers;
20. Confidentiality of information;
21. Specific provision that, in the instance of default by Vendor, the agreement should be passed to BMS or its agent for continued provision of NEMT Services. All terms, conditions, and rates established by the agreement should remain in effect until or unless otherwise terminated by BMS at its sole discretion;
22. Indemnification language to protect the State of West Virginia and BMS;
23. Evidence of insurance for vehicle and driver;
24. Submission of documentation as required by BMS;
25. Appeal and dispute resolution; and
26. Assurance of no over-lap of services with other programs

C. NEMT Provider Reimbursement

The Vendor is to provide timely payment to each contracted NEMT Provider for the services rendered. The WV state mileage rate is to be the minimum payment rate. The Vendor may reimburse NEMT Providers through any payment arrangement agreeable to both parties, including a sub-capitation arrangement. All payment arrangements are to include an incentive or safeguard to ensure utilization data for every encounter is submitted to Vendor. The Vendor's Proposal is to describe the following:

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

The Vendor's billing options are to include options for electronic submission of invoices by NEMT Providers. The Vendor should pay all "clean claims" from NEMT Providers within thirty (30) calendar days following receipt.

A "clean claim" is defined as a claim that can be processed without obtaining additional information from the NEMT Provider or from a third party, with the exception of any claim submitted by or on behalf of a NEMT Provider or Provider who is under investigation for Fraud or Abuse, or a claim that is under review for medical necessity. Complaints are to be subject to the Vendor's Provider grievance resolution system.

D. Geographic Coverage Area

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

The Vendor should submit for BMS review and approval the NEMT Provider Network and Geographic Coverage Report, including information for the final subcontracted network, thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved version of this deliverable.

III. Modes of Transportation

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

A. Fixed Route

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

The Vendor is encouraged to maximize the utilization of fixed route transportation whenever more economical and appropriate. The Vendor is to be familiar with schedules of fixed route transportation in communities where it is now available and in areas where it becomes available during the term of the Contract. The Vendor may distribute or arrange for the distribution of fixed route passes to Members for whom fixed route transportation is the most appropriate mode of transportation. The furthest distance a Member should be required to walk to or from a fixed route transportation stop is one-half (½) mile.

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

1. The Member's ability to travel independently, including the age of the Member and any permanent or temporary debilitating physical

or mental condition that precludes use of fixed route transportation.

2. The availability of the fixed route transportation in the Member's area or community including the accessibility of the location to

   which the Member is traveling and whether the Member is to travel more than one-half (½) mile to and from the fixed route transportation stop;
3. Inclement weather conditions (including extreme heat or cold) or other pertinent factors that make use of fixed route transportation unfeasible;
4. The compatibility of the fixed route transportation schedule with the Member's appointment times for the Covered Medical Service. The schedule for the fixed route transportation should allow the Member to arrive at the drop off location no more than ninety (90) minutes prior to the scheduled appointment time, and should allow the Member forty-five (45) minutes after the estimated time the appointment may end to arrive at the pick-up location; and
5. Any special needs of the Member which requires the coordination of services with other Providers.

B. Private Auto

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

C. Basic Vehicle

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

D. Enhanced Vehicle

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

E. Other Transportation

Other transportation may include any commercial carrier (e.g., Amtrak), buses (e.g., Greyhound), taxis and/or airplanes.

IV. Miscellaneous Operation Rules

A. Excessive Distance

The Vendor should question whether a Covered Medical Service could be provided closer to the Member's residence. Examples of possible excessive distance requests include a request for NEMT Services to a Provider that is not in the area where the Member resides, or a request for NEMT Services to a Provider that is not in the same county, bordering county or metropolitan area in a bordering state for Members living in rural areas. Vendor may deny the request if the Covered Medical Services are available closer to the Member's residence and they do not provide medical certification that the closer Provider cannot provide the care.

Generally, in determining if the transport is within reasonable proximity of a Member, the Vendor is to permit transports to contiguous counties, and/or any bordering counties or parishes in adjoining states (Ohio, Virginia, Pennsylvania, Maryland, and Kentucky) which are considered to be in-network/in-state Providers, defined as enrolled Providers located in-state and/or within 30 miles of the WV border. Vendor is to ensure that any transportation requests for NON- in-network/in-state providers are prior authorized by the UMC.

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

B. On-Time Arrival

The driver should make his presence known to the Members and wait until at least five (5) minutes after the scheduled pick-up time. If the Member is not present for pick up, the driver is to notify the NEMT Provider's dispatcher before departing from the pick-up location. Providers are not to change the assigned pick-up time without permission from the Vendor. If the NEMT Provider cannot arrive on time to the pick-up location, the NEMT Provider or Vendor should contact the Member or the Member's representative and the Provider. No more than five percent (5%) of the scheduled trips should be late or missed per day.

C. Travel Time on Board

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

D. Adverse Weather Plan

The Vendor should have a written plan for transporting Members who need critical medical care during adverse weather conditions. "Adverse weather conditions" includes, but is not limited to, extreme heat, extreme cold, hurricane, tropical storms, flooding, tornado warnings, and heavy snowfall. The Vendor should submit a final completed plan to BMS for approval no later than two (2) weeks prior to the Operations Start Date and thereafter upon BMS request. The Vendor should not begin operations without an approved Adverse Weather Plan.

E. Vendor as a NEMT Provider

Under no circumstances may the NEMT Broker also serve a NEMT Provider under the WV NEMT Services Program.

F. Post–Transportation Authorization Requests

The Vendor's Proposal should include a description of the Vendor's approach to post-transportation authorization of NEMT Services. The Vendor should not implement a policy to allow for post-transportation authorization of NEMT Services without BMS review and approval. The Vendor should submit a final completed policy to BMS for approval no later than thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved Post-Transportation Authorization of NEMT Services Policy.

Post-transportation authorization is to be allowed in instances when prior authorization was not obtainable, such as services requested when the Vendor's Call Center was closed. Vendor's post-transportation authorization policy should ensure that all applicable requirements of pre-transportation authorization are considered for the post–transportation authorization and should establish a timeliness requirement for the submission of post-transportation authorization requests.

G. Accidents and Incidents

The Vendor is to document accidents and incidents that occur in conjunction with a scheduled trip when a Member is present in the vehicle. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as passenger becomes unruly or ill.

Details are to be reported in the Accident and Incident Report (as described in Appendix 3, Reporting Requirements).

V. NEMT Service Denials

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

A. Denial Policies and Procedures

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

1. If a request for a NEMT Service is received that meets one of the denial reasons listed below, the Vendor is to deny the request and record the reason(s) for the denial in its information system on the same business day.
2. The Vendor is to generate and mail denial letters to Members and Providers no later than the next business day following the date the denial decision was made. The Vendor should bear all costs of generating and sending denial notices. The denial letter should notify the Members to the right to appeal the denial. The Vendor is to develop the denial letter and criteria for sending of the denial letter. The Vendor should submit the final completed denial letter and criteria to BMS for approval no later than thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without approved versions of these deliverables.
3. In the event a Member does not have sufficient information to arrange the transport and has to hang up and call back at a later time, the initial phone call with incomplete information should not be considered a trip denial for reporting purposes.

B. Denial Reasons

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

1. The Member is not eligible for NEMT Services on the date of service;
2. The Member does not have a medical need that required NEMT Services;
3. The medical service for which NEMT Service is requested is not a Covered Medical Service;
4. The medical service for which NEMT Service is requested requires prior authorization and prior authorization has not been obtained;

5. The service was done out-of-network without a prior authorization and did not meet policy criteria for an emergency or foster child placed out-of-state;
6. The Member has access to affordable transportation;
7. The medical service for which NEMT Service is requested is covered under another program;
8. The request was for post-transportation authorization and was not received timely or did not meet established criteria;
9. The medical appointment is not scheduled or was not kept;
10. Vendor cannot verify that there was a medical appointment;
11. The trip was not requested within an appropriate timeframe and the request cannot be a accommodated because of this;
12. Additional documentation was requested and was not received within an appropriate timeframe;
13. The Member refuses the appropriate mode of transportation; or
14. The Member refuses the NEMT Provider assigned to the trip and another NEMT Provider is not available.
15. The Members medical need requires an ambulance level of transportation. Vendor is to refer the Member to appropriate resources, such as local ambulance providers in their area.

VI. Timeliness

A. Routine NEMT Services

The Vendor should authorize and schedule routine NEMT Services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request. Vendor should authorize and schedule routine NEMT Services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request.

B. Non-Routine NEMT Service

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

In those instances, the Vendor should authorize single trips and pursue receipt of necessary information to authorize a standing order.

VII. Validation Checks

The Vendor's payment procedures should ensure that NEMT Provider claims for reimbursement match authorized trips and that the trips actually occurred. The Vendor should have a written plan for validating that transportation services paid for under the Contract are properly authorized and rendered. The Vendor should perform validation checks on at least five percent (5%) of NEMT Services requests in a month, both prior to the authorization of the request and after the services are rendered, as specified below. BMS at its sole discretion may require validation checks of trips to specific services.

The Vendor is to submit a final completed Validation Plan to BMS for review and approval no later than thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved Validation Plan.

A. Pre-Transportation Validation Checks

The Vendor is to conduct pre-transportation validation checks prior to authorizing the request for no fewer than three percent (3%) of the NEMT Services requests received in a month. The Vendor should contact the Provider and verify that the Member has an appointment for a Covered Medical Service. The Vendor is not required to verify the medical necessity of an appointment. If the Vendor verifies with the Provider that no appointment exists, or that the service is not a Covered Medical Service, the Vendor should record in its computer system the reason for the failed validation check, and the Vendor is to deny the request. If a pre-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer, the Vendor should flag the request for a post-transportation validation check, and the attempt at validation should not be counted toward the three percent (3%) pre-transportation validation check rate.

B. Post-Transportation Validation Checks

The Vendor is to conduct post-transportation validation checks on no fewer than two percent (2%) of the NEMT Services requests received in a month. The Vendor is to verify that the Member had an appointment for Covered Medical Service. The Vendor should verify that the Member received a Covered Medical Service. The Vendor is not required to verify the necessity of the transportation or of the medical service, but only that the service occurred. If the Vendor verifies with the Provider that there was no appointment, that the service was not kept, or that the service was not a Covered Medical Service, the Vendor should record in its computer system the reason for the failed validation check. If a post-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer after three (3) attempts, the Vendor should enter into its system information that is to alert Call Center staff

that any future requests to this specific Provider are to be validated before it can be authorized.

C. Fixed Route

The Vendor should perform pre-transportation and post-transportation validation checks for a percentage of fixed route transportation. The policy and procedures for validation of fixed route transportation, including the inclusion in the overall five percent (5%) validation check Service Level Agreement, should be developed by the Vendor with input from BMS.

VIII. Suspected Fraud, Abuse, and Misuse

Vendor is to refer suspected fraud, abuse, or misuse by Members, NEMT Providers, Providers, or Contractor staff to BMS's Office of Quality and Program Integrity (OQPI) and the BMS Contract Manager within three (3) calendar days after discovery of the suspected fraud, abuse, or misuse. The Vendor should expect the contact for all investigations to be provided by BMS prior to Operations Start Date. The referral is to detail the NEMT Provider's name and Medicaid ID number, the Member's name and Medicaid ID number, the Provider's name and Medicaid ID number and a narrative of all information the Vendor has regarding the suspected fraud, abuse, or misuse, including whether the Vendor was able to verify that the Member was transported to or from a source of medical care. Vendor's staff and management are to be available and are to fully cooperate with any Office of Inspector General (OIG) or law enforcement investigations or review. Vendor is to require adherence with these requirements in any contracts it enters into with subcontractors, NEMT Providers or Providers.

IX. Vehicle Requirements

A. Americans with Disabilities (ADA) Compliance

Vehicles are to comply with the Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation. The Vendor is to supply all NEMT Providers with a copy of the ADA vehicle requirements or post on the NEMT provider portal, and inspect the vehicles for compliance. Vehicles used for transporting Members with disabilities are to be in compliance with applicable ADA vehicle requirements in order to be approved for use under this program. BMS may require Vendor to supply additional notice of ADA vehicle requirements to NEMT Providers.

B. Other Compliance

Vehicles should also comply with all federal, state, county, and local requirements, and the requirements listed below:

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

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

15. Smoking is to be prohibited in all vehicles at all times. All vehicles should have an easily visible interior sign that states: “NO SMOKING”.
16. All vehicles should carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.
17. All vehicles should be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves and sterile eyewash.
18. Each vehicle should contain a current map (where a GPS unit may be considered a map) of the applicable geographic area with sufficient detail to locate Member and Provider addresses.
19. Each vehicle should be equipped with a multipurpose dry chemical fire extinguisher for use on Class A, B, and C fires. With the exception of sedans, the fire extinguisher should be mounted securely within reach of the driver and visible to passengers for use in emergencies when the driver is incapacitated. In sedans, the extinguisher may be mounted securely in a rear compartment if there is no space for mounting it in the interior of the vehicle.
20. Insurance coverage for all vehicles at all times during the Contract period should be in compliance with state law, and any county or local ordinance. The Vendor should be listed as “an additional interested party” to ensure notification is made to the Vendor in the event of a lapse in insurance coverage.
21. Each vehicle should be equipped with a “spill kit” that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.
22. The Vendor should document the lifting capacity of each vehicle in its network in order to route trips to NEMT Providers that have appropriate lift capacity for Members.
23. The Vendor should require that every vehicle in a NEMT Provider’s fleet has a real–time link, phone or two way radios. Pagers are not acceptable as a substitute.
24. The Vendor should have in its network NEMT Providers that have the capability to perform bariatric transports of patients up to eight-hundred (800) pounds.
25. Each vehicle which requires the Members to step up to enter the vehicle should include a step, or a safe stool to aid in passenger boarding. The step stool should be used to minimize ground-to-first-step height, should have four (4) legs with anti-skid tips, and

be sturdy metal with non-skid treads. Under no circumstances should a milk crate, plastic stool, or similar substitute be considered a viable alternative for a step stool. Milk crates, plastic stools, or similar substitutes should not be permitted on any vehicle. Step stools should be secured away from aisles and doorways while the vehicle is in motion in order to avoid obstructing the paths of passengers in the event of an emergency evacuation.

26.

27. Each wheelchair vehicle is to comply with the following:
    a. Wheelchair Lifts. Each wheelchair vehicle with a
    b. Mechanical lift should have an engine-wheelchair lift interlock system, which requires the transmission to be placed in park and emergency brake engaged to prevent vehicle movement when the lift is deployed. All wheelchair lifts should meet current ADA guidelines.
    c. Wheelchair Securement Devices. Each wheelchair vehicle should have, for each wheelchair position, a wheelchair securement device (or "tie-down") which meets current ADA guidelines.

C. Vehicle Inspection

The Vendor should inspect all NEMT Provider's vehicle prior to the Operations Start Date and at least every six (6) months thereafter. The Vendor should ensure that NEMT Providers maintain all vehicles to meet or exceed local, state, and federal requirements, and manufacturer's safety, mechanical, operating, and maintenance standards. In addition, the Vendor should test all communication equipment during regularly scheduled vehicle inspection.

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

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

The Vendor should submit the final plan for vehicle inspection, forms, inspection sticker and a list of trained inspectors to BMS at least thirty (30) calendar days prior to the Operations Start Date. The plan is to include the names of all employees or sub-Vendors who are authorized to inspect the vehicles for the Vendor, and the Vendor's inspection requirements, including those mandated by local, state and federal law. The Vendor should not begin operations without an approved NEMT Vehicle Inspection Plan.

X. NEMT Providers' Drivers Policies and Procedures

A. Driver Requirements

The Vendor is to ensure that NEMT Providers' drivers are in compliance with the following requirements:

1. All drivers should abide by state and local laws.
2. All drivers, at all times during their employment, should be at least eighteen (18) years of age and have a current valid driver's license to operate the transportation vehicle to which they are assigned.
3. Drivers who receive citations and are convicted of two (2) moving violations or accidents related to transportation provided under the NEMT Brokerage Program are to be removed from service.
4. Drivers should not have had their driver's license suspended or revoked for moving traffic violations in the previous five (5) years.
5. The Vendor agrees to require that NEMT Providers' drivers comply with the West Virginia State Plan regarding criminal background checks. The Vendor should conduct criminal background checks on all drivers, and the Vendor's Proposal should include the specific criteria the Vendor may use to determine if a driver can provide services under the NEMT Brokerage Program.
6. All drivers should be courteous, patient, and helpful to all passengers and be neat and clean in appearance.
7. No driver is to use alcohol, narcotics, illegal drugs, over-the-counter medications or prescription medications that impair the ability to perform.
8. All drivers should wear and have visible a nametag that is easily readable and identifies the employee and the employer.
9. No drivers should smoke while in the vehicle, while assisting a Member, or in the presence of any Member. Members should not be allowed to smoke in the vehicle.

10. Drivers should not wear any type of headphones at anytime while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT Provider or to call 911 in an emergency. Drivers should not talk on mobile phones and/or text when the vehicle is in motion.
11. Drivers should provide an appropriate level of assistance to a Member when requested or when necessitated by the Member's mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand assistance, as required. Before departing the drop-off point, the driver should confirm that the Member is safely inside the destination. The Driver should be responsible for properly securing any mobility devices utilized by the Member.
12. The driver should assist the Member in the process of being seated and confirm that all seat belts are fastened properly, and that all passengers are safely and properly secured.
13. Upon arrival at the destination, the driver should park the vehicle so that the Member does not have to cross streets to reach the entrance of the destination.
14. The driver should not leave a Member unattended at anytime.
15. If a Member or other passenger's behavior or any other condition impedes the safe operation of the vehicle, the driver should park the vehicle in a safe location out of traffic, notify the dispatcher, and request assistance.
16. Drivers with more than one confirmed incident of failure to properly secure a Member's wheelchair should be removed from providing services until such time as the NEMT Provider submits documentation to the Vendor to support that the driver has been properly trained in the use of the securement devices.

B. Provider Daily Trips Logs

The Vendor should require that the NEMT Providers' drivers maintain daily trip logs containing, but not limited to, the information listed below. Fixed route transportation should be excluded from this requirement.

1. Date of service;
2. Driver's name;
3. Driver's signature;
4. Member's name;
5. Member's or attendant's signature;

6. Vehicle Identification Number (VIN) or other identifying number on file with the Vendor;
7. NEMT Provider's name;
8. Trip ID Number;
9. Mode of transportation authorized;
10. Actual drop off time in military time;
11. Miles driven per trip odometer; and
12. Notes, if applicable. The log is to show notes in the case of, but not limited to, the following: cancellation, incomplete requests, "no-shows", accident and incident.

C. Trip Manifests

1. At least forty-eight (48) hours prior to the trip, the Vendor is to provide a trip manifest to the NEMT Provider.
2. To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Vendor should send trip manifests to the NEMT Provider by a facsimile device or secure electronic transmission.
3. NEMT Providers and Vendor are to have dedicated telephone lines available at all times for faxing purposes.
4. The trip manifests supplied to NEMT Providers should include all necessary information for the driver to perform, including, but not limited to, the following:
    a. Request Tracking Number;
    b. Member's name;
    c. Member's phone number;
    d. Address and time of the pick-up and the address and time of the appointment for Covered Medical Service (including the name and phone number of facility);
    e. Mode of transportation;
    f. Directions to Member's home, if appropriate;
    g. Return trip time(s), if appropriate;
    h. Any special needs of the Member or instructions to the driver.
5. If the Vendor sends a trip manifest to a NEMT Provider less than forty-eight (48) hours before the pick-up time, the Vendor should also contact the NEMT Provider by telephone or electronically to confirm that the trip may be accepted.
6. The Vendor is to include provisions regarding these requirements in any subcontracts with NEMT Providers.

D. Real-Time Communication

The Vendor should require that every vehicle in a NEMT Provider's fleet has a real-time link, phone or two-way radio. Pagers are not acceptable as a substitute. In its Proposal, the Vendor should detail the communications equipment that may be used to fulfill the requirements of the Vendor including how communication among Members, Vendor, NEMT Providers, and drivers should be managed to ensure that there are no delays in services or in emergency relief. The Vendor should list by name the Management staff that may be responsible for real-time communication efficiency.

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

1. **Emergencies.** In the event of an emergency (such as accidents, incidents, and vehicle breakdowns), the driver is to notify the NEMT Provider immediately to report the emergency and arrange for alternative transportation for the Member(s) on board (if necessary).
2. **Cancellation of a trip by a Member.** Vendor should communicate information regarding cancellations to the NEMT Provider in an expeditious manner to avoid unnecessary trips.
3. **No-Shows.** In the event of a no-show, the driver is to immediately notify the NEMT Provider and the NEMT Provider is to immediately notify the Vendor so that the authorization may be cancelled.

E. Monitoring Plan

The Vendor is to develop and implement a plan for monitoring NEMT Providers' compliance with all applicable local, state and federal laws and regulations. The Vendor is to ensure that NEMT Providers comply with the terms of their contracts and all NEMT Provider-related requirements of the Vendor, including driver requirements, vehicle requirements, complaint resolution requirements and the delivery of courteous, safe, timely and efficient transportation services. The Vendor is to ensure that all NEMT Providers comply with applicable WV Medicaid policies and procedures, including financial requirements and enrollment policies. The Vendor is to submit a final completed plan to BMS for approval no later than thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved NEMT Provider Monitoring Plan.

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

1. On-street observations;
2. Accident and incident reporting;
3. Statistical reporting of trips;

4. Analysis of complaints;
5. Driver licensure, driving record, experience and training;
6. Member safety;
7. Member assistance;
8. Completion of driver trip logs;
9. Driver communication with dispatcher; and
10. Routine scheduled vehicle inspection and maintenance.

The Vendor's NEMT Provider monitoring plan should include written procedures for ensuring that an appropriate corrective action is taken when NEMT Provider furnishes inappropriate or substandard services, when a NEMT Provider does not furnish services that should have been furnished, or when a NEMT Provider is out of compliance with federal or state laws or regulations. The Vendor should report monthly to BMS on monitoring activities, monitoring findings, corrective actions taken, and improvements made by the NEMT Provider.

F. Member Satisfaction Surveys

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

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

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

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

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

XI. Call Center

A. Facility

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

B. Telephone Access

The Vendor Call Center is to adhere to the following telephone access specifications:

1. The Call Center should include, but not be limited to, at least one (1) statewide toll-free telephone number for receipt of requests for NEMT Services and one (1) statewide toll-free telephone number for all members to call if their ride is more than fifteen (15) minutes late.
2. The Call Center toll-free telephone numbers are to be answered by live operators Monday through Friday, 7:00 a.m. to 6:00 p.m. Eastern Time including state holidays except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Official State holidays the Call Center is to be in operation include:

   Martin Luther King Day (Third Monday in January)
   President's Day (Third Monday in February)
   West Virginia Day (June 20)
   Columbus Day (Second Monday in October)
   Veterans Day (November 11)
   Lincoln's Day (Fourth Friday in November)
   half day on Christmas Eve (December 24)
   half day on New Year's Eve (December 31)
   Primary or General Election days

Other officially declared holidays

3. Calls placed during hours that the Call Center is not open are to receive a voice message, in English, stating the hours of operation and advising the caller to dial "911", or the appropriate emergency number, in the case of an emergency.
4. The Vendor may also route calls placed during hours that the Call Center is not required by BMS to be open to any Call Center operated by the Vendor staff in any location in the continental United States of America.
5. The Vendor should accommodate for callers who are deaf, hard of hearing, blind, and/or speech disabled.
6. The Vendor should release and transfer the toll-free telephone number(s) to BMS or a successor Vendor upon termination of Contract.

C. Language Requirements

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

D. Customer Care

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

The Vendor is to monitor at least two (2) "live" calls for each Call Center staff member on a monthly basis by listening to the conversation as it occurs. The Vendor should use this monitoring to identify problems or issues, for quality control or training purposes. The Vendor should document and retain results of this monitoring and subsequent training and report results to BMS as defined in Appendix 3 (Reporting Requirements).

The Vendor's Proposal should provide a plan for customer service monitoring, including the following: the process to be used to monitor phone conversations of

the customer service representatives (CSRs) to evaluate the quality and appropriateness of the services provided to callers; and the evaluation scoring process used to score CSR's performance.

E. Automatic Call Distribution System

The Vendor should operate an automatic call distribution (ACD) system. Callers shall be advised that calls are monitored and recorded for quality assurance purposes. Administrative lines need not be recorded. The ACD and reporting system should be able to record and aggregate the following information and should be able to produce the reports listed below daily, weekly, or monthly, as well as on an ad hoc basis.

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

F. Data Analysis

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

G. Multiple Queues

The Vendor should route incoming calls to multiple areas of operation, including non-English speaking Member queue and Provider queues. The Vendor should

obtain BMS approval prior to implementing any queue not specified in the Contract.

H. Sufficient Resources

The Vendor should maintain sufficient equipment and Call Center staff to ensure that, on a monthly basis:

1. The ACD system is programmed to answer all calls within three (3) rings.
2. The average queue time after the initial automatic voice response is five (5) minutes or less.
3. The average abandonment rate is no more than five percent (5%).
4. All criteria stated in Appendix 1, Section XI (E) are captured or met.
5. Sufficient qualified staff are available on-site to communicate with callers who speak English and an interpreter telephone service is available for callers who speak other languages;
6. The Vendor is to record all incoming calls for quality control, program integrity and training purposes. The Vendor should provide prior notification to the caller that the conversations be recorded. Vendor should maintain the recordings for up to twelve (12) months, at the direction of BMS.
7. In the event of a power failure or outage, the Vendor should have a battery back-up system capable of operating the telephone system for at least of eight (8) hours at full capacity, with no interruption of data collection as identified in the Contract or the Vendor may route calls to a redundant call center as a back-up resource. The Vendor should notify BMS immediately when its phone system is on battery power, routed to a redundant call center or is inoperative. Vendor should have a manual back-up procedure to allow it to continue to take requests if its computer system is down.
8. The ACD system logs should be maintained daily, tallied and sent to BMS on a monthly basis by the 15th day of the month following the report month, in a reporting format approved by BMS. The Vendor should also maintain daily logs on the Call Center to comply with the reporting requirements of the Contract.

The Vendor's Proposal is to include a detailed description of the proposed ACD system and its capabilities and capacities. The Vendor should describe how the ACD is to meet the specifications of this section (Section XI), and include a

sequence of questions and criteria that the Call Center representatives are to use to determine the Member's eligibility, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip. All scripts are to be approved by BMS prior to use by the Vendor.

XII. Training and Education

A. NEMT Provider Manual

The Vendor is to develop and maintain a NEMT Provider Manual. The Vendor's NEMT Provider Manual should contain all policies and procedure for the NEMT Brokerage Program. The Vendor is to work closely with BMS on the development of the NEMT Provider Manual, and is to obtain BMS approval prior to release of the manual. The manual is to be reviewed, updated, and distributed to all NEMT Providers annually and whenever changes in operation are made. Updates and changes are to be approved by BMS before distribution. BMS is to notify the Vendor in writing if a modification is required, and the Vendor should incorporate any modifications within ten (10) business days after such notification.

The Vendor should submit a draft outline of the NEMT Provider Manual with the Vendor's Proposal. The Vendor is to submit a final completed manual to BMS for approval no later than thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved NEMT Provider Manual. The Manual should include, at least, the following:

1. NEMT Provider enrollment and participation requirements;
2. NEMT Provider file maintenance and record keeping requirements;
3. Standard reimbursement requirements;
4. Covered and Non-Covered Services;
5. Vehicle requirements;
6. Limitations and considerations of NEMT Services to Covered Medical Services.

The Vendor should provide the NEMT Provider Manual to all NEMT Providers in Vendor's network and to all Vendor staff. Vendor should make the NEMT Provider Manual available electronically through a link on Vendor's website, and is to incorporate the NEMT Provider Manual into all training programs for NEMT Providers and Vendor's employees.

B. NEMT Provider and Provider Training and Education

The Vendor's Proposal should include an overview of the Vendor's plan to educate NEMT Providers and Providers, including information on training sessions, training materials, ongoing meetings with NEMT Providers and Medical Providers, and continuing education. Separate training programs should be

submitted for NEMT Providers and Providers, for the purposes of educating and training NEMT Providers regarding the NEMT Brokerage Program and training Providers regarding request for transportation, standing orders and documentation of need from Provider.

The Vendor should submit its final plans for educating NEMT Providers and Providers at least thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved version of the NEMT Provider and Provider Training and Education Plan.

No later than fifteen (15) business days prior to the Operations Start Date, the Vendor should conduct NEMT Provider and Provider training sessions in at least five (5) locations throughout the state. BMS is to prior-approve these training locations, and all costs of the training sessions should be borne by the Vendor. The Vendor should not begin operations without completion of these training sessions. The Vendor may perform additional NEMT Provider or Medical Provider training, as deemed necessary and approved by BMS.

C. Member Outreach and Education Plan

The Vendor's Proposal should include an overview of the Vendor's plan to develop and implement NEMT Member outreach and education regarding the NEMT Brokerage Program. The Member Outreach and Education Plan included with the Vendor's Proposal should describe, but not be limited to, the following:

1. The Vendor's plan to educate current and future Members and other NEMT program stakeholders (e.g., facilities, local human service agencies, NEMT Providers, and Providers) in the state on NEMT Services, procedures and the transition of service administration from county BCF staff to the Broker.
2. Written and verbal instructions to educate Members and other NEMT program stakeholders. All Member outreach and education instructions and other materials should:
    a. Emphasize the availability of NEMT Services, eligibility for these services, standing orders, medical documentation of need, and how to request and use NEMT Services;
    b. Be easily understood and written on an approximately 5th grade reading level;
    c. Be available in English and in Spanish; and
    d. Be available in alternative format for the intellectually disabled as well as for those with vision and hearing impairments.
3. Strategies for working with Members who do not comply with established policies and procedures (as described below).

4. Strategies for working with facilities such as hospitals, nursing homes, and dialysis centers to achieve NEMT efficiencies.

The Vendor is to submit a final completed Member Outreach and Education Plan to BMS for approval no later than thirty (30) calendar days prior to the Operations Start Date. The Vendor should not begin operations without an approved Participant Education Plan.

At least thirty (30) calendar days prior to the Operations Start Date, the Vendor is to mail, by first class mail and at the Vendor's expense, written materials to inform and educate Members and other stakeholders about the NEMT Brokerage Program. The Vendor should work with BMS to obtain a listing of Members, other stakeholders and addresses. The Vendor should not begin operations without mailing of these materials.

D. Non-Compliant Member Education

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

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

The Vendor's Member Outreach and Education Plan should include an education policy and transportation options for Members whose behavior en-route threatens the safety of the Member, driver, or other passengers.

XIII. Operations Procedures Manual

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

The manual is to be reviewed, updated and distributed to Vendor staff annually and whenever changes in operating procedures are made. BMS may require modification of the Operations Procedures Manual at any time, and notify the Vendor in writing of the

required modification. The Vendor is to modify the Operations Procedures Manual within ten (10) business days of notification.

XIV. Complaint Policies and Procedures

The Vendor's Proposal should include a description of the Vendor's approach to Member and NEMT Provider complaint policies and procedures, including separate complaint resolution processes for Members and NEMT Providers (as described below). The policies and procedures should provide for prompt resolution, and ensure the participation of individuals who have authority to require corrective action. The Vendor should attempt to resolve any complaint in accordance with the complaint resolution process. The Vendor should work with all parties, and BMS, as necessary, to resolve complaints.

The Vendor should submit a final Complaint Policies and Procedures Manual to BMS at least thirty (30) calendar days prior to the Operations Start date for BMS review and approval. The Vendor should not begin operations without a BMS-approved Complaint Policies and Procedures Manual. The Vendor should review its complaint policies and procedures every six (6) months, and notify BMS if it determines that an amendment is necessary. The Vendor should perform amendments only with the prior written consent of BMS. The Vendor's approach to review and amend complaint policies and procedures should be included with the Proposal's description of these policies and procedures.

A. Member Complaint Resolution and Appeal Process

The Vendor should have a complaint resolution process for Members. Each complaint should be assigned a unique tracking number. The Vendor should respond to a complainant within one (1) business day after receipt of a complaint. The Vendor should attempt to resolve complaints in accordance with the complaint resolution process. The Vendor should work with all parties and BMS, as necessary, to resolve the complaint.

Complaint information provided to BMS should include:

1. Documentation or testimony by the Project Manager or other medical or expert consultant who is familiar with and able to testify to the specific case being appealed.
2. Records and documentation regarding a denial of a NEMT Service. Records should be maintained as outlined in Section V of this Appendix, and information should be reported as outlined in Appendix ~~2~~ 3.
3. Comprehensive documentation specific to the particular case.

If BMS overturns the denial and authorizes the NEMT Services, the Vendor should notify the Member and the NEMT Provider of the appeal decision; then the Vendor is to approve the NEMT Services and reimburse the NEMT Provider.

B. NEMT Provider Complaint Resolution and Grievance Process

The Vendor should establish and maintain a procedure for reviewing complaints and grievances made by NEMT Providers. Each complaint or grievance is to be assigned a unique tracking number. The NEMT Provider should be allowed fifteen (15) calendar days to request a review of the decision by the Vendor or BMS or both. Failure to request a review within fifteen (15) calendar days is to be a waiver of the NEMT Provider's right to request a review.

XV. Contract Close-Out and Turnover Procedures

A. Turnover Plan

The Vendor is to submit a Turnover Plan to BMS no later than fourteen (14) calendar days after the date of Contract award. The Plan should provide for an orderly and controlled turnover of the Vendor's responsibilities to a successor Vendor or to BMS at the end of the Contract period or upon termination of the Contract, and minimize the disruption of NEMT Services to Members.

The Turnover Plan should include the following:

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

B. Turnover Notification and Turnover Period

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

C. Specific Close-Out Requirements

The Vendor is to complete all duties required in the Contract with regard to requests for NEMT Services for dates of services up to and including 11:59 p.m. Eastern Time on the termination date of the Contract. These duties should include, but not be limited to, the following:

1. Screening, authorization, scheduling, and provision of NEMT Services;
2. Successful submission to BMS of all utilization data;
3. Generation and sending of all required notices to Providers and Members;
4. Validation Checks as required in Section VII of this Appendix; and
5. Submission and correction, as necessary, of all reports required by this RFP.

D. Agency Access

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

E. Specific Turnover Requirements

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

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

F. Vendor Response to Questions

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

G. Turnover Meetings

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Appendix 2: Implementation Specifications

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

I. Implementation Work Plan

The Vendor's Proposal should include an Implementation Work Plan to be maintained throughout the implementation period that includes all tasks required to successfully begin operation of the NEMT Brokerage Program. The Work Plan should be sufficiently detailed to satisfy BMS that the work should be performed in a logical sequence, in a timely manner, and with an efficient use of resources. The Vendor should submit the final implementation Work Plan electronically and in hard copy to BMS no later than fourteen (14) calendar days after the date of Contract award.

A. Work Plan Tasks

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

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

1. Acquisition of office space, furniture, and telecommunications, computer equipment, including software, and installation of utilities;
2. Hiring and training of central office staff, Call Center staff, and all other Vendor staff;
3. Recruitment and contracting of NEMT Providers;
4. Verification that NEMT Provider vehicles meet Vendor standards, including inspection and certification requirements;
5. Verification that drivers meet Contract standards;
6. Testing of daily operational requirements, including, but not limited to, Call Center, dispatch and real time communications with drivers, to ensure that all components are functioning adequately prior to BMS's Readiness Review;
7. Installation of trip scheduling, reservation, and dispatch systems;
8. Member, NEMT Provider and Medical Provider education; and
9. Development of required deliverables, including reports, Operations Procedure Manual, NEMT Provider Manual, eligibility

file requirement, utilization data submission procedures, Quality Assurance Plan (as described in Section II of this Appendix), and Business Continuity and Disaster Recovery Plan (as described in Section V of this Appendix).

II. Quality Assurance Plan

At least thirty (30) calendar days prior to the Operations Start Date, the Vendor is to submit a final Quality Assurance Plan to BMS for its review and approval. The Quality Assurance Plan should include at least the following:

1. The Vendor's procedures for certification that all NEMT Services paid for are properly authorized and actually rendered;
2. The Vendor's plan to develop safeguards against fraud or abuse by NEMT Providers, Medical Providers, Members and Vendor staff and fulfill BMS reporting requirements regarding such activity;
3. The Vendor's agreement to indemnify BMS against any causes of actions or claims of payment brought by NEMT Providers or Members;
4. The Vendor's plan to ensure that NEMT Providers meet standards for vehicle maintenance, operation, and inspection; driver qualifications and training; complaint resolution; and delivery of courteous, safe and timely NEMT Services.

The Vendor should not begin operations without a BMS-approved Quality Assurance Plan. BMS reserves the right to make quality assurance reviews on services provided by the Vendor under the Contract anonymously and without advance notice.

III. Operational Readiness Review

Approximately two (2) weeks prior to the Operations Start Date, the Vendor should expect that BMS may conduct an operational readiness review of the Vendor, after which BMS may approve the Vendor for implementation. The Vendor is to receive written BMS approval of all submission and demonstration requirements prior to the Operations Start Date.

A. Readiness Review Deliverables

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

1. The Vendor's data systems (as described in Appendix 2, Section IV);
2. The Vendor's information systems screen prints and logic;

3. The Vendor's brokerage process, including authorization, scheduling, dispatch, coordination, management, generation of denial letters, and reimbursement process;
4. The Vendor's NEMT Provider Network and Geographic Coverage Report (as described in Appendix 1, Section II (D));
5. Proof of the Vendor's NEMT Provider network sufficiency;
6. The Vendor's Adverse Weather Plan (as described in Appendix 1, Section IV (D));
7. The Vendor's Post-Transportation Authorization of NEMT Services Policy (as described in Appendix 1, Section IV (F));
8. The Vendor's NEMT Service denial criteria and service denial letter (as described in Appendix 1, Section V (A, #2));
9. The Vendor's Validation Policy (as described in Appendix 1, Section VII);
10. The Vendor's Vehicle Inspection Plan (as described in Appendix 1, Section IX (C));
11. Proof of compliance with vehicle and driver requirements;
12. The Vendor's NEMT Provider Monitoring Plan (as described in Appendix 1, Section X (E));
13. The Vendor's final NEMT Provider Manual (as described in Appendix 1, Section XII (A));
14. The Vendor's NEMT Provider and Provider Training and Education Plan (as described in Appendix 1, Section XII (B));
15. The Vendor's final Member Outreach and Education Plan (as described in Appendix 1, Section XII (C);
16. Verification that education of Members, NEMT Providers, Providers, and other agencies occurred (as described in Appendix 1, Section XII);
17. The Vendor's Operations Procedures Manual (as described in Appendix 1, Section XIII);
18. The Vendor's final Complaint Policies and Procedures Manual (as described in Appendix 1 Section XIV);
19. The Vendor's Quality Assurance Plan (as described in Appendix 2, Section II);
20. The Vendor's Business Continuity Plan and Disaster Recovery Plan (as described in Appendix 2, Section V); and
21. The Vendor's reporting capabilities, including the ability to produce BMS-Specific reports (as described in Appendix 3).

B. Call Center Readiness Requirements

As part of the readiness review, the Vendor is to demonstrate to BMS that the Vendor's Call Center meets all Contract requirements, including reporting capabilities. The Vendor's data system is to meet and/or demonstrate compliance with all Contract requirements, including the following:

1. The Vendor's data collection;
2. The Vendor's method by which Member information is recovered by the Vendor and displayed on screens used by Call Center staff at their work stations;
3. The Vendor's method by which BMS overrides and/or special instructions should be displayed on screens;
4. The Vendor's ability to determine Member eligibility;
5. The Vendor's ability to produce denial letters to Members, NEMT Providers, and Providers, as appropriate;
6. The Vendor's functionality of the web-based inquiry system for NEMT Providers;
7. The Vendor's quality control procedures and edits;
8. The Vendor's reporting capabilities, including the ability to produce BMS-Specific reports (see Call Center reporting described in Appendix 3);
9. The Vendor's staff is appropriately trained; and
10. The Vendor's staff is sufficient to meet the timeliness and telephone system requirements (as described in Appendix 1, Section XI (G)).

C. Remediation & Start-Up

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

IV. Data Systems Requirements

A. Eligibility Verification

Each week, the Vendor should expect BMS to provide the Vendor with Member and Provider extract files. The Member extract file should contain eligibility information for all persons enrolled in the Medicaid Program who are eligible to receive NEMT benefits. The Provider extract file should contain eligibility

information for all Providers enrolled in the WV Medicaid program. The Vendor should upload the weekly Member and Provider extract files within two (2) business days after receipt.

In addition, the Vendor should expect BMS to provide the Vendor with limited access to the West Virginia Medicaid Management Information System (MMIS) Automated Voice Response System (AVRS) to verify Member eligibility as needed for eligibility changes made between extract files.

B. Data Capture

The Vendor should capture and retain data used to administer the NEMT Brokerage Program. The data captured and retained should be sufficient to meet Contract requirements, including reporting requirements.

The Vendor should have the capability to manually enter eligibility data for Members, including name and Member ID number. The Vendor should be capable of reconciling the information entered manually against the weekly Member eligibility extract file to ensure that the information in Vendor's system is accurate.

C. Encounter Data

The Vendor should provide BMS with a monthly aggregate file of detailed encounter data on each trip made on behalf of Medicaid Members. The transactions are to comply with HIPAA regulations in the version prescribed by BMS.

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

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

The Vendor should submit the monthly aggregate file and a summary report to be used for reconciliation purposes to BMS by the 20th of the following month. The summary report is to balance to the detailed aggregate file.

D. Audit

The Vendor is to provide BMS or their designee access to the Vendor's data system for auditing and monitoring purposes. Access is to include, but not be limited to, all equipment, systems, and communications software necessary for BMS to obtain utilization information.

The Vendor is to use accurate and reliable software to calculate mileage. The Vendor is to be responsible for the accuracy of the calculation and is to represent such in audit or legal.

E. Web-Based Inquiry System

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

The Vendor's web-based inquiry system is to comply with the following:

1. The web-based inquiry system is to conform to BMS's security requirements including, but not limited to, the following:
    a. HIPAA Privacy Guidelines;
    b. HTTPS Web Page;
    c. 128-Bit Encryption; and
    d. User Authentication and Authorization.
2. Web-based screens are to conform to the requirements for readability set forth in the Americans with Disabilities Act (ADA).
3. The screens are to provide the following information.
    a. Summary of trips for a date range;
    b. Summary of trips by a Member for a date range; and
    c. Details of trips by request tracking number.

V. Business Continuity and Disaster Recovery Plan

The Vendor's Proposal should include a Business Continuity and Disaster Recovery Plan that details the steps the Vendor should take to enable the Vendor to continue to meet all requirements of the Contract in the event of a failure of BMS's or the Vendor's data,
communication or technical support systems. The plan should include a process for back-up of the Vendor's data systems, phones, and electronic media records in an appropriate location that is protected against fire, theft or disaster. The Vendor should ensure that its back-up system minimizes the potential for loss of data.

At least thirty (30) calendar days prior to the Operations Start Date, the Vendor is to submit a final Business Continuity and Disaster Recovery Plan to BMS for review and approval. The Vendor should not begin operations without a BMS-approved Business Continuity and Disaster Recovery Plan. The Vendor is to review and update the Business Continuity Plan and Disaster Recovery Plan at least annually.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Appendix 3: BMS-Specific Reporting Requirements

The Vendor is to provide BMS with sample versions of the reports specified below at least thirty (30) calendar days prior to the Operations Start Date for BMS review and approval. The Vendor should not begin operations without BMS approval of reports. Report formats may include paper reports or data files. Upon BMS request, the Vendor should supply the underlying data to support any report submitted. The data is to be in a BMS-approved electronic file format.

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

#	Name	Frequency/Delivery	Description
R12	Monthly Denial Detail Report	Monthly, due no later than the 15th of the month following the report month.	This report should provide the following information for each denied trip during the month: 1. Member's Medicaid ID number; 2. Member's name; 3. Member's address; 4. Date of denial; 5. Trip ID number; 6. Denial reason; and 7. Vendor staff who denied trip.
R13	Monthly Network Report	Monthly, due no later than the 15th of the month following the report month.	This report should provide a listing of NEMT Providers which details the Level of Service available through the NEMT Provider and the Counties they serve.
R14	NEMT Services Scheduled Trip Requests Report	Within 2 calendar days of BMS request.	This report should be transmitted to BMS upon request; should be formatted as a batch file in a BMS-approved file layout; and should contain information regarding each requested trip.
R15	Provider Training Schedule	Monthly (for months during which Provider training is to be conducted), due no later than five (5) calendar days before the start of the month in which training to occur.	This report should provide the schedule of NEMT Providers and Provider training sessions for the report month. Any changes to the scheduled training sessions should be reported immediately, via facsimile transmission, to BMS. This report is not to include training conducted prior to the Operations Start Date.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

#	Name	Frequency/Delivery	Description
R16	Accident and Incident Report	For each accident or incident, due within twenty-four (24) hours after an accident or incident with injuries and within seventy-two (72) hours after an accident or incident without injuries.	This report should include the details of accidents or incidents (as defined in Appendix 1, Section IV (G) of this RFP), including, but not limited to, the following: 1. Date of accident or incident; 2. Description of accident or incident; 3. Member's Medicaid ID number; 4. Member's name; 5. Attendant's name (if applicable); 6. Driver's name; 7. Vehicle Identification Number (VIN) or other identifying number on file with the Vendor; 8. NEMT Provider's Name; 9. Trip ID Number; 10. Other information or notes, as applicable (e.g., police report, location of accident or incident, resolution/follow-up, associated complaint).
R17	Biannual Member Satisfaction Survey Report	Bi-annually, due no later than the 30th calendar day after the end of each six (6) month reporting period.	This report should provide a summary of the results of the Member surveys (as described in Appendix 1, Section X (F) of this RFP), an analysis of the results and any actions the Vendor has initiated or to initiate based on the survey results. Upon the request of BMS, the Vendor should also provide BMS with the raw data of the survey results.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

#	Name	Frequency/Delivery	Description
R18	Quarterly Suspected Fraud, Abuse and/or Misuse Summary Report	Quarterly, due no later than the 30th calendar day after the end of each calendar quarter.	This report is to include a summary of all cases forwarded to BMS's Office of Quality and Program Integrity (OQPI) and copied to the Contract Manager during the previous quarter (as specified in Appendix 1, Section VIII, of this RFP). The report should include the Member's name and Medicaid ID number, the NEMT Provider's name and Medicaid Provider ID number, and a brief description of the suspected fraud, abuse or misuse.
R19	Annual Report	Annually, due no later than the 60th calendar day following the end of the twelve (12) month period (Operations Start Date to be used as the start date).	This report should include a narrative summary of all NEMT Brokerage Program activity, Vendor accomplishments, remaining challenges, and Vendor's recommendations.
R20	Records of Vehicle Inspection	Monthly, due no later than the 15th of the month following the report month.	This report should include records of all vehicle inspections performed during the month (as described in Appendix 1, Section VIII (C) of this RFP). The report should include the license plate number, vehicle identification number, inspection sticker date, Vendor's inspection form, and whether the vehicle passed inspection.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

#	Name	Frequency/Delivery	Description
R24	Monthly Multi-passenger Trip Report	Monthly, due no later than the 20th of the month following the report month.	This report should detail the NEMT Provider's performance against Contract Service Level Agreements (as described in Appendix 4, Service Level Agreements) for Travel Time On Board of multi-passenger trips. The report should include, but not be limited to, the following detail for each SLA: 1. Number of multi-passenger trips for the reporting month; 2. Time of pick-up for each multi-passenger trip; 3. Time of arrival at appointment destination for each multi-passenger trip; 4. Travel distance for each multi-passenger trip.
R25	Monthly Behavioral Health Transportation Report	Monthly, due no later than the 20th of the month following the report month.	This report should detail the NEMT Provider's performance against Contract Service Level Agreements (as described in Appendix 4, Service Level Agreements) for licensed behavioral health center transports. The report should include, but not be limited to, the following detail for each SLA: 12. Total number of trips; 13. Total mileage; and 14. Total cost to the Vendor by Level of Service.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Appendix 4: Service Level Agreements (SLAs)

Because performance failures by the Vendor may cause BMS to incur additional administrative costs, BMS may assess liquidated damages against the Vendor pursuant to this section, and deduct the amount of the damages from any payments due the Vendor. Unless specified otherwise, BMS may give written notice to the Vendor of the failure that might result in the assessment of damages and the proposed amount of the damages. The Vendor shall have thirty (30) calendar days from the date of the notice in which to dispute BMS's determination.

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Service Level Agreement Description	Penalty
NEMT Services **1. On-Time Arrival** No more than two percent (5%) of the scheduled trips should be late or missed per day. **2. Travel Time On Board** For multi-passenger's trips, the NEMT Provider should schedule trips so that a Member does not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for direct transportation of that Member. (This specification does not apply to commercial air or fixed-wing transports.) **3. Average Wait Time** The Vendor is to ensure that the average waiting time for a pick-up does not exceed fifteen (15) minutes for a scheduled appointment and one (1) hour after notification of a hospital discharge. **4. Authorization & Scheduling Timeliness – Three Day Turn-Around** The Vendor should authorize and schedule routine NEMT Services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request. **5. Authorization & Scheduling Timeliness – Ten Day Turn-Around** The Vendor should authorize and schedule routine NEMT Services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request.	Up to **3%** of the monthly operating fee, as follows: • Any 2 of 5 not met: **1%** • Any 3 of 5 not met: **2%** • Any 5 of 5 not met: **3%**

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Service Level Agreement Description	Penalty
Transportation Validation Checks **6. Pre-Transportation Validation Checks** The Vendor is to conduct pre-transportation validation checks prior to authorizing the request (as described in Appendix 1, Section VII) for no fewer than three percent (3%) of the NEMT Services requests received in a month. A busy signal or no answer should not be counted toward the three percent (3%) pre-transportation validation check rate. **7. Post-Transportation Validation Checks** The Vendor is to conduct post-transportation validation checks (as described in Appendix 1, Section VII) on no fewer than two percent (2%) of the NEMT Services requests received in a month. If a post-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer after three (3) attempts, the Vendor should enter into its system information to alert Call Center staff that any future requests to this specific Provider are to be validated before it can be authorized.	Up to **5%** of the monthly operating fee, as follows: • Any 1 of 2 not met: **3%** • Any 2of 2 not met: **5%**
8. Utilization Reporting Submission The Vendor shall submit the utilization reporting on the day of the week specified by BMS (as described in Appendix 3, Report #R3). BMS may assess damages for each business day the complete and accurate report has not been submitted, retroactive to the original due date.	Up to $1,000 per day for each business day the report is late.
9. Suspected Fraud, Abuse, and Misuse Reporting Submission Vendor is to refer suspected fraud, abuse, or misuse by Members, NEMT Providers, Providers, or Contractor staff to BMS's Office of Quality and Program Integrity (OQPI) and the BMS Contract Manager within three (3) calendar days after discovery of the suspected fraud, abuse, or misuse. BMS may assess damages for each business day the report has not been submitted, retroactive to the original discovery date.	Up to $10,000 per day for each business day the report is late.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Service Level Agreement Description	Penalty
Call Center Performance **13. Call Center - Speed of Answer** The ACD system is programmed to answer all calls within three (3) rings. **14. Call Center - Average Wait Time** The average queue time after the initial automatic voice response is five (5) minutes or less. **15. Call Center - Average Call Abandonment Rate** The average abandonment rate is no more than five percent (5%).	Up to 2% of the monthly operating fee, as follows: • Any 1 of 3 not met: **1%** • Any 2 or 3 not met: **2%**
Training, Outreach and Education **16. Provider Training and Education** Vendor will conduct separate NEMT Provider and Provider training sessions in at least five (5) locations throughout the state, and ensure continued education, training sessions, training materials, ongoing meetings with NEMT Providers and Medical Providers. Vendor is to develop and maintain a Provider Manual which contains all policies and procedures for the NEMT Brokerage Program. The manual is to be reviewed, updated, and distributed annually and whenever changes in operation are made. **17. Member Outreach, Education and Satisfaction Surveys** Vendor will develop and implement NEMT Member outreach and education for current and future Members and other NEMT program on NEMT Services, procedures, and the transition of service administration from county BCF staff to the Broker. Every six (6) months, the Vendor is to conduct a Member satisfaction survey regarding the NEMT Brokerage program to verify availability, appropriateness and timeliness of trips provided and the manner in which the Vendor's staff and NEMT Provider's staff interacted with Members.	Up to 2% of the monthly operation fee, as follows: • Any 1 of 2 not met: **1%** • Any 2 of 2 not met: **2%**

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Service Level Agreement Description	Penalty
Driver and Vehicle Validation Checks **18. Transportation Provider Driver Requirements Validation Checks** Transportation providers must ensure NEMT Drivers meet all driver requirements including, age and driver's license requirements, criminal background checks, driver impairment and smoking policies, member assistance and safety policies, and driver vehicle operation daily trips logs policies. **19. Vehicle and Vehicle Inspection Requirements Validation Checks** Vehicle inspections are to be performed prior to Operations Start Date and at least every six (6) months thereafter. Providers must ensure compliance with vehicle requirements and must maintain all vehicles to meet or exceed local, state, and federal requirements, including ADA Compliance and manufacturer's safety, mechanical, operating and maintenance standards, and test all communications equipment.	Up to 2% of the monthly operation fee, as follows: • Any 1 of 2 not met: **1%** • Any 2 of 2 not met: **2%**
20. Behavioral Health Transports The Vendor should schedule routine NEMT Services for one hundred percent (100%) of all requests from NEMT members receiving behavior health services with a licensed behavioral health center.	1% of the monthly operating fee.

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Appendix 5: Implementation Deliverables*, Milestones, and Payments

* *Deliverables are due to BMS for review and approval no later than thirty (30) calendar days prior to the Operations Start Date, unless noted otherwise.*

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

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

REQUEST FOR PROPOSAL
Department of Health and Human Resources
Bureau for Medical Services
RFP # BMS14156

Appendix 6: Glossary

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

ACCIDENT: An unforeseen and unplanned event or circumstance.

APPEAL: An action initiated by a Member to challenge a decision made by BMS or Contractor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> **AMBULATORY LEVEL OF SERVICE:** An ambulatory Member is able to move and pivot without assistance. It may also include a Member in a manual wheelchair who is capable of transferring without assistance.
>
> **WHEELCHAIR LEVEL OF SERVICE:** A Member who uses an electric or manual wheelchair and is unable to transfer on their own.

MEDICAID IDENTIFICATION NUMBER/MEDICAID ID NUMBER: A unique number assigned to a Member by BMS.

NEMT PROVIDER: Person or entity that is approved by BMS and participates in the Vendor's network to furnish non-emergency medical transportation services to Members under the Medical Assistance Program.

PROVIDER: Person enrolled with BMS to furnish medical, educational, or rehabilitative services to Members under BMS's Medical Assistance Program.

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

STANDING ORDER: A request or authorization for NEMT Services to multiple recurring medical appointments for the same Member with the same Provider for the same treatment or condition.

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

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

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

42 CFR §440.170

(e) Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

[72 FR 68091, Dec. 4, 2007, as amended at 74 FR 31196, June 30, 2009]

§440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

(2) Except as provided in paragraph (a)(4), transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency.

(3) "Travel expenses" include—

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging en route to and from medical care, and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary.

(4) Non-emergency medical transportation brokerage program. At the option of the State, and notwithstanding §431.50 (statewide operation) and §431.51 (freedom of choice of providers) of this chapter and §440.240 (comparability of services for groups), a State plan may provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide non-emergency medical transportation services for individuals eligible for medical assistance under the State plan who need access to medical care or services, and have no other means of transportation. These transportation services include wheelchair vans, taxis, stretcher cars, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation otherwise covered under the state plan.

(i) Non-emergency medical transportation services may be provided under contract with individuals or entities that meet the following requirements:

(A) Is selected through a competitive bidding process that is consistent with 45 CFR 92.36(b) through (i) and is based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs.

(B) Has oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and that transport personnel are licensed, qualified, competent, and courteous.

(C) Is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services.

(D) Is subject to a written contract that imposes the requirements related to prohibitions on referrals and conflicts of interest described at §440.170(a)(4)(ii), and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or subcontract.

(ii) Federal financial participation is available at the medical assistance rate for the cost of a written brokerage contract that:

(A) Except as provided in paragraph (a)(4)(ii)(B) of this section, prohibits the broker (including contractors, owners, investors, Boards of Directors, corporate officers, and employees) from providing non-emergency medical transportation services or making a referral or subcontracting to a transportation service provider if:

(*1*) The broker has a financial relationship with the transportation provider as defined at §411.354(a) of this chapter with "transportation broker" substituted for "physician" and "non-

emergency transportation'' substituted for ''DHS''; or

(*2*) The broker has an immediate family member, as defined at §411.351 of this chapter, that has a direct or indirect financial relationship with the transportation provider, with the term ''transportation broker'' substituted for ''physician.''

(B) Exceptions: The prohibitions described at clause (A) of this paragraph do not apply if there is documentation to support the following:

(*1*) Transportation is provided in a rural area, as defined at §412.62(f), and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(*2*) Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

(*3*) Except for the non-governmental broker, the availability of other Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

(*4*) The broker is a government entity and the individual service is provided by the broker, or is referred to or subcontracted with another government-owned or operated transportation provider generally available in the community, if the following conditions are met:

(*i*) The contract with the broker provides for payment that does not exceed the actual costs calculated as though the broker were a distinct unit, and excludes from these payments any personnel or other costs shared with or allocated from parent or related entities; and the governmental broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the brokerage program will be completely separate from any other program;

(*ii*) The broker documents that, with respect to the individual's specific transportation needs, the government provider is the most appropriate and lowest cost alternative; and

(*iii*) The broker documents that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for comparable services.

(C) Transportation providers may not offer or make any payment or other form of remuneration, including any kickback, rebate, cash, gifts, or service in kind to the broker in order to influence referrals or subcontracting for non-emergency medical transportation provided to a Medicaid recipient.

(D) In referring or subcontracting for non-emergency medical transportation with transportation providers, a broker may not withhold necessary non-emergency medical transportation from a Medicaid recipient or provide non-emergency medical transportation that is not the most appropriate and a cost-effective means of transportation for that recipient for the purpose of financial gain, or for any other purpose.

(b) *Services furnished in a religious nonmedical health care institution.* Services furnished in a religious nonmedical health care institution are services furnished in an institution that:

(1) Is an institution that is described in (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under section 501(a) of that section.

(2) Is lawfully operated under all applicable Federal, State, and local laws and regulations.

(3) Furnishes only nonmedical nursing items and services to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.

(4) Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients.

(5) Furnishes these nonmedical items and services to inpatients on a 24-hour basis.

(6) Does not furnish, on the basis of its religious beliefs, through its personnel or otherwise, medical items and

services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.

(7) Is not owned by, is not under common ownership with, or does not have an ownership interest of 5 percent or more in, a provider of medical treatment or services and is not affiliated with a provider of medical treatment or services or with an individual who has an ownership interest or 5 percent or more in a provider of medical treatment or services. Permissible affiliations are described in paragraph (c) of this section.

(8) Has in effect a utilization review plan that meets the following criteria:

(i) Provides for the review of admissions to the institution, duration of stays, cases of continuous extended duration, and items and services furnished by the institution.

(ii) Requires that the reviews be made by a committee of the institution that included the individuals responsible for overall administration and for supervision of nursing personnel at the institution.

(iii) Provides that records be maintained of the meetings, decisions, and actions of the utilization review committee.

(iv) Meets other requirements as CMS finds necessary to establish an effective utilization review plan.

(9) Provides information CMS may require to implement section 1821 of the Act, including information relating to quality of care and coverage determinations.

(10) Meets other requirements as CMS finds necessary in the interest of the health and safety of patients who receive services in the institution. These requirements are the conditions of participation found at part 403, subpart G of this chapter.

(c) *Affiliations.* An affiliation is permissible for purposes of paragraph (b)(7) of this section if it is between one of the following:

(1) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of an RNHCI and a provider of medical treatment or services.

(2) An individual who is a director, trustee, officer, employee, or staff member of an RNHCI and an another individual, with whom he or she has a family relationship, who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

(3) The RNHCI and an individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and RNHCIs.

(d) *Skilled nursing facility services for individuals under age 21.* "Skilled nursing facility services for individuals under 21" means those services specified in §440.40 that are provided to recipients under 21 years of age.

(e) *Emergency hospital services.* "Emergency hospital services" means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§440.10 and 440.20.

(f) [Reserved]

(g) *Critical access hospital (CAH).* (1) CAH services means services that (i) are furnished by a provider that meet the requirements for participation in Medicare as a CAH (see subpart F of part 485 of this chapter), and (ii) are of a type that would be paid for by Medicare when furnished to a Medicare beneficiary.

(2) Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48540, Oct. 1, 1981; 58 FR 30671, May 26, 1993; 62 FR 46037, Aug. 29, 1997; 64 FR 67051, Nov. 30, 1999; 72 FR 73651, Dec. 28, 2007; 73 FR 77530, Dec. 19, 2008; 74 FR 31196, June 30, 2009]

§440.180 Home or community-based services.

(a) *Description and requirements for services.* "Home or community-based services" means services, not otherwise

West Virginia State Code § 9-5-11

Enrolled Version - Final Version

ENROLLED

COMMITTEE SUBSTITUTE

for

H. B. 2512

(By Mr. Speaker, (Mr. Thompson) and Delegate Armstead)

(By Request of the Executive)

[Passed April 12, 2013; in effect ninety days from passage.]

AN ACT to amend and reenact §9-5-11 of the Code of West Virginia, 1931, as amended, all relating to state Medicaid subrogation; establishing definitions; establishing recipient assignment of subrogation rights against third parties; excluding Medicare benefits from assignment; authorizing release of information; prioritizing the department's subrogation right; establishing notice requirements for third party claims, civil actions and settlements; permitting the department to enter appearance in an action against a third party; establishing penalties for failure to notify the department; requiring consent to settle; establishing procedures for agreed allocation of award or judgment proceeds from third parties; establishing procedures when allocation is disputed; establishing procedures for jury trial; establishing post-trial payment procedures; establishing allocation of attorneys fees; prohibiting certain class actions and multiple plaintiff actions; and authorizing authority to settle.

Be it enacted by the Legislature of West Virginia:

That §9-5-11 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-11. Definitions; Assignment of rights; right of subrogation by the Department for third-party liability; notice requirement for claims and civil actions; notice requirement for settlement of third-party claim; penalty for failure to notify the department; provisions related to trial; attorneys fees; class actions and multiple plaintiff actions not authorized; and Secretary's authority to settle.

(a) *Definitions.*— As used in this section, unless the context otherwise requires:

(1) "Bureau" means the Bureau for Medical Services.

(2) "Department" means the West Virginia Department of Health and Human Resources, or its contracted designee.

(3) "Recipient" means a person who applies for and receives assistance under the Medicaid Program.

(4) "Secretary" means the Secretary of the Department of Health and Human Resources.

(5) "Third-party" means an individual or entity that is alleged to be liable to pay all or part of the costs of a recipient's medical treatment and medical-related services for personal injury, disease, illness or disability, as well as any entity including, but not limited to, a business organization, health service organization, insurer, or public or private agency acting by or on behalf of the allegedly liable third-party.

(b) *Assignment of rights.*—

(1)Submission of an application to the department for medical assistance is, as a matter of law, an assignment of the right of the applicant or his or her legal representative to recover from third parties past medical expenses paid for by the Medicaid program.

(2) At the time an application for medical assistance is made, the department shall include a statement along with the application that explains that the applicant has assigned all of his or her rights as provided in this section and the legal implications of making this assignment.

(3) This assignment of rights does not extend to Medicare benefits.

(4) This section does not prevent the recipient or his or her legal representative from maintaining an action for injuries or damages sustained by the recipient against any third-party and from including, as part of the compensatory damages sought to be recovered, the amounts of his or her past medical expenses.

(5) The department shall be legally subrogated to the rights of the recipient against the third party.

(6) The department shall have a priority right to be paid first out of any payments made to the recipient for past medical expenses before the recipient can recover any of his or her own costs for medical care.

(7) A recipient is considered to have authorized all third-parties to release to the department information needed by the department to secure or enforce its rights as assignee under this chapter.

(c) *Notice requirement for claims and civil actions.*—

(1) A recipient's legal representative shall provide notice to the department within 60 days of asserting a claim against a third party. If the claim is asserted in a formal civil action, the recipient's legal representative shall notify the department within 60 days of service of the complaint and summons upon the third party by causing a copy of the summons and a copy of the complaint to be served on the department as though it were named a party defendant.

(2) If the recipient has no legal representative and the third party knows or reasonably should know that a recipient has no representation then the third party shall provide notice to the department within sixty days of receipt of a claim or within thirty days of receipt of information or documentation reflecting the recipient is receiving medicaid benefits, whichever is later in time.

(3) In any civil action implicated by this section, the department may file a notice of appearance and shall thereafter have the right to file and receive pleadings, intervene and take other action permitted by law.

(4) The department shall provide the recipient and the third party, if the recipient is without legal representation, notice of the amount of the purported subrogation lien within thirty days of receipt of notice of the claim. The department shall provide related supplements in a timely manner, but no later than fifteen days after receipt of a request for same.

(d) *Notice of settlement requirement.*—

(1) A recipient or his or her representative shall notify the department of a settlement with a third-party and retain in escrow an amount equal to the amount of the subrogation lien asserted by the department. The notification shall include the amount of the settlement being allocated for past medical expenses paid for by the Medicaid program. Within 30 days of the receipt of any such notice, the department shall notify the recipient of its consent or rejection of the proposed allocation. If the department consents, the recipient or his or her legal representation shall issue payment out of the settlement proceeds in a manner directed by the Secretary or his or her designee within 30 days of consent to the proposed allocation.

(2) If the total amount of the settlement is less than the department's subrogation lien, then the settling parties shall obtain the department's consent to the settlement before finalizing the settlement. The department shall advise the parties within 30 days and provide a detailed itemization of all past medical expenses paid by the department on behalf of the recipient for which the department seeks reimbursement out of the settlement proceeds.

(3) If the department rejects the proposed allocation, the department shall seek a judicial determination within 30 days and provide a detailed itemization of all past medical expenses paid by the department on behalf of the recipient for which the department seeks reimbursement out of the settlement proceeds.

(A) If judicial determination becomes necessary, the trial court is required to hold an evidentiary hearing. The recipient and the department shall be provided ample notice of the same and be given just opportunity to present the necessary evidence, including fact witness and expert witness testimony, to establish the amount to which the department is entitled to be reimbursed pursuant to this section.

(B) The department shall have the burden of proving by a preponderance of the evidence that the allocation agreed to by the parties was improper. For purposes of appeal, the trial court's decision should be set forth in a detailed order containing the requisite findings of fact and conclusions of law to support its rulings.

(4) Any settlement by a recipient with one or more third-parties which would otherwise fully resolve the recipient's claim for an amount collectively not to exceed $20,000 shall be exempt from the provisions of this section.

(5) Nothing herein prevents a recipient from seeking judicial intervention to resolve any dispute as to allocation prior to effectuating a settlement with a third party.

(e) *Department failure to respond to notice of settlement.*— If the department fails to appropriately respond to a notification of settlement, the amount to which the department is entitled to be paid from the settlement shall be limited to the amount of the settlement the recipient has allocated toward past medical expenses.

(f) *Penalty for failure to notify the department.*— A legal representative acting on behalf of a recipient or third party that fails to comply with the provisions of this section is liable to the department for all reimbursement amounts the department would otherwise have been entitled to collect pursuant to this section but for the failure to comply. Under no circumstances may a pro se recipient be penalized for failing to comply with the provisions of this section.

(g) *Miscellaneous provisions relating to trial.*—

(1) Where an action implicated by this section is tried by a jury, the jury may not be informed at any time as to the subrogation lien of the department.

(2) Where an action implicated by this section is tried by judge or jury, the trial judge shall, or in the instance of a jury trial, require that the jury, identify precisely the amount of the verdict awarded that represents past medical expenses.

(3) Upon the entry of judgment on the verdict, the court shall direct that upon satisfaction of the judgment any damages awarded for past medical expenses be withheld and paid directly to the department, not to exceed the amount of past medical expenses paid by the department on behalf of the recipient.

(h) *Attorneys' fees.*— Irrespective of whether an action or claim is terminated by judgment or settlement without trial, from the amount required to be paid to the department there shall be deducted the reasonable costs and attorneys' fees attributable to the amount in accordance with and in proportion to the fee arrangement made between the recipient and his or her attorney of record so that the department shall bear the pro-rata share of the reasonable costs and attorneys' fees: Provided, that if there is no recovery, the department shall under no circumstances be liable for any costs or attorneys' fees expended in the matter.

(i) *Class actions and multiple plaintiff actions not authorized.*— Nothing in this article shall authorize the department to institute a class action or multiple plaintiff action against any manufacturer, distributor or vendor of any product to recover medical care expenditures paid for by the Medicaid program.

(j) *Secretary's authority.* — The Secretary or his or her designee may compromise, settle and execute a release of any claim relating to the department's right of subrogation, in whole or in part.

West Virginia
State Medicaid Manual
Chapter 524

CHAPTER 524–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRANSPORTATION SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Attachment 3	Covered Codes for Transportation Services	08/10/05	09/15/05

SEPTEMBER 15, 2005

Attachment 3

Introduction: Made changes in procedure code reimbursement rate for Non-Ambulance Transportation.

Change: Changed reimbursement rate for procedure codes A0120 from $10.00 to $9.00 and S0215 with a reimbursement rate of $0.75 per mile each mile exceeding 15 to a rate of $0.66 per mile each mile exceeding 15.

Directions: Replace the pages containing these sections.

CHAPTER 524 COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR TRANSPORTATION SERVICES

TABLE OF CONTENTS

TOPIC **PAGE NO.**

Introduction 3
524.1 Specific Medicaid Enrollment Requirements 3
524.1.1 Air and Ground Ambulances 3
524.1.2 Non-Ambulance Transport Vehicles 4
524.1.2.a Specialized Multi-Passenger Van Transportation (SMPVT) 4
524.1.2.b Specialized Multi-Patient Medical Transport (SMPMT) 4
524.1.2.c Common Carriers and Individual Transportation 4
524.2 On Going Compliance 4
524.3 Covered Transportation Services 5
524.3.1 Air Ambulance Services 5
524.3.1.a Fixed Wing 5
524.3.1.b Rotary Wing 5
524.3.2 Ground Ambulance 6
524.3.2.a Advanced Life Support (ALS) 6
524.3.2.b Basic Life Support—Emergency 7
524.3.2.c Basic Life Support—Non-Emergency 7
524.3.3 Non-Ambulance Transportation 7
524.3.3.a Specialized Multi-Patient Medical Transport (SMPMT) 8
524.3.3.b Specialized Multi-Passenger Van Transport (SMPVT) 8
524.3.3.c Common Carrier 8
524.3.3.d Individual Transportation 9
524.3.4 Paramedic Intercept (PI) 9
524.4 Limitations, Conditions, and Special Circumstances 9
524.5 Non-Covered Transportation Services 9
524.6 Managed Care 10

524.7 Reimbursement and Billing 10

524.7.1 Code Modifiers 10

Attachment 1: Medical Necessity Chart for Ground Ambulance Services

Attachment 2: Form for Member/Provider Verification/Certification of Attendance at Scheduled Medical Appointment.

Attachment 3: West Virginia Medicaid Reimbursement Rates for Covered Transportation Services

CHAPTER 524–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRANSPORTATION SERVICES

INTRODUCTION

The WV Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise by the Bureau for Medical Services (BMS) in writing.

WV Medicaid covers and reimburses air and ground ambulance services rendered to Medicaid members, subject to medical necessity and appropriateness criteria. In addition, WV Medicaid covers the non-ambulance transportation of members to appropriate medical appointments for diagnostic and therapeutic services, subject to various requirements.

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV. The BMS in the WV Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the WV Medicaid Program.

524.1 SPECIFIC MEDICAID ENROLLMENT REQUIREMENTS

To enroll and participate in the WV Medicaid Program, a transportation provider must meet applicable general requirements in Chapter 300, as well as the specific requirements summarized here. The provider must also meet the certification requirements of Part B of the Medicare Program. Ambulance transportation providers must be licensed by and meet the personnel certification requirements of the WV Bureau for Public Health, Office of Emergency Medical Services (OEMS). Transportation providers must also comply with all applicable Federal and State laws, regulations, and certification requirements, including those established and regulated by the WV Public Service Commission (PSC).

All transportation providers shall have a valid and current WV business license, and remain current with Workers Compensation and Employment Security premiums and all State and local taxes. All participating patient transportation providers must have current coverage of errors and omissions liability and/or auto insurance liability of an amount not less than one million dollars or as required under current WV law. Copies of documentation verifying compliance must be submitted with application.

524.1.1 AIR AND GROUND AMBULANCES

In addition to the provider enrollment application, an ambulance transportation provider must submit a copy of its license as an Emergency Medical Services (EMS) agency by the WV Office of EMS and a copy of its Medicare Part B certification.

All vehicles and personnel must be in compliance with requirements as set forth by WV State Code §16-4C and WV Health Legislative Rule §64 CSR 48.

524.1.2 NON-AMBULANCE TRANSPORT VEHICLES

This category includes two types of specialty transport vehicles—specialized multi-passenger vans and specialized multi-patient medical transport vans along with common carriers and individual transportation.

524.1.2.a SPECIALIZED MULTI-PASSENGER VAN TRANSPORTATION (SMPVT)

Providers must submit a PSC Certificate of Convenience and Necessity to the Bureau for Medical Services at the time of application and with all changes and renewals. (Senior Services Centers may be exempt from PSC certification pursuant to W. Va. Code §24A-1-3(11)).

Multi-passenger van drivers must have current certification in first aid and CPR as evidenced by a certification document filed with the BMS Enrollment Unit. Re-certification documents are to be current, and kept on site and made available for review upon request by BMS or their authorized representative.

Multi-passenger van services must operate an approved multi-passenger vehicle as evidenced by a copy of the vehicle registration that must be filed with the Provider Enrollment Unit in the BMS. Standard passenger sedans and limousines are not acceptable as transportation vehicles for this category.

524.1.2.b SPECIALIZED MULTI-PATIENT MEDICAL TRANSPORT (SMPMT)

Applicants must submit a copy of their EMS agency license with their application. The applicant must meet and adhere to the requirements set forth in WV Health Legislative Rule §64 CSR 29.

524.1.2.c COMMON CARRIERS AND INDIVIDUAL TRANSPORTATION

The WV DHHR, Office of Family Support (OFS) administers these transportation programs through their county offices. Providers of these services do not need to register with the BMS enrollment unit. All services are subject to procedural requirements outlined in the OFS Income Maintenance Manual.

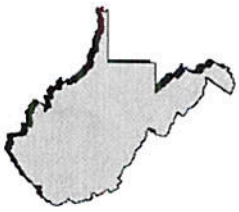
524.2 ONGOING COMPLIANCE

All transportation providers must maintain a valid and current WV business license, and remain in good standing with Workers Compensation and Employment Security Premiums and all State and local taxes. Documentation that verifies compliance with the requirements must be provided upon request to the BMS or its authorized representative.

Records and documentation that fully disclose the type, level, and volume of services provided must be maintained for 6 years from the date of service and made available upon request to the BMS. For ambulance services, the documentation must include a fully completed pre-hospital care record and any other required documents. For non-ambulance transportation services, the documentation must include the necessary signed certification verification forms as described in Section 524.30.3.

All participating transportation providers must maintain and be able to verify current errors and omissions liability and/or auto insurance liability coverage of an amount not less than one million dollars or as required under WV current law.

All transport vehicles must be inspected annually by appropriate regulatory authority and satisfy



the corresponding requirements. Additionally, providers must maintain their license and remain in good standing with the appropriate regulatory agency. Any modifications made to organization, personnel, or fleet must be submitted in writing to the enrollment unit of the WV Medicaid Program.

524.3 COVERED TRANSPORTATION SERVICES

The following is a list of WV Medicaid covered transportation services:

Patient Transportation Services	Patient Care Service	Classifications
Air Ambulance		1. Fixed Wing 2. Rotary Wing
Ground Ambulance		1. Advanced Life Support 2. Basic Life Support – Emergency 3. Basic Life Support - Non-emergency
Non-Ambulance Transportation		1. Specialized Multi-Passenger Van Transport 2. Specialized Multi-Patient Medical Transport 3. Common Carrier 4. Individual Transportation
	Paramedic Intercept	1. Advanced Life Support

NOTE: The fact that a medical provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Nor does it mean that the patient is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility before services are provided. Payment is based on the level of service provided and only when that level of service is medically necessary and within benefit limits.

524.3.1 AIR AMBULANCE SERVICES

WV Medicaid covers fixed wing and rotary wing transportation services for eligible members who need emergency transportation by an air ambulance.

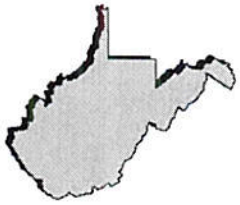
524.3.1.a FIXED WING

Transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a fixed wing air ambulance and is designed, constructed or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in WV Health Legislative Rules §64 CSR 48.

Transport by fixed wing may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude rapid delivery by ground transport to the nearest appropriate facility.

524.3.1.b ROTARY WING

Transportation by a helicopter that is certified by the FAA as a rotary wing ambulance and is designed, constructed or modified; equipped, maintained, appropriately staffed, and operated for the transportation of patients as provided and classified in WV Health Legislative Rules §64 CSR 48.



Transport by rotary wing may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude rapid delivery by ground transport to the nearest appropriate facility.

524.3.2 GROUND AMBULANCE

There are three levels of ground ambulance service—advanced life support (ALS), basic life support- emergency, and basic life support-non-emergency. Each level has it own medical necessity requirements, documentation standards, and payment rates. The patient care report must contain documentation to support the medical necessity for the level of transport service provided. Providers should use **Attachment 1** as a guideline to assist in determining medical necessity for ground ambulance services.

Current conditions or history that is not identified as a current disabling condition with ongoing or present limitations do not constitute a need for ambulance transport. Describing a patient as being "non-ambulatory," "bed confined," or needing "stretcher transport" without more specific description of the patient's condition, is not adequate documentation to support ambulance as the only means of transport that could be utilized without endangering the patient's health. A physician order for ambulance transportation does not negate the need for documentation describing the medical condition that necessitates ambulance transport, nor does a physician order for ambulance transportation guarantee that the transport is reimbursable by the WV Medicaid Program.

Medicaid reimbursement for ambulance services is based upon the patient's condition at the initial assessment by the ambulance squad and the medical intervention provided throughout the transport. The WV OEMS Patient Care Record provides the documentation to support the billing submitted to Medicaid. The documentation on this form should include all pertinent information regarding the patient's condition and support the need for transport as well as providing sufficient information to determine the appropriate level of service for billing.

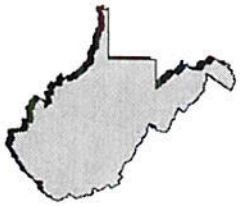
If a post payment review is conducted, decisions will be based on the documentation on the patient care record. This documentation should stand alone to verify billing. Supporting information regarding the patient's status gathered after the fact will not be considered in the review process.

524.3.2.a ADVANCED LIFE SUPPORT (ALS)

Transportation by ground ambulance and the provision of medically necessary supplies and services including the provision of an ALS assessment and at least one ALS intervention as defined in West Virginia State Code 16-4C, related legislative rules, and protocols established by the Office of Emergency Medical Services.

ALS service is deemed appropriate when the member has experienced a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to patient's health
2. Impairment to bodily functions, or
3. Serious dysfunction to any bodily organ or part.



ALS services are also deemed necessary and reasonable when a patient is transferred from one health care facility and admitted to another health care facility for treatment not available at the sending facility, and certified advanced life support personnel are needed to insure continuity of ALS medical care.

524.3.2.b BASIC LIFE SUPPORT - EMERGENCY

Transportation by ground ambulance and the provision of medically necessary supplies and services, including BLS ambulance services as defined in West Virginia State Code 16-4C, related legislative rules and protocols established by the Office of Emergency Medical Services.

An emergency transport is one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Serious jeopardy to patient's health
2. Impairment to bodily functions, or
3. Serious dysfunction to any bodily organ or part.

Personnel staffing and vehicles must conform to the requirements listed in WV Health Legislative Rule §64 CSR 48.

524.3.2.c BASIC LIFE SUPPORT - NON-EMERGENCY

Scheduled or unscheduled transports that do not meet the criteria for emergency as defined above, regardless of the origin or destination, are considered non-emergency services. Scheduled services are generally regularly scheduled transportation for the diagnosis or treatment of a patient's medical condition.

Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicaid ambulance benefits. It is simply one element of the member's condition that may be taken into account in the determination of medically necessary. The term "bed-confined" is not synonymous with "bed rest" or "non-ambulatory." Bed confined requires all the following criteria to be met:

- The member is unable to get up from bed without assistance
- The member is unable to ambulate
- The member is unable to sit in a chair or wheelchair.

Personnel staffing and vehicles must conform to the requirements listed in WV Health Legislative Rule §64 CSR 48.

524.3.3 NON-AMBULANCE TRANSPORTATION

There are two types of non-ambulance transportation services—Specialized Multi-Patient Medical Transport, which is provided in vans operated by EMS, and Specialized Multi-Passenger Van Transportation provided in all other approved multi-passenger vans.

In general, a provider of van transportation services must transport the member from the member's home to the scheduled medical service or from the location of the medical

appointment directly to the member's residence. The transporting company is responsible for maintaining records that verify the transport was appropriate and completed. **Mileage can only be calculated using the shortest, most direct route between the recipient's residence and medical facility.** Mileage cannot be accumulated over this distance even if recipient remains in vehicle while other recipients are being transported. Only those miles that exceed fifteen (15) miles are reimbursable.

If transportation to more than two medical appointments is scheduled on the same day, documentation that supports the additional transport(s) must be submitted for review to:

Bureau for Medical Services
Transportation Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707

Attachment 2 is an example of the form for Member/Provider Verification/Certification of Attendance at Scheduled Medical Appointment. This specific format does not have to be used, but all of the data required to complete the form must be collected for each trip and retained at the provider's location for review by the BMS when applicable.

524.3.3.a SPECIALIZED MULTI-PATIENT MEDICAL TRANSPORT (SMPMT)

Emergency medical services providers furnish Specialized Multi-Patient Medical Transport for ambulatory patients with a medical history, but who have no apparent immediate need for any level of medical supervision while being transported to and from scheduled medical appointments and as defined in WV Code 16-4-C. This category of provider submits claims directly to the BMS.

Ambulance companies that provide Multi-Patient Medical Transport Services must use vehicles that conform to definitions and requirements in Division of Health Rule (64 CSR 29-3.1.d.1).

524.3.3.b SPECIALIZED MULTI-PASSENGER VAN TRANSPORT (SMPVT)

Providers of Specialized Multi-Passenger Medical Transport services transport Medicaid members to and from medical appointments in a safe, sanitary, and comfortable manner. Providers of this service must have a Certificate of Convenience and Necessity from the WV Public Service Commission in order to participate in the WV Medicaid Program. The vehicles and personnel may not be utilized for the transportation of BLS or ALS medical patients. This category of provider submits claims directly to the BMS.

Medicaid-approved providers of multi-passenger van services are prohibited from identifying themselves in any way as ambulance services or entities associated with emergency medical services agencies. The organization or entity may not advertise or utilize a company name or logo that could be misinterpreted by the general public as having the capacity to provide medical care, or be construed as associated with an emergency medical service agency.

524.3.3.c COMMON CARRIER

Common carrier services are transportation services provided by public railways, buses, cabs, airlines or other common carriers at rates established by the WV Public Service Commission, or applicable Federal regulatory agency. The local DHHR office must prior approve these services

for Medicaid members.

524.3.3.d INDIVIDUAL TRANSPORTATION

The transportation of individual Medical members by a private vehicle is also reimbursed through the Non-Emergency Medical Transportation Program. The local DHHR reimburses for these services. The local DHHR office must approve in advance any room allowances or lodging and out-of-state travel by private automobile in order for these costs to be reimbursed.

524.3.4 PARAMEDIC INTERCEPT (PI)

Paramedic intercept refers to advanced life support (ALS) procedures performed by an EMS agency other than the EMS agency that provides transport. Under these circumstances, the EMS agency that provides basic life support and transportation may bill for the BLS services and loaded mileage. The EMS agency that assists and provides paramedic intercept ALS may bill for the ALS services at the established ALS add-on rate but no mileage. As an example, Agency X provides basic life support services to a critical patient. Agency X's crew requests an advanced life support unit to meet them on the way to the hospital. Agency Y's ALS unit responds to Agency X's request. Agency Y's paramedic boards Agency X's ambulance and provides ALS service while the patient is being transported to the hospital. Agency X will be reimbursed the current BLS rate and mileage, while Agency Y will be reimbursed at the current paramedic intercept rate (ALS add-on). Agency Y cannot bill for mileage since its unit did not transport the patient.

The exception would be if the patient were removed from the BLS unit and transported in the ALS unit. Then the EMS agency providing transport may bill for the ALS services and mileage, while the BLS agency would not have any billable services.

524.4 LIMITATIONS, CONDITIONS, AND SPECIAL CIRCUMSTANCES

WV Medicaid covers transportation services subject to the following limitations conditions, and special circumstances:

- Ground and air ambulances must transport the member to the nearest facility that has the appropriate equipment and personnel necessary to diagnose and treat the member.
- Ambulance transportation from one hospital to a more distant hospital must be for specialized medical care that is not available at the first hospital.
- Ambulance transportation to or from a helipad, airport or landing zone is covered when such transportation is provided in conjunction with air ambulance transport.

524.5 NON-COVERED TRANSPORTATION SERVICES

WV Medicaid does not cover or reimburse transportation services provided to Medicaid members under the following circumstances:

- Ground or air ambulance services beyond the nearest appropriate facility.
- Scheduled air ambulance transportation without prior approval.
- Same-day, round-trip, ambulance transportation from one medical facility to another.
- Transportation to any location that does not render covered medical, diagnostic, or

therapeutic services.

- Transportation of multiple Medicaid members in the same ambulance at the same time, unless an emergency warrants that multiple patients be transported, as in the case of mass casualty incidents. In this event, mileage may be billed as if only one patient was transported.
- Transportation using inadequate or inappropriate level of staff personnel on board transporting vehicle.
- Transportation of members who do not meet the medical necessity requirements for level of service billed.
- Transportation of patient's guardian or family members.

524.6 MANAGED CARE

Health Maintenance Organizations (HMOs) are responsible for all covered medically necessary scheduled and emergency ambulance trips that their Medicaid members require. The HMO is responsible for paying the costs associated with transporting a member when a life-threatening medical emergency exists, regardless of whether the particular ambulance is enrolled as a participant or contractor with the HMO.

Scheduled ambulance transportation services require HMO approval. Providers should follow the particular prior authorization rules of the member's HMO.

524.7 REIMBURSEMENT AND BILLING

Attachment 3 is a list of the procedure codes for covered transportation services and the corresponding WV Medicaid reimbursement rates.

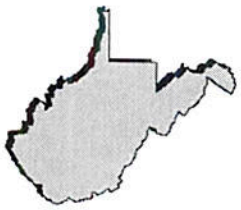
524.7.1 CODE MODIFIERS

Below is a list of the modifiers that are affixed to the procedure codes to indicate a trip's origin or destination. The appropriate code modifier must be entered in the proper space on the CMS-1500 claim form.

D	Diagnostic or therapeutic site
E	Residential, domiciliary, custodial facility
H	Hospital
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of an accident or acute event

The preceding codes are combined to report a trip's origin and destination of a member's trip. For example:

EH	From an extended care facility to a hospital
EP	From an extended care facility to a physician's office
HE	From a hospital to an extended care facility
HR	From a hospital to patient's residence
PH	From a physician's office to a hospital



RH From a patient's residence to a hospital
SH From the scene of an accident to a hospital
RPPR Van round trip from a member's residence to a physician's office and back to the member's residence

CHAPTER 524
TRANSPORTATION
SEPTEMBER 3, 2003

ATTACHMENT 1
MEDICAL NECESSITY CHART
FOR GROUND AMBULANCE SERVICES
PAGE 1 OF 6

MEDICAL NECESSITY

Ambulance Transportation

Note: The listed symptoms and transport suggestions are guidelines only and are not intended to be all-inclusive or to guarantee medical necessity and payment. The medical necessity and appropriate method transport must be determined on a case-by-case basis.

On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Abdominal pain	With other signs or symptoms	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding.	Advanced Life Support (ALS)
Abdominal pain	Without other signs or symptoms		Basic Life Support – Non-Emergency
Abnormal cardiac rhythm/ Cardiac dysrhythmia	Potentially life-threatening	Bradycardia, junctional and ventricular blocks, non-sinus tachycardias, PVC's >6/min., bi and trigeminy, vtach, vfib, atrial flutter, PEA, asystole.	Advanced Life Support (ALS)
Abnormal skin signs		Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled, other ALS emergency conditions.	Advanced Life Support (ALS)
Abnormal vital signs (includes abnormal pulse oximetry)	With symptoms	Other ALS emergency conditions.	Advanced Life Support (ALS)
Alcohol intoxication, drug overdose (suspected)	Unable to care for self; unable to ambulate; airway at risk, pharmacological intervention, cardiac monitoring		Advanced Life Support (ALS)
Alcohol intoxication, drug overdose (suspected)	Unable to care for self; unable to ambulate; no risk to airway; no other symptoms		Basic Life Support – Non-Emergency
Allergic reaction	Potentially life-threatening	Other ALS emergency conditions, rapid progression of symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing.	Advanced Life Support (ALS)
Allergic reaction	No life-threatening signs or symptoms	Hives, itching, rash, slow onset, local swelling, redness, erythema	Basic Life Support – Emergency
ALS monitoring required	Cardiac/hemodynamic monitoring required en route	Expectation monitoring is needed before and after transport	Advanced Life Support (ALS)
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
ALS monitoring required	IV meds required en route	Does not apply to self administered IV medications	Advanced Life Support (ALS)

Animal bites/sting/envenomation	Potentially life or limb-threatening	Symptoms of specific envenomation, significant face, neck, trunk, and extremity involvement; other ALS emergency conditions.	Advanced Life Support (ALS)
Animal bites/sting/envenomation	Not potentially life or limb-threatening	Local pain and swelling, special handling considerations and patient monitoring required	Basic Life Support – Emergency
Bed confined (at the time of transport)	Unable to get up from bed without assistance; and Unable to ambulate; and Unable to sit in a chair or wheelchair	Patient is being transported to medical facility for treatment, medical procedure, testing, or evaluation that is medically necessary and reimbursable by Medicaid. Also included are: admissions to and discharges from hospitals, nursing homes or other medical facilities.	Basic Life Support – Non-Emergency
Blood glucose	Abnormal - <80 or >250, with symptoms.	Altered mental status, vomiting, signs of dehydration, etc.	Advanced Life Support (ALS)
Burns	Major – per ABA	Partial thickness burns >10% TBSA; involvement of face, hands, feet, genitalia, perineum, or major joints; third degree burns; electrical, chemical; inhalation burns with preexisting medical disorders; burns and trauma	Advanced Life Support (ALS)
Burns	Minor – per ABA	Burns other than those listed in ALS	Basic Life Support – Emergency
Cardiac Arrest – Resuscitation in progress			Advanced Life Support (ALS)
Cardiac symptoms other than chest pain	Atypical pain or other symptoms	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom and other ALS emergency conditions	Advanced Life Support (ALS)

On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Choking episode		Partial or complete airway obstruction	Advanced Life Support (ALS)
Cold exposure	Potentially life or limb threatening	Body temperature <95° F, deep frost bite, other emergency conditions.	Advanced Life Support (ALS)
Cold exposure	With symptoms	Shivering, superficial frost bite, and other emergency conditions	Basic Life Support – Emergency
Convulsions/Seizures	Seizing, immediate post-seizure, or at risk of seizure & requires medical monitoring/observation.		Advanced Life Support (ALS)
Difficulty breathing	With signs and symptoms	Other ALS emergency conditions.	Advanced Life Support (ALS)

Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations		Basic Life Support – Emergency
Heat exposure	Potentially life-threatening	Hot and dry skin, Temp >105° F, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other ALS emergency conditions	Advanced Life Support
Heat exposure	With symptoms	Muscle cramps, profuse sweating, fatigue	Basic Life Support – Emergency
Hemorrhage	Severe (quantity)	Active, uncontrolled bleeding with significant signs of shock, Active vaginal, rectal, or post-surgical bleeding, hematemesis, hemoptysis, epistaxis, other emergency conditions.	Advanced Life Support (ALS)
Infectious diseases requiring isolation procedures/public health risk			Basic Life Support – Non-Emergency
Medical device failure	Life or limb threatening malfunction, failure, or complication	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device	Advanced Life Support (ALS)
Medical conditions that may contraindicate transport by other means	Patient safety: Danger to self or others. Seclusion (Flight risk)	Behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely.	Basic Life Support – Non-Emergency
Medical conditions that may contraindicate transport by other means	Patient safety. Danger to self and others. In restraints.		Basic Life Support – Emergency
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Medical conditions that may contraindicate transport by other means	Special handling en route; Orthopedic device	Backboard, halotraction, use of pins and traction etc.	Basic Life Support – Non-Emergency
Medical Device Failure	Health maintenance device failures	0_2 supply malfunction	Basic Life Support – Emergency
Near Drowning			Advanced Life Support (ALS)
Neurological distress	Facial drooping; loss of vision; aphasia; difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations, paralysis, paresis (focal weakness; abnormal movements; vertigo; unsteady gait/balance; slurred speech, unable to speak		Advanced Life Support (ALS)
Pain, severe not otherwise specified in this list	Acute onset, unable to ambulate or sit	Patient receiving out-of-hospital pharmacologic intervention	Advanced Life Support (ALS)
Pain, severe, not otherwise specified in this list	Acute onset, unable to ambulate or sit	Pain is the reason for the transport	Basic Life Support – Emergency
Poisons, ingested, injected, inhaled, absorbed	Adverse drug reaction, poison exposure by inhalation, injection or absorption		Advanced Life Support (ALS)

Post-operative procedure complications	Major wound dehiscence, evisceration, or requires special handling for transport	Orthopedic appliance; prolapse	Basic Life Support – Emergency
Pregnancy complication/ abnormal delivery		High risk delivery, newborn distress, other ALS emergency conditions	Advanced Life Support (ALS)
Pregnancy/labor/normal delivery			Basic Life Support – Emergency
Psychiatric/Behavioral	Abnormal mental status; drug withdrawal	Suicidal, homicidal, hallucinations, violent, disoriented, DT's, withdrawal symptoms, transport required by state law/court order	Basic Life Support – Emergency
Psychiatric/Behavioral	Threat to self or others, severe anxiety, acute episode or exacerbation of paranoia, or disruptive behavior		Basic Life Support – Non-Emergency
Respiratory arrest		Apnea, hypoventilation requiring ventilatory assistance and airway management.	Advanced Life Support (ALS)
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Trauma, major	As defined by ACS field triage decision scheme	Trauma with two or more of the following conditions: Glasgow <12; systolic BP <90; RR <10 or >29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; pelvic fracture; 2 or more long bone fractures; paralysis; severe mechanism of injury including ejection, death of another passenger in same compartment as patient, falls >20 feet, 20" deformity of passenger compartment, auto vs. pedestrian/bike, motorcycle accident at speeds >20 mph and rider separated from vehicle	Advanced Life Support (ALS)
Trauma	Need to monitor or maintain airway	Decreased LOC, bleeding into airway; trauma to head, face, or neck	Advanced Life Support (ALS)
Trauma	Major bleeding	Uncontrolled or significant bleeding with significant hemodynamic changes	Advanced Life Support (ALS)
Trauma	Amputation (other than digits)		Advanced Life Support (ALS)
Trauma	Suspected internal, head, chest, or abdominal injuries	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdomen signs on exam, internal bleeding criteria, evisceration	Advanced Life Support (ALS)

Trauma	Severe pain requiring pharmacologic pain control		Advanced Life Support (ALS)
Trauma	Suspected fracture/dislocation requiring splinting/immobilization for transport	Spinal, long bones, and joints, including shoulder elbow, wrist, hip, knee, and ankle deformity of bone or joint	Basic Life Support – Emergency
On-scene condition (general)	On-scene condition (specific)	Comments and examples (not all inclusive)	Level of Service
Trauma	Amputation – digits		Basic Life Support – Emergency
Trauma	Penetrating extremity injuries	Isolated with bleeding stopped and good CSM	Basic Life Support – Emergency
Unconscious, Fainting, Syncope	Transient unconscious episode or found unconscious	With other ALS emergency conditions	Advanced Life Support (ALS)

CHAPTER 524

TRANSPORTATION

SEPTEMBER 1, 2003

ATTACHMENT 2

FORM FOR MEMBER/PROVIDER VERIFICATION/CERTIFICATION OF ATTENDANCE AT SCHEDULED MEDICAL APPOINTMENT

RECIPIENT/PROVIDER VERIFICATION/CERTIFICATION OF ATTENDANCE AT SCHEDULED MEDICAL APPOINTMENT

The West Virginia Medicaid Program reimburses approved providers for non-ambulance non-emergency medical transportation of Medicaid eligible individuals to scheduled medical appointments. Such reimbursement is allowed only after the transportation has been provided, and recipient attendance at the scheduled medical service verified. By affixing their signatures below on this document, the medical service provider, transportation provider, and Medicaid recipient certify that the named Medicaid recipient attended a scheduled medical appointment with the named medical provider, transported by the named transportation provider, on the date or dates indicated on this form.

Date of Scheduled Medical Appointment: ____/____/____ Appointment Time: _____:_____ AM/PM

Patient's Name:_____ Medicaid I.D. Number_____

Name and Address of Medical Vendor:_____

_____

Name and Address of Transportation Provider:_____

_____

Vehicle Identification:_____

Time of Client Pickup:_____:_____AM/PM Mileage at Point of Pickup:_____

Time of Client Drop-off:_____:_____AM/PM Mileage at Point of Drop-off:_____

I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Signature of Medical Vendor's Representative:_____Date:____/____/____

Signature of Driver:_____ Date:____/____/____

Signature of Medicaid Patient:_____Date:____/____/____

Revised 05/03

BMS Form 26-01

CHAPTER 524
TRANSPORTATION
SEPTEMBER 1, 2003

ATTACHMENT 3
WEST VIRGINIA MEDICAID REIMBURSEMENT RATES FOR COVERED TRANSPORTATION SERVICES

REVISED SEPTEMBER 15, 2005

Air Ambulance-Rotary Wing

Code	Item	Description	Payment Rate
A0431	Base rate	All inclusive	$940.00
A0436	Mileage	Distance patient transported	$25.00 per mile
A0021	Ground transport	Out of State	Up to $350.00 per occurrence

Air Ambulance - Fixed Wing

Code	Item	Description	Payment Rate
A0430	Base rate	All inclusive	$972.00
A0435	Mileage	Distance patient transported	$9.00 per mile
A0021	Ground transport	Out of State	Up to $350.00 per occurrence

Ground Ambulance - Basic Life Support Emergency

Code	Item	Description	Payment Rate
A0429	Base rate	BLS, emergency transport	$112.50
A0422	Oxygen	Unit rate	$25.00 per unit up to a $100.00 maximum
A0425	Mileage	Distance patient transported	$3.80 per mile

Advanced Life Support

Code	Item	Description	Payment Rate
A0426	Base Rate	ALS, non-emergency transport	$377.50
A0427	Base Rate	ALS, emergency transport (level 1)	$377.50
A0433	Base Rate	ALS, emergency transport (level 2)	$377.50
A0425	Mileage	Distance patient transported	$3.80 per mile

Basic Life Support Non-emergency

Code	Item	Description	Payment Rate
A0428	Base rate	All inclusive	$90.00
A0425	Mileage	Distance patient transported	$3.80 per mile

Non-Ambulance Transportation

a. Specialized Multi-Patient Medical Transport (SMPMT)

b. Specialized Multi-Passenger Van Transport (SMPVT)

Code	Item	Description	Payment Rate
A0120	Base rate	Transportation to and/or from therapeutic or diagnostic medical service that is covered by Medicaid.	$9.00
S0215	Mileage	Mileage exceeding 15 miles	$0.66 per each mile over 15

Common Carrier

- PSC approved rate per mile

Private Vehicle

- State travel allowance per mile
- Turnpike fees
- $5 for certain meals
- Economic room allowances

Paramedic Intercept

Code	Item	Description	Payment Rate
S0207	Base rate	Hospital based EMS agency	$265.50
S0208	Base rate	Non-hospital based EMS agency	$265.50

West Virginia Bureau for Children And Families Income Maintenance Manual Chapter 27

27.1 INTRODUCTION 1

27.2 APPLICATION/REDETERMINATION PROCESS 2

A. CONTENT OF THE INTERVIEW 2

B. AGENCY DELAYS 2

C. BEGINNING DATE OF ELIGIBILITY 2

D. REDETERMINATION SCHEDULE 2

E. THE BENEFIT 3

F. EXPEDITED PROCESSING 3

G. THE APPLICATION FORM 3

27.3 THE CASE MAINTENANCE PROCESS 5

A. CLOSURES 5

B. CHANGE IN INCOME 5

C. UPDATE OF CASE INFORMATION 5

27.4 DATA EXCHANGE 6

27.5 VERIFICATION 7

27.6 RESOURCE DEVELOPMENT 8

27.7 CLIENT NOTIFICATION 9

27.8 COMMON ELIGIBILITY REQUIREMENTS 10

A. RESIDENCE 10

B. CITIZENSHIP AND ALIEN STATUS 10

C. COOPERATION WITH QUALITY CONTROL (QC) 10

D. LIMITATIONS ON RECEIPT OF OTHER BENEFITS 10

E. NON-DUPLICATION OF BENEFITS 10

F. ENUMERATION 10

27.9 ELIGIBILITY DETERMINATION GROUPS 11

A. THE ASSISTANCE GROUP (AG) 11

B. THE INCOME GROUP 11

C. THE NEEDS GROUP 11

27.10 INCOME 12

27.11 ASSETS 13

27.12 WORK REQUIREMENTS 14

27.13 SPECIFIC ELIGIBILITY REQUIREMENTS 15

A. EXCEPTIONS TO ELIGIBILITY 15

B. TRANSPORTATION REQUIRING PRIOR APPROVAL FROM BMS 15

C. REQUESTS WHICH REQUIRE APPROVAL BY THE WORKER 16

D. ROUTINE AUTOMOBILE TRANSPORTATION REQUESTS 16

E. REQUESTS FOR TRANSPORTATION FOR EMERGENCY ROOM SERVICES 17

F. APPROVED TRANSPORTATION PROVIDERS 17

G. DETERMINING THE AMOUNT OF PAYMENT 17

1. Mileage 18
2. Common Carrier 18
3. Lodging 19
4. Meals 20
5. Related Expenses 20
6. Limitations and Restrictions 20

27.14 BENEFIT REPAYMENT 21

27.15 BENEFIT REPLACEMENT 22

APPENDIX A HOSPITALS WITH BORDER STATUS FOR MEDICAID A-1

APPENDIX B PUBLIC FORMS B-1

DFA-NEMT-1, NEMT Application
DFA-NEMT-1A, Supplement to NEMT Application

27.1 INTRODUCTION

Non-emergency medical transportation (NEMT) is a reimbursement program for recipients of Medicaid and Children with Special Health Care Needs (CSHCN) for the cost of transportation and other expenses associated with receiving medical services.

Since the program is intended for reimbursement only, payment in advance of a scheduled appointment is not appropriate and cannot be issued from RAPIDS.

27.2 APPLICATION/REDETERMINATION PROCESS

A. CONTENT OF THE INTERVIEW

A face-to-face interview is not required in order to apply for NEMT reimbursement. The DFA-NEMT-1 is designed to be completed by the applicant.

If an interview is conducted due to the need for prior approval and an emergency situation exists, the Worker obtains all information required on the DFA-NEMT-1 and as required in Section 27.13.

B. AGENCY DELAYS

The Worker must process applications received for travel upon receipt, provided the date for which reimbursement is being requested occurred no earlier than 60 days prior to the date of application. Delay caused by failure on the part of the agency to process an application in a timely manner, is not a reason to deny payment.

C. BEGINNING DATE OF ELIGIBILITY

Medicaid recipients are eligible for NEMT beginning the first day of the month for which Medicaid is approved, including months for which backdating occurred. Applicants awaiting approval must be instructed to apply for NEMT within the 60-day time limit, but applications must be held by the Worker until Medicaid is approved except for transportation expenses related to an appointment(s) scheduled by the Worker and/or requested by MRT.

When a client is pending Medicaid approval and has not been instructed by the Worker to apply for NEMT within the 60-day time limit, that client must be given a reasonable amount of time to submit NEMT applications for the time prior to Medicaid approval.

Recipients of CSHCN and others who qualify for reimbursement of transportation expenses are eligible as determined by the program which provides the medical services.

D. REDETERMINATION SCHEDULE

There is no redetermination process for NEMT other than that for Medicaid. Each request for reimbursement is treated as a separate application.

E. THE BENEFIT

Services provided under this program include reimbursement for transportation and certain related expenses necessary to secure medical services normally covered by Medicaid. Funding for this program is provided by three different sources:

- Title XIX funds for all Medicaid recipients, including foster children,
- Title V funds for non-Medicaid eligible recipients of the Children with Special Health Care Needs Program (CSHCN), and
- Agency administrative funds for applicants for cash assistance or Medicaid who need a physical examination in order to complete the eligibility process.

Reimbursement for transportation and related expenses is available to Medicaid recipients who:

- Require transportation to keep an appointment for medical services covered under the Medicaid group for which he was approved;
- Receive scheduled Medicaid-covered services at a clinic, hospital or doctor's office;
- Receive pre-authorization as necessary; and
- Comply with the 60-day application submittal deadline.

Reimbursement is also available for applicants for Medicaid who must travel to obtain necessary medical examinations and tests required to determine eligibility. See Section 27.13 for specific eligibility requirements.

F. EXPEDITED PROCESSING

Procedures for expedited processing do not apply to NEMT.

G. THE APPLICATION FORM

The required form for all Medicaid recipients, including ART clients, is the DFA-NEMT-1. It must be completed by the recipient or by a parent, guardian or other responsible person when the recipient is a child or an incapacitated adult. The form is mailed or brought to the recipient's local DHHR office.

The ART client completes the DFA-NEMT-1 and submits it to the Designated Care Coordinator (DCC) for verification and approval. In addition, the DCC may

sign the application in lieu of the doctor or his designee when the DCC has verified the appointment was kept. The approved DFA-NEMT-1 is then forwarded to DHHR by the DCC for processing. The same 60-day deadline for submission applies to ART clients and other Medicaid recipients as well.

The medical service provider, his designee or the DCC is required to sign the section verifying that the individual had an appointment and was seen for Medicaid-covered treatment or services. Medical service providers include doctors, nurses, nurse practitioners, physicians' assistants, lab technicians, and others who perform a Medicaid-covered service. The DCC may sign in place of the physician or his designee routinely. There is no requirement that the client fail to obtain the signature of the physician or designee in order for the DCC to sign the form. Only when the form is signed by the DCC is it used to verify the reimbursement amount and that the appointment for a Medicaid-covered service was kept.

When prior approval is required for out-of-state travel, the applicant may apply in person at the local DHHR office so that the required documentation can be made and/or obtained. Coordination of the process may be facilitated by telephone and/or fax with BMS and the physician, as necessary.

The form may be used for verification of up to 4 trips. Each trip date must be entered in the space titled "Date of Appointment." Regardless of the number of trips included on the form, payment for any trips which occurred more than 60 days prior to the date the form is submitted to DHHR for payment must be denied. See Section 27.2,C for exceptions.

As noted above, the submission deadline for the completed DFA-NEMT-1 is 60 days from the date of the trip(s). Compliance is determined by comparing the date of the earliest trip entered on the form with the date the application is received by DHHR for processing.

Altered forms which include questionable entries will result in denial of the application, unless the Worker is able to resolve the discrepancies. Items which have been corrected must be initialed by the applicant or other person providing the information.

27.3 THE CASE MAINTENANCE PROCESS

A. CLOSURES

The AG is ineligible for NEMT when Medicaid is closed.

B. CHANGE IN INCOME

Changes in income that do not affect Medicaid eligibility have no effect on NEMT.

C. UPDATE OF CASE INFORMATION

Updates in case information are not required for NEMT, except when such changes affect Medicaid eligibility.

27.4 IEVS

IEVS is not used for NEMT.

27.5 VERIFICATION

Specific requirements for verification of travel expenses are included on the DFA-NEMT-1. Forms submitted by a DCC for the ART program are considered verified and approved for payment.

Additional verification is not required, unless the Worker has reason to suspect misuse or abuse of the program. When deemed necessary, policy in Section 27.14 applies.

27.6 RESOURCE DEVELOPMENT

NEMT recipients are assumed to have met requirements to develop resources under Medicaid eligibility guidelines, including application for Medicare, as appropriate.

27.7 CLIENT NOTIFICATION

Notification of the decision for NEMT applications must be received by the client no later than 30 days following the date the application is received by DHHR.

27.8 COMMON ELIGIBILITY REQUIREMENTS

A. RESIDENCE

All applicants for NEMT must be residents of West Virginia.

B. CITIZENSHIP AND ALIEN STATUS

Applicants must be citizens of the United States or be qualified aliens in accordance with Chapter 18.

C. COOPERATION WITH QUALITY CONTROL (QC)

NEMT is not reviewed by QC. However, Medicaid recipients who fail to cooperate with QC and lose their Medicaid no longer qualify for NEMT.

D. LIMITATIONS ON RECEIPT OF OTHER BENEFITS

Except for the requirement to be a Medicaid recipient or covered by the qualifying programs listed in Section 27.2. NEMT is not affected by the receipt of any other benefits.

E. NON-DUPLICATION OF BENEFITS

Applications submitted for trips or other expenses which have already received reimbursement from any other source are denied.

HCB, TBI and I/DD Waiver Medicaid recipients may have some transportation costs billed directly to BMS up to a set mileage limit. The Worker must verify if BMS has paid before issuing NEMT payment to any Waiver Medicaid recipients.

F. ENUMERATION

A valid SSN is required.

27.9 ELIGIBILITY DETERMINATION GROUPS

A. THE ASSISTANCE GROUP (AG)

The AG is the individual(s) for whom transportation is required.

B. THE INCOME GROUP (IG)

The IG is the same as for Medicaid in each coverage group.

C. THE NEEDS GROUP (NG)

The NG is the same as for Medicaid in each coverage group.

27.10 INCOME

There are no specific income guidelines for NEMT. Medicaid recipients and those who meet guidelines for reimbursements under other programs are considered income-eligible for NEMT.

27.11 ASSETS

There are no specific asset limits for NEMT as applicants with valid Medicaid coverage are considered to meet applicable asset tests.

27.12 WORK REQUIREMENTS

There are no work requirements for NEMT.

27.13 SPECIFIC ELIGIBILITY REQUIREMENTS

A. EXCEPTIONS TO ELIGIBILITY

The following individuals are not eligible for NEMT:

- Individuals designated only as Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLIMB), or Qualified Disabled Working Individuals (QDWI) and who are not dually eligible for any full-coverage Medicaid group.

- Medicaid public school patients being transported to schools for the primary purpose of obtaining an education, even though Medicaid-reimbursable school-based health services are received during normal school hours, except for children receiving services under the Individuals with Disabilities Education Act (IDEA) when the child receives transportation for a Medicaid-covered service and both the transportation and service are included in the child's Individualized Education Plan (IEP).

- WV CHIP recipients.

Reimbursement is not approved for trips to pick up medicine, eye glasses, dentures or medical supplies or for repairs or adjustments to medical equipment.

When services are paid for by any other program, or otherwise not charged to Medicaid, NEMT is not approved.

When other reimbursement is available, Medicaid is always the last payer.

Reimbursement is not approved for services normally provided free to other individuals.

B. TRANSPORTATION REQUIRING PRIOR APPROVAL FROM BMS

All requests for out-of-state transportation and certain related expenses must have prior approval from the Bureau for Medical Services, Case Planning Unit, except for travel to those facilities which have been granted border status. Facilities granted border status are considered in-state providers. The current list of providers with border status is located in Chapter 27, Appendix A. The Worker must contact Provider Enrollment at (888) 483-0793 for the status of any facility not listed.

Requests to the Case Planning Unit are made in writing when time permits, or by telephone, and must include the following information:

- The Medicaid recipient's name, address and case number,

- The physician's order for the service, including any necessary documentation, as well as the following related items:

  - The specific medical service requested
  - Where the service will be obtained, who will provide it, and the reason why an out-of-state provider is being used
  - The diagnosis, prognosis and expected duration of the medical service; and
  - A description of the total round-trip cost of transportation and any related expenses (lodging, meals, tolls, parking, etc.).

NOTE: Individuals who receive both Medicare and Medicaid do not require prior approval for out-of-state transportation.

C. REQUESTS WHICH REQUIRE APPROVAL BY THE WORKER

The following must be approved by the local DHHR Worker:

- Transportation of an immediate family member (parent, spouse, or child of the patient) to accompany and/or stay with the patient at a medical facility when the need to stay is based on medical necessity and documented by the physician. Exceptions require supervisory approval.
- Two round trips per hospitalization (1 for admittance and 1 for discharge) when the parent or family member chooses not to stay with the patient
- Lodging
- Meals only when lodging is approved
- Transportation via common carrier judged to be the most economical. If the applicant insists on incurring expenses beyond those approved by the Department, the Worker must inform the applicant that such costs will not be reimbursed.

Travel for parents/children to visit or participate in a treatment plan for hospitalized individuals is not authorized when it does not coincide with the patient's travel.

D. ROUTINE AUTOMOBILE TRANSPORTATION REQUESTS

Applicants may request reimbursement for costs related to automobile travel, such as mileage, tolls, and parking fees when free parking is not available. The travel must be for scheduled appointments and treatment. Mileage is paid from

the patient's home to the facility and back to the home. When comparable treatment may be obtained at a facility closer to the patient's home than the one he chooses, mileage reimbursed is limited to the distance to the nearest facility. The client's statement about the availability of a closer facility is accepted unless the information is questionable. See Determining the Amount of Payment below.

Meals are not reimbursed for any travel which does not include an overnight stay.

When travel by private automobile is an option, but the applicant chooses more costly transportation, the rate of reimbursement is limited to the private auto mileage rate.

When the applicant chooses to rent an automobile and submits the costs of the rental and connected fees, when the total is less than the private mileage rate, the lower cost is paid.

Applicants must car-pool when others in the household have appointments the same day at the same facility.

Round trips are limited to 1 per household per day. Parents must make an effort to schedule appointments for children at the same time or on the same day whenever possible.

E. REQUESTS FOR TRANSPORTATION FOR EMERGENCY ROOM SERVICES

Applicants who use emergency rooms for routine medical care are not reimbursed for transportation. When the Worker documents that emergency room treatment was necessary, he may approve the NEMT application and record the reason for the approval, including whether or not the individual's physician was involved in the decision to go to the emergency room.

F. APPROVED TRANSPORTATION PROVIDERS

The least expensive method of transportation must always be considered first and used, if available.

Providers are listed below in the order in which they must be considered. Applicants who choose a more expensive method than the one available are reimbursed at the least expensive rate.

- The patient or a member of his family, friends, neighbors, interested individuals, foster parents, adult family care providers or volunteers
- Volunteers or paid employees of community-based service agencies such as Community Action and Senior Services
- Common carriers (bus, train, taxi or airplane)

- An employee of DHHR, with supervisory approval only, after it is determined that no other provider is available

NOTE: If the status of a provider is questionable, contact the Policy Unit for assistance.

G. DETERMINING THE AMOUNT OF PAYMENT

The amount of reimbursement for transportation expenses depends on the method of transportation, the round-trip mileage and/or whether lodging was required.

Payment may be authorized for 1 round trip per patient per day with a maximum of 2 round trips per hospital admission. Exceptions require documentation of medical necessity and Supervisory approval.

1. Mileage

Round-trip mileage from the patient's home to the medical facility is paid at the current state mileage reimbursement rate. If more than one patient was transported, payment is approved for one trip only. The round trip must be made over the shortest route, as determined by a road map or certified odometer reading. The Worker may use the applicant's statement of the total mileage, unless the amount appears incorrect.

The Worker is encouraged to combine applications for trips to avoid issuing numerous checks for small amounts. A single check may be written to the applicant, who is then responsible for reimbursing the drivers if they have not already been paid. Case comments must reflect that mileage claimed is for more than one trip and may be for more than one provider.

As stated above, mileage is limited to the nearest comparable facility for routine services such as allergy shots, blood pressure readings, etc., when the physician has not specified that a specific facility must be paid.

NOTE: The client's choice of physician cannot be restricted. See Benefit Repayment Section below for additional information.

2. Common Carrier

When a common carrier is the provider, the established round-trip fare is paid. The cost of waiting time is paid only when travel between cities is required. This waiting time is permitted only for obtaining medical

services. When waiting time is claimed, the Worker must obtain a dated and signed statement from the taxi company indicating the rate, elapsed time, and total charges for the waiting time.

3. Lodging

When an overnight or longer stay is required, lodging may be paid for the patient and one additional person if the patient is not the driver. Accommodations must be obtained at the most economical facility available. Resources such as Ronald McDonald Houses or facilities operated by the hospital must be used whenever possible.

West Virginia currently has three Ronald McDonald Houses which invoice the Department directly for payment. The client must not be reimbursed unless he provides a receipt to verify he made the payment. Their addresses, telephone numbers, and the medical facilities with which they are affiliated are as follows:

- Ronald McDonald House of Southern WV, Inc.
  302 - 30th Street
  Charleston, WV 25304
  Telephone Number: (304) 346-0279
  Hospital affiliate: CAMC

- Ronald McDonald House
  Charities of the Tri-State, Inc.
  1500 17th Street
  Huntington, WV 25701
  Telephone Number: (304) 529-2970
  Hospital affiliates: Cabell-Huntington Hospital and St. Marys Hospital

- Ronald McDonald House of Morgantown
  841 Country Club Drive
  Morgantown, WV 26505
  Telephone Number: (304) 598-0050
  Hospital affiliates: Chestnut Ridge Hospital, Monongalia General Hospital, Ruby Memorial Hospital, and Mountaineer Rehabilitation Center

Lodging prior to the day of the appointment is determined necessary when the appointment is scheduled for 8:00 a.m. or earlier and travel time to the facility is 2 hours or more from the patient's home. It may also be determined necessary when the patient is required to stay overnight to receive additional treatment. Exceptions require Supervisory approval.

4. Meals

Reimbursement for meals is available only in conjunction with lodging and only for meals which occur during the time of the travel or the stay. Meals are permitted for the patient and/or the person approved to stay with the patient. The rate is $5 per meal per person, regardless of which meals the reimbursement covers. In order to determine which meals to include, the Worker must know the time the trip started and when the patient returned home.

5. Related Expenses

Reimbursement may be made for other travel-related expenses, such as turnpike tolls and parking fees. Parking is limited to $3 per day when free parking is not available within reasonable walking distance of the facility. A receipt is required. Metered parking is limited to $2 per day with no receipt required.

6. Limitations and Restrictions

Anyone may volunteer to provide transportation for Medicaid recipients for reimbursement of expenses only. However, DHHR does not reimburse any volunteer for more than 6,000 miles in any calendar year except as follows:

- No public transportation is available and the recipient does not drive and has no one else who can provide transportation; and/or

- The patient requires frequent medical treatment (such as dialysis, chemotherapy, etc.) and local staff has approved the continued use of the same provider.

NOTE: A volunteer is a person, other than the client, his family or friends, that provides transportation to medical appointments for Medicaid recipients. The 6,000 mile limit does not apply to family or friends who have been selected by the Medicaid recipient to provide the transportation. The limit does not apply to common carriers.

Employees of entities that provide Medicaid services (homemaker, behavioral health, rehabilitation providers, etc.) cannot be reimbursed as NEMT providers when transporting individuals while "on the clock" or otherwise during official business hours.

27.14 BENEFIT REPAYMENT

There is currently no repayment procedure for NEMT. However, recipients must be informed that fraudulent claims will result in denial of subsequent requests up to the amount of the claim and could result in permanent ineligibility for NEMT.

Workers who become aware that a client may be obtaining NEMT reimbursements to which he is not entitled must monitor all applications from the client to determine if misuse or abuse of the program is actually taking place. Any information deemed questionable must be verified, even if not routinely required.

If the Worker has reason to suspect that reimbursement is being requested for trips that were not taken, he must contact the medical provider(s) listed and verify appointment dates and whether or not the appointments were kept.

Unless the Worker has sufficient reason to suspect misuse or abuse, and/or finds reasonable proof that misuse or abuse has occurred, properly completed and signed applications will be assumed to be correct.

27.15 BENEFIT REPLACEMENT

See Chapter 21 for the replacement of a WV WORKS Supportive Service payments and Medicaid NEMT checks. The DF-36 must reflect that the check is for NEMT.

APPENDIX A

HOSPITALS WITH BORDER STATUS FOR MEDICAID

KENTUCKY

King's Daughters Medical Center, Ashland

Our Lady of Bellefonte Hospital, Ashland

Pikeville Methodist Hospital

Three Rivers Medical Center, Louisa

University of Kentucky Hospital, Lexington

Williamson ARH Hospital, South Williamson

MARYLAND

Cumberland Memorial Hospital

Frederick Memorial Hospital, Cumberland

Garrett County Memorial Hospital, Oakland

Johns Hopkins Bayview Medical Center, Baltimore

Johns Hopkins Medical Center, Baltimore

Sacred Heart Hospital, Cumberland

Washington County Hospital, Hagerstown

NORTH CAROLINA

Duke University Medical Center, Durham

North Carolina Baptist Hospital, Winston-Salem (Wake Forest)

OHIO

Arthur G. James Cancer Hospital and Research Institute, Columbus

Belmont Community Hospital, Bellaire

Cincinnati Children's Hospital Medical Center

Cleveland Clinic

Columbus Children's Hospital

Convalescent Hospital for Children, Cincinnati

East Liverpool City Hospital

East Ohio Regional Hospital, Martin's Ferry

Holzer Medical Center, Gallipolis

Lawrence County General Hospital, Ironton

Marietta Memorial Hospital

Marietta Memorial Rehabilitation Center

Ohio State University Medical Center, Columbus

Selby General Hospital, Marietta

Trinity Medical Center, Steubenville

Veteran's Memorial Hospital, Pomeroy

PENNSYLVANIA

Allegheny General Hospital, Pittsburgh

Children's Hospital, Pittsburgh

Magee-Women's Hospital, Pittsburgh

Medical Center, Beaver

Mercy Hospital, Pittsburgh

North Hills Passavant Hospital, Pittsburgh

St. Francis Medical Center, Pittsburgh

United Community Hospital, Grove City

University of Pittsburgh Medical Center UPMC Presbyterian, Pittsburgh UPMC Shadyside, Pittsburgh Western Pennsylvania Hospital, Pittsburgh **VIRGINIA** Buchanan General Hospital, Grundy Carilion Giles Memorial Hospital, Pearisburg Carilion Medical Center for Children, Roanoke Community Hospital Carilion New River Valley Medical Center, Christiansburg Clinch Valley Medical Center, Richlands Columbia Allegheny Regional Hospital, Low Moor	Inova Fairfax Hospital Lewis-Gale Medical Center, Salem Medical College of Virginia, Richmond Rockingham Memorial Hospital, Harrisonburg Shenandoah Memorial Hospital, Woodstock Tazewell Community Hospital University of Virginia Health Sciences Center, Charlottesville Warren Memorial Hospital, Front Royal Winchester Medical Center	**WASHINGTON, D.C.** Children's National Medical Center

APPENDIX B

PUBLIC FORMS

FORM NUMBER	FORM TITLE
DFA-NEMT-1	NEMT Application
DFA-NEMT-1A	Supplement to NEMT Application

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
APPLICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM (NEMT)

Section I: TO BE COMPLETED BY APPLICANT.
Note: This must be completed **in ink** and turned in to the local DHHR office **within 60 days of the earliest trip**.

Name: _____ Date(s) of Travel: _____

Street, Route or PO Box Number: _____

City _____ Zip Code _____ County _____

Telephone Number _____ Social Security Number _____

MA ID number from each patient's Medicaid card (this is the 11-digit number to the left of the person's name on the card):

_____

_____

Section II: APPLICANT RESPONSIBILITIES AND SIGNATURE

Please read each statement carefully and check either Yes or No.

1. ☐ Yes ☐ No — I **understand** that I may request a Fair Hearing if I am not satisfied with the decision regarding my application for non-emergency medical transportation payments (NEMT). I may also request a Fair Hearing if I feel that I have been discriminated against because of race, color, national origin, sex, age, religion, or political belief, or because I am disabled. I **further understand** that I may be represented by an attorney at a Fair Hearing, but that neither DHHR nor any of its authorized representatives will pay for the legal services.

2. ☐ Yes ☐ No — I **understand** that I may be asked to verify any or all information on this application form or to provide additional information and that failure to provide this verification or information will result in denial. I **also understand** that alterations on this form must be initialed by me or the application may be denied.

3. ☐ Yes ☐ No — I **understand** that this completed application, including all required verification, must be received by the local DHHR office no later than 60 days from the date of the trip for which I am requesting payment. I **further understand** that if the application or verification is received 61 or more days after the trip, that my application will be denied.

4. ☐ Yes ☐ No — I **understand** that I am to use the least expensive transportation available, taking into consideration my physical condition and the travel locations.

5. ☐ Yes ☐ No — I **understand** that the following expenses must be approved before the trip is taken: lodging, out-of-state transportation, double round trips on the same day and requests for an immediate family member to stay with a patient at a medical facility. Receipts for lodging must be provided with the application.

6. ☐ Yes ☐ No — I **understand** that meals are permitted for the patient and the driver of a private vehicle when overnight lodging is approved. All meals are the responsibility of the patient and driver when an overnight stay has not been approved.

7. ☐ Yes ☐ No I **understand** that waiting time charges for a taxi may be included for travel from city to city, but not within the city of taxi operation.

8. ☐ Yes ☐ No I **understand** that neither DHHR nor any of its employees is responsible for any damages from an accident which may occur during the trip for which I am requesting payment.

9. ☐ Yes ☐ No I **understand** that the Criminal Investigations Unit investigates all allegations of NEMT program abuse and, when warranted, refers such cases for prosecution under WV Code 61-3-24. I also **understand** that criminal penalties may include jail/prison sentences and/or fines. In addition, I **understand** that I may also be required to repay any benefits to which I was not entitled.

10. ☐ Yes ☐ No I **understand** that my signature means that I have read, or had someone read to me, all statements on this form and that I understand all questions. My signature also **indicates** that these expenses are not reimbursable by anyone else and that all information given is true and correct to the best of my knowledge.

Applicant's Signature _____ Date_____

Section III: VERIFICATION OF TRAVEL AND ATTENDANCE

NOTE: The following section requires signatures from the medical provider or representative and from the driver or other transportation provider. Please fill out in ink and initial any changes or corrections after striking out the information in error. Do not use correction fluid or tape. Additional trips (up to a maximum of 4) may be listed using the DFA-NEMT-1a supplemental form which must be attached to this application.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SUPPLEMENT TO APPLICATION FOR NEMT REIMBURSEMENT PROGRAM

This supplemental sheet is used with the DFA-NEMT-1 and contains space for 3 additional trips for a total of 4 per application. Application must be received by DHHR **within 60 days of the date of the first trip**.

IMPORTANT: Payment will be made to the person or company named on each verification form. If you provide your own transportation, you must enter your own name and address in this section as the Driver. If the wrong name and/or address is entered, duplicate payment will not be made. Payment cannot be processed unless the Driver's SSN or tax ID number is entered.

Mileage is reimbursed at the current state mileage reimbursement rate for the shortest round-trip route from the patient's home to the medical facility or physician's office. Lodging must be pre-approved for the most economical rate and must be verified as necessary due to the length of travel, time of appointment, and/or length of treatment. Meals are reimbursed only when lodging has been approved. Additional reimbursement may be made for tolls and parking, as appropriate.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____ Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____

The back of this sheet provides space for 2 additional trips. This form must be attached to the DFA-NEMT-1 (NEMT application form) if you are requesting reimbursement for more than one trip.

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____

VERIFICATION OF TRAVEL AND ATTENDANCE FOR NEMT

Medical Provider: Do not sign if the medical service/treatment is not billable or billed to the Medicaid Program.

For DHHR Use Only:
MA ID _____
Driver's VN _____

Patient's Name _____ SSN _____

Purpose of Visit: Routine ☐ Follow-up ☐ Walk-in ☐ Initial ☐

Name and Address of Medical Provider _____

Date of Appointment _____ Time of Appointment _____

_____ _____
Signature of Medical Provider or Authorized Representative Date

Transportation Provider: Private Vehicle ☐ Taxi ☐ Bus ☐ Plane ☐ Community Van ☐ Other ☐

_____ _____
Driver's/Carrier's Name (Please print) SSN or Tax ID

Driver's Signature _____ Date _____

Mailing address _____ Phone _____

Private Vehicle Cost: Mileage_____ Parking _____Tolls _____
Common/contract Carrier: Round-trip fare _____
Lodging: Cost per night _____ Number of nights_____
Meals: Number of persons_____ Number of meals per person_____

(Receipts must be attached for lodging, parking and common carrier fare.)

For DHHR Use Only:
Miles _____X_____=_____
Total lodging _____
Other costs _____
Total for this trip _____

42 U.S.C.

§1396a(a)(37)(A)

from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1320a–3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a–3 of this title;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practition-